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Department of Labor

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Reporting by Multiple Employer Welfare Arrangements and Certain Other Entities That Offer or Provide Coverage for Medical Care to the Employees of Two or More Employers; Interim Final Rule

The Assessment of Civil Penalties Under Section 502(c)(5) of ERISA; Interim Final Rule

Governing Procedures for Administrative Hearings Regarding the Assessment of Civil Penalties Under Section 502(c)(5) of ERISA; Interim Final Rule

DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

29 CFR Part 2520

RIN 1210–AA54

Interim Final Rule for Reporting by Multiple Employer Welfare Arrangements and Certain Other Entities That Offer or Provide Coverage for Medical Care to the Employees of Two or More Employers

AGENCY: Pension and Welfare Benefits Administration, Department of Labor.

ACTION: Interim final rule with request for comments.

SUMMARY: This document contains an interim final rule governing certain reporting requirements under Title I of the Employee Retirement Income Security Act of 1974 for multiple employer welfare arrangements (MEWAs) and certain other entities that offer or provide coverage for medical care to the employees of two or more employers. The interim final rule requires the administrator of a MEWA, or other entity, to file a form with the Secretary of Labor for the purpose of determining whether the requirements of certain recent health care laws are being met.

DATES: Effective Date: This interim final rule is effective beginning April 11, 2000.

Comment Date: Written comments concerning this interim rule are invited and must be received by the Department of Labor on or before March 13, 2000.

Compliance Dates: Compliance dates are set forth in paragraph (i) of this section. In general, this paragraph states that reports filed pursuant to this interim rule are first due by May 1, 2000.

ADDRESSES: Interested persons are invited to submit written comments (preferably with three copies) to: Pension and Welfare Benefits Administration, Room C–5331, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. Attention: MEWA reporting. Written comments may also be sent by Internet to the following address: MEWArpt@pwba.dol.gov.

All submissions will be open to public inspection and copying from 8:30 a.m. to 4:30 p.m. in the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N–5638, 200 Constitution Avenue, NW., Washington, DC 20210.

FOR FURTHER INFORMATION CONTACT: Amy J. Turner, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room C–5331, 200 Constitution Avenue, NW., Washington, DC 20210 (telephone (202) 219–7006). This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

A. Background

The Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA), was enacted on August 21, 1996. HIPAA amended the Employee Retirement Income Security Act of 1974 (ERISA or the Act) to provide for, among other things, improved portability and continuity of health insurance coverage. The Mental Health Parity Act of 1996 (Pub. L. 104–204) (MHPA), was enacted on September 26, 1996. MHPA amended ERISA to provide parity in the application of annual and lifetime dollar limits for certain mental health benefits with such dollar limits on medical and surgical benefits. The Newborns' and Mothers' Health Protection Act of 1996 (Pub. L. 104–204) (Newborns' Act) also was enacted on September 26, 1996. The Newborns' Act amended ERISA to provide new protections for mothers and their newborn children with regard to the length of hospital stays in connection with childbirth. The Women's Health and Cancer Rights Act of 1998 (WHCRA) (Pub. L. 105–277) was enacted on October 21, 1998. WHCRA amended ERISA to provide individuals new rights for reconstructive surgery in connection with a mastectomy. All of the foregoing provisions are set forth in Part 7 of Subtitle B of Title I of ERISA.[1] Section 734 of ERISA authorizes the Secretary to promulgate regulations as may be necessary or appropriate to carry out the provisions of Part 7 and to promulgate any interim final rules as the Secretary determines are appropriate to carry out Part 7.

HIPAA added a new section 101(g){h} to ERISA.[2] This section provides that:

the Secretary [of Labor] may, by regulation, require *multiple employer welfare arrangements* providing benefits consisting of medical care (within the meaning of section 733(a)(2))[3] which are not group health plans[4] to report, not more frequently than annually, in such form and such manner as the Secretary may require for the purpose of determining the extent to which the requirements of part 7 are being carried out in connection with such benefits. (Emphasis added.)

The term *multiple employer welfare arrangement* is defined in section 3(40) of ERISA to mean, in pertinent part:

(A) * * * an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing [welfare plan benefits] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

(i) Under or pursuant to one or more agreements which the Secretary [of Labor] finds to be collective bargaining agreements,

(ii) By a rural electric cooperative, or

(iii) By a rural telephone cooperative association.

(B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

(ii) the term ''control group'' means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under ''common control'' with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in

[1] Parallel HIPAA, MHPA, and Newborns' Act provisions are also contained in Chapter 100 of Subtitle K of the Internal Revenue Code (Code) and Title XXVII of the Public Health Service Act (PHS Act). In addition, parallel WHCRA provisions are also contained in the PHS Act. Accordingly, all references to ''Part 7'' in this document include the relevant parallel provisions of the Code and the PHS Act, unless otherwise specified.

[2] Section 1421(d)(1) of the Small Business Job Protection Act of 1996 (Pub. L. 104–188) created a new section 101(g) of ERISA relating to Simple Retirement Accounts. Subsequently, section 101(e)(1) of HIPAA also created a new section 101(g) of ERISA relating to MEWA reporting. Accordingly, when referring to section 101(g) of ERISA relating to MEWA reporting, this document cites section 101(g){h} of ERISA.

[3] Section 733(a)(2) of ERISA defines *medical care* to mean:

''amounts paid for—

(A) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) Amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) Amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).''

[4] Section 733(a) of ERISA defines a *group health plan* to mean ''an *employee welfare benefit plan* to the extent that the plan provides medical care * * * to employees or their dependents * * * directly or through insurance, reimbursement, or otherwise.'' (Emphasis added.)

Section 3(1) of ERISA defines *an employee welfare benefit plan* to mean, in pertinent part:

Any plan, fund, or program * * * established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * 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. * * *''

determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent. * * * [5]

The purpose of this regulation is to provide the Department with information concerning compliance by MEWAs with the requirements of Part 7. In determining how best to obtain this information, the Department considered a number of alternatives, including requiring reporting only by MEWAs that are not ERISA-covered group health plans as described in section 101(g){h} of ERISA. For a number of reasons, explained more fully in the Economic Analysis section of this document, the Department determined that it was necessary to exercise various other regulatory authority in Title I of ERISA (see ''Statutory Authority'' section, below) to require annual reports from MEWAs that are group health plans and from entities that claim not to be MEWAs because they are established or maintained pursuant to a collective bargaining agreement. An important reason for requiring these groups to file is that the administrator of a MEWA may incorrectly determine that it is a group health plan or that it is established or maintained pursuant to a collective bargaining agreement. A reporting requirement limited only to MEWAs that are not group health plans may not result in reporting by many such MEWAs, thus greatly reducing the value of the data collected.

The Department also believes that imposition of the reporting requirements on MEWAs that are group health plans is appropriate to carry out the provisions of Part 7 because such reporting will provide more complete data on the MEWA universe. Such additional data will support a thorough analysis of the market segment represented by MEWAs. Information regarding compliance by MEWAs with the provisions of Part 7 is particularly important to the Department because it has been the Department's experience that compliance with ERISA by such arrangements, whether or not they claim to be group health plans, has been inconsistent. At the same time, in recent years MEWAs have become more attractive to small employers as a means to pool risks and obtain health benefits at a lower cost. The Department seeks to determine the extent of compliance with the requirements of Part 7 by this important sector of the employee health benefits market.

The Department recognizes that multiemployer plans established by an association of employers and one or more labor organizations are structurally and operationally different from most MEWAs. The Department does not seek reporting by such plans except to the extent appropriate to assure that all MEWAs file a report. The Department is aware that administrators of some MEWAs have sought to avoid State insurance regulation by mischaracterizing their arrangements as being established or maintained pursuant to collective bargaining agreements. In many cases, such mischaracterized entities are not operated in a financially responsible manner and become unable to pay benefits within a short time. *See* GAO/HRD–92–40. Therefore, in order to obtain information on all entities that are MEWAs, the Department has determined that it is appropriate to require reporting by entities that claim the collective bargaining exception unless the entity has been in existence for at least three years.

B. Overview of the Interim Rule

Basis and Scope

Paragraph (a) of the interim rule sets forth the basis and scope for this annual reporting requirement for MEWAs and certain other entities (referred to as Entities Claiming Exception or ECEs) that offer or provide coverage for medical care to the employees of two or more employers (including one or more self-employed individuals).

Definitions

Paragraph (b) of the interim rule provides most of the definitions used in the interim rule. This definitions section includes both statutory definitions provided in ERISA, as amended by HIPAA, as well as certain other definitions used in the regulations. In particular, the terms ''group health plan,'' ''health insurance issuer,'' ''medical care,'' and ''MEWA'' are defined by reference to existing statutory and regulatory provisions. In addition, the term ''administrator'' is defined as the person specifically designated as the administrator by the terms of the instrument under which the MEWA or ECE is operated. However, if an administrator is not designated and the MEWA or ECE is a group health plan, the plan sponsor [6] is the administrator. Moreover, if an administrator is not designated and a plan sponsor cannot be identified, the administrator is the person or persons actually responsible (whether or not so designated under the terms of the instrument under which the MEWA or ECE is operated) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent or trustee designated by such person or persons.[7]

The term ''entity claiming exception'' or ''ECE'' is defined as an entity that claims it is not a MEWA due to the exception in section 3(40)(A)(i) of the Act. In general, this exception is for entities that are established or maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements. In connection with this exception, on August 1, 1995, the Department published a proposed rule for plans established or maintained pursuant to collective bargaining agreements under section 3(40)(A)(i) of ERISA. 60 FR 39208. Subsequently, in September of 1998, the Secretary established the ERISA Section 3(40) Negotiated Rulemaking Advisory Committee. *See* 63 FR 50542. This Committee has negotiated a proposed rule establishing a process and criteria for a finding by the Secretary of Labor that an agreement is a collective bargaining agreement for purposes of section 3(40)(A)(i) of ERISA. Upon issuance of a final regulation relating to ERISA section 3(40)(A)(i), this regulation may be modified to reflect the scope of this exception.

Finally, the term ''origination'' is defined to mean the occurrence of any

[5] This provision was added to ERISA by the Multiple Employer Welfare Arrangement Act of 1983, Sec. 302(b), Pub. L. 97–473, 96 Stat. 2611, 2612 (29 U.S.C. 1002(40)), which also amended section 514(b) of ERISA. Section 514(a) of ERISA provides that State laws that relate to employee benefit plans are generally preempted by ERISA. Section 514(b) sets forth several exceptions to the general rule of section 514(a) and subjects employee benefit plans that are MEWAs to various levels of State regulation depending on whether the MEWA is fully insured. Sec. 302(b), Pub. L. 97–473, 96 Stat. 2611, 2613 (29 U.S.C. 1144(b)(6)).

[6] The term *plan sponsor* is defined under section 3(16)(B) of ERISA as:

(i) The employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

[7] In these circumstances, the Department has previously expressed its view that the person or persons with such responsibility is the administrator for purposes of section 3(16) of ERISA. *See* Advisory Opinion Letter 83–43 to Robert J. Tanguay, August 23, 1983.

of the following events (and a MEWA or ECE will be considered to have been ''originated'' when any of these events occur):

(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals);

(2) The MEWA or ECE begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals) after a merger with another MEWA or ECE (unless all MEWAs or ECEs participating in the merger were last originated at least 3 years before the merger); or

(3) The number of employees receiving coverage for medical care under the MEWA or ECE is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless such increase is due to a merger with another MEWA or ECE and all MEWAs and ECEs that participated in the merger were last originated at least three years before the merger).

Whether a merger triggering a filing occurs is determined based on all the relevant facts and circumstances. However, in general, the addition of a new contributing employer to a MEWA or ECE would not constitute a merger that would trigger a filing. In addition, generally no merger triggering a filing occurs when participants represented by a local union that joins an existing MEWA or ECE begin receiving coverage under the MEWA or ECE.

Persons Required To Report

Paragraph (c) of the interim rule sets forth the persons required to report under the interim rule. First, the administrator of a MEWA that provides benefits consisting of medical care is required to report, whether or not the MEWA is a group health plan. For the reasons discussed above, the Department determined that it was necessary and appropriate to exercise various other regulatory authority in Title I of ERISA (see Statutory Authority, below) to require all MEWAs to report, regardless of whether they are group health plans. In addition, the administrator of an ECE is required to file if the ECE was originated at any time within 3 years before the annual filing due date. (This due date is described in paragraph (e)(2)(i) of the interim rule).

However, because a health insurance issuer, such as an insurance company, fits within the statutory definition of a MEWA, paragraph (c)(2) of the interim rule clarifies that nothing in the interim rule is to be construed to require reporting by the administrator of a MEWA or ECE if the MEWA or ECE is licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees.

Accordingly, subject to the exception described above for health insurance issuers, the administrator of a MEWA is required to file annually. By contrast, the administrator of an ECE is only required to file annually for the first three years following an origination. Under the interim rule, whether or not an entity is a MEWA or ECE is determined by the administrator acting in good faith. Therefore, if an administrator makes a good faith determination at the time that a filing would otherwise be due that the entity is maintained pursuant to one or more collective bargaining agreements, the entity is an ECE, and the ECE would not be required to file because its most recent origination was more than three years ago, then a filing is not required. Even if the entity is later determined to be a MEWA (for example, pursuant to regulations developed by the ERISA Section 3(40) Negotiated Rulemaking Advisory Committee), filings would not be required prior to the determination that the entity is a MEWA if at the time the filings were due, the administrator made a good faith determination that the entity was an ECE. However, filings would be required for years after the determination that the entity is a MEWA.

This interim rule further provides that, while an administrator's good faith determination that an entity is an ECE may eliminate the requirement that the administrator of the entity file under this section for more than three years after the entity's origination date, the administrator's determination, nonetheless, does not affect the applicability of State law to the entity. Accordingly, incorrectly claiming the exception may eliminate the need to file under this section, if the exception is claimed in good faith. However, the claiming of the exception for ECEs under this filing requirement does not preclude States from applying State law to an entity that is later determined to be a MEWA. This is because the filing, or the failure to file, under this section does not in any way affect the application of State law to a MEWA.

Information To Be Reported.

Paragraph (d) of the interim rule describes the information required to be filed under this interim rule. Specifically, the administrator is required to file a completed copy of the Form M–1.[8] The substance of this form is published at the end of this document.

Also under paragraph (d), the Secretary may reject any filing that the Secretary determines to be incomplete, in accordance with § 2560.502c–5 (published separately in this issue of the **Federal Register**). If the Secretary rejects a filing as incomplete and if the administrator fails to submit a revised filing within 45 days of the rejection, paragraph (c) provides that the administrator may be subject to a civil action for legal and equitable relief, including civil penalties of up to $1,000 per day under section 502(c)(5) of ERISA as amended by HIPAA. (*See* § 2560.502c–5, published separately in this issue of the **Federal Register** for interim rules governing the assessment of civil penalties under section 502(c)(5) of ERISA.)

Timing

Paragraph (e) of the interim rule describes the timing rules applicable to a filing. Generally, a ''year to be reported'' is any calendar year in which the entity offered coverage. For an annual filing, the Form M–1 is generally required to be filed by the March 1 following any ''year to be reported'' (unless March 1 is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the next business day). For the year 1999 ''year to be reported,'' however, a transition rule makes clear that a completed copy of the Form M–1 is required to be filed no later than May 1, 2000.

There is, under paragraph (e)(2)(iii), an additional, special filing requirement when a MEWA or ECE is originated. Under this special rule, in general, the administrator of a newly originated MEWA or ECE is required to file a completed copy of a Form M–1 within 90 days of the origination date (unless 90 days after the origination date is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the next business day). (This report is referred to as a 90-Day Origination Report.) However, this special rule does not apply if the origination occurred between October 1 and December 31. Thus, for example, if a MEWA is originated on November 1, 2000, the administrator of the MEWA is not required to file an origination report in February of 2001. Instead, in the year 2001, the administrator is required to

[8] Section 505 of ERISA authorizes the Secretary to ''prescribe such regulations as he finds necessary or appropriate to carry out the provisions of [Title I of ERISA]. Among other things, such regulations may * * * prescribe forms * * * ''

file only the annual report due March 1, 2001.

In addition, the interim rule provides that no 90-day origination reports are required before May 1, 2000. Therefore, for an entity that is originated, for example, on January 1, 2000, no 90-day origination report is required. Nonetheless, for an entity originated, for example, on April 1, 2000, a 90-day origination report is required to be completed and filed no later than June 30, 2000.

In any event, under paragraph (e)(2)(iv), an extension may be granted for filing reports if the administrator complies with the extension procedure prescribed in the Instructions to the Form M–1.

Filing Address

Paragraph (f) provides that the address to be used for filings is set forth in the Instructions to the Form M–1.

Civil Penalties and Procedures; Transition Rule Creating Good Faith Safe Harbor Period

Paragraph (g) contains a cross-reference for civil penalties and procedures. The penalty and procedure regulations are being published separately in this issue of the **Federal Register**.[9] These regulations, and the instructions to the Form M–1 (also being published at the end of this document, make clear that the Department does not intend to assess penalties in cases where there has been a good faith effort to comply with a filing due in the year 2000. During this first year in particular, the Department is focused on educating administrators about this filing requirement and is committed to working with them to help them comply. In this regard, the Department has developed filers' guides which may be helpful in filing the Form M–1. These filers' guides will be made available on the Pension and Welfare Benefits Administration's website at www.dol.gov/dol/pwba and through their toll-free publication hotline at 1–800–998–7542. Also, the Pension and Welfare Benefits Administration's help desk (202–219–8818) is available in case administrators have questions or if they need any assistance in completing the Form M–1.

Compliance Dates

Paragraph (i) provides that reports filed pursuant to this reporting requirement are first due by May 1, 2000. (Therefore, on May 1, 2000, filings are due with respect to MEWAs or ECEs that provided coverage in calendar year 1999.) However, no 90-Day Origination Reports (described in paragraph (e)(2)(ii) of this section) are due before May 1, 2000. Therefore, for an entity that is originated, for example, on January 1, 2000, no 90-day origination report is required. Nonetheless, for an entity originated, for example, on April 1, 2000, a 90-day origination report is required to be completed and filed no later than June 30, 2000.

C. Interim Rule with Request for Comments

The principal purpose of these regulations is to determine the extent of compliance by MEWAs with part 7 of ERISA. ERISA Section 734 authorizes the Secretary to issue ''any interim final rules as the Secretary deems are appropriate to carry out the provisions of [Part 7].'' Thus, the authority in ERISA section 734 to issue interim regulations applies to this rule. As explained below, the Secretary has determined that this regulation should be issued as an interim final rule with requests for comments.

Part 7 was enacted as part of the Health Insurance Portability and Accountability Act of 1996. To implement certain requirements of part 7, the Secretary promulgated interim final regulations in April, 1997. During the period following promulgation of the April, 1997 regulations, the Department carried out an extensive educational campaign to assist all sectors of the regulated community to learn to apply the new requirements and received numerous comments on these regulations.

The Department decided not to promulgate the instant regulations during this period of adapting to the new requirements. Now that the regulated community has had more than two years to become familiar with the part 7 requirements, it is now appropriate, in the Secretary's view, that the instant regulations become effective, on an interim basis, as quickly as possible.

The Secretary believes that a period of interim effectiveness will provide a sound basis for developing a final rule. The Department is seeking comments from all those affected by these regulations and the Department will consider such comments, and will reevaluate these regulations following the comment period in the same way that it would if the regulation had been published as a non-final proposal. Based on such comments and other information obtained through the operation of this interim reporting requirement, the Department will make any necessary modifications to the reporting requirement when the regulation is issued in final.

The Secretary believes that the purpose of the MEWA reporting requirement will be best served if these rules are made effective as quickly as possible, now that the regulated community has had time to familiarize itself with part 7 and the substantive interim regulations. Registration of MEWAs was first recommended in a 1992 Government Accounting Office Report (GAO/HRD–92–40). The problems pointed out in that report continue to this day. To date, the Department has initiated approximately 358 civil and 70 criminal investigations (with 45 criminal convictions) affecting over 1.2 million participants and beneficiaries and involving over $83.6 million in unpaid claims. During each of the past 3 years, the Department has had an average of about 100 MEWA cases under active investigation. Thus, the identification of problem MEWAs and correction of violations remains an important investigative priority and consumes substantial resources.

Obtaining reimbursement for such losses is the greatest challenge the Department faces in pursuing these cases. Too often, when the Department discovers an unsound MEWA, it has already failed and there is no money to cover the participants' unpaid medical claims. In such cases discovered by the Department, where there has been a failure to pay claims, over 90% of the claims are likely to remain unpaid, unless the Department is able to intervene at an early stage of the problem. When the MEWA becomes unable to pay the health benefits it has promised, employees, employers and health care providers may suffer serious financial losses. The reporting requirements of these interim regulations are designed to allow earlier detection of unsound MEWAs and will reduce the risk of financial harm to these parties.

Economic Analysis Under Executive Order 12866

Under Executive Order 12866, the Department must determine whether a regulatory action is ''significant'' and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f) of the Executive Order, a ''significant regulatory action'' is an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition,

[9] Moreover, other relevant criminal penalties may apply. *See, e.g.,* 18 U.S.C. 1021 and 1035.

jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. OMB has determined that this action is significant under section 3(f)(4) because it raises novel legal or policy issues arising from the President's priorities.

The total cost of this interim final rule is estimated at $437,000 per year, or an average of approximately $163 for each of the 2,678 entities expected to be required to file the annual reporting form for MEWAs. HIPAA amended ERISA to add section 101(g){h}, which authorizes the Secretary of Labor to require reporting by MEWAs which are not group health plans for the purpose of determining the extent of their compliance with Part 7 of ERISA. The principal intent of Congress in enacting this provision was to ensure that all participants and beneficiaries of such arrangements receive the new health care protections incorporated into ERISA by HIPAA, MHPA, the Newborns' Act, and WHCRA.

The reporting requirement implemented by this interim final rule provides the most cost effective means of facilitating compliance with Part 7, as well as with the full range of other federal and State requirements that may apply to MEWAs under ERISA, the Internal Revenue Code, the Public Health Service Act, and State insurance statutes. The data collected as a result of the filing requirement will serve as the only source of uniform and complete information identifying these arrangements that will allow federal and State regulators to evaluate their compliance with all applicable requirements. Evaluations of compliance based on the information reported will be significantly more cost effective for both governmental entities and MEWAs than the alternative of active intervention by compliance examiners.

Increased compliance by these arrangements will be beneficial to participants and beneficiaries who are able to fully realize their rights under these new laws. A greater assurance of compliance by these arrangements will also be beneficial because, due at least in part to the interaction of federal and State requirements, their compliance with the various requirements which apply to them has been shown to be inconsistent. Although the provisions of Title I and IV of ERISA generally supercede State laws that relate to employee benefit plans, the regulation of MEWAs is a joint federal and State responsibility pursuant to ERISA section 514(b)(6). Section 514(b)(6) of ERISA provides, among other things, that State laws that regulate insurance may apply to fully insured MEWAs to the extent that these laws establish rating, solvency, and similar standards, and to other MEWAs to the extent that State insurance laws are not inconsistent with Sections 1 through 513 of ERISA. Knowledge of both federal and State requirements is therefore needed for an arrangement to make an appropriate determination concerning the requirements that apply to it.

Because State insurance statutes are not uniform, an arrangement doing business in more than one State may be required to comply with a range of States' varying requirements. Other legal and factual issues, such as whether an entity is established pursuant to a collective bargaining agreement or whether an arrangement for a staff leasing organization is maintained by more than one employer, may contribute to uncertainty about applicability of regulatory requirements. Identification of these entities and determination of the applicability of State insurance law through this reporting requirement will help ensure that administrators of these arrangements are aware of the requirements that apply, and that the protections intended to be provided under federal and State laws are actually implemented for the benefit of employers and participants who obtain their group health coverage through these arrangements.

Substantial ancillary benefits are expected to result from the public disclosure of this data. Participants with greater access to information about the arrangements through which they obtain group health coverage may better exercise their rights in the event of a dispute with the arrangement. The data collected will also enhance the capability to conduct analysis of the market segment represented by MEWAs, which will be useful to policy makers in evaluating the role of these entities in providing employment-based health benefits. The potential benefits of this interim final rule are, therefore, expected to outweigh its costs.

Paperwork Reduction Act

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3506(c)(2)(A)). This helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed.

Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the information collection request (ICR) included in this interim final rule, which would require reporting by MEWAs and certain other entities on a prescribed form. Respondents are not required to comply with the ICR incorporated in the form unless it displays a currently valid OMB control number. A copy of the ICR may be obtained by contacting the office of the Pension and Welfare Benefits Administration listed below.

The Department has submitted the ICR included in this interim final rule, using emergency review procedures, to OMB for review and clearance in accordance with PRA 95. OMB approval has been requested by February 28, 2000. The Department and OMB are particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.*, permitting electronic submission of responses.

Comments regarding the ICR should be sent to the Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235,

New Executive Office Building, Washington, DC 20503; Attention: Desk Officer for the Pension and Welfare Benefits Administration. Although comments may be submitted through April 11, 2000, OMB requests that comments be received within 30 days of publication of this interim final rule to ensure their consideration.

Address requests for copies of the ICR to Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, NW, Room N–5647, Washington, D.C. 20210. Telephone: (202) 219–4782; Fax: (202) 219–4745. These are not toll-free numbers.

The ICR implemented with this interim final rule will require administrators of MEWAs, as defined in section 3(40) of ERISA, and certain other multiple employer arrangements that seek to utilize the exception described in section 3(40)(A)(i) of ERISA (referred to in the interim final rule as ''Entities Claiming Exception'' (ECEs)), to file certain information with the Secretary of Labor. This filing is generally required to be made annually by March 1 for the calendar year just ended. In addition, expedited filing is required following origination of an entity required to file. However, an ECE is required to file for only the first three years following its origination. A form has been prescribed for this filing, the substance of which is published at the end of this document.

The information to be filed includes basic identifying information (names and addresses, telephone numbers, employer identification numbers), and the date of origination of the arrangement. The filer will also be required to identify the States in which the arrangement provides coverage, whether it is licensed as an insurer or otherwise authorized to operate in those States (with the corresponding license or registration numbers), and whether the arrangement, if not licensed, is fully insured by a health insurance issuer in each State. The filer must also state the number of participants in the arrangement and the number of States in which at least 20 percent of the arrangement's business (based on number of participants) is conducted.

The form poses specific questions concerning compliance with Part 7 of ERISA, including yes/no questions about litigation involving Part 7 of ERISA or corresponding provisions of the Internal Revenue Code or Public Health Service Act (with specific additional information to be provided, if there was litigation), and about compliance with provisions of Part 7 and implementing regulations with respect to HIPAA, MHPA, Newborns' Act, and WHCRA. The form must also be signed and dated.

Detailed instructions are supplied with the form, as are compliance worksheets, which are intended to provide filers with convenient summaries of the requirements of the HIPAA, MHPA, Newborns' Act, and WHCRA provisions of Part 7 of ERISA, and references to the statutory requirements. These worksheets are not required to be filed.

The information collected in connection with this filing requirement will be useful to the Department, other federal agencies, and the States, in determining the extent of compliance by MEWAs and ECEs with Part 7 of ERISA and parallel provisions of the Internal Revenue Code and the Public Health Service Act.

The information will be useful to federal and State authorities with oversight responsibilities for these arrangements, and to the public for a variety of reasons. The enforcement activities of the Department and the States have shown that, due at least in part to the complex interaction of State and federal regulatory requirements for multiple employer arrangements providing group health coverage, compliance with all the applicable State and federal rules has been inconsistent. For example, the March, 1992 General Accounting Office (GAO) Report entitled, ''EMPLOYEE BENEFITS—States Need Labor's Help Regulating Multiple Employer Welfare Arrangements'' (GAO/HRD–92–40) states that ''MEWAs have proven to be a source of regulatory confusion, enforcement problems, and in some instances, fraud.'' This is supported by results of GAO's 1991 survey in which 46 States reported non-compliance by MEWAs with applicable reporting, disclosure, funding, licensing and registration requirements.

MEWAs doing business in several States may be required to comply with licensing and solvency requirements of each State, which often differ significantly. Although ERISA was amended in 1983 to clarify the role of the States in the regulation of MEWAs [10] these arrangements must still make judgments with respect to a number of relatively complex legal and factual issues in order to determine which requirements are applicable. The absence of uniform information as to the identity and location of these entities often prevents both federal and State regulators from taking a proactive approach to ensuring compliance by these arrangements with the full range of requirements imposed upon them.

Although MEWAs which are group health plans under ERISA, and multiemployer group health plans established pursuant to a collective bargaining agreement are generally required to file Form 5500 in accordance with ERISA sections 101(b) and 104(a), these entities will also be required to file the annual report for MEWAs under this interim final rule. This is in part because Form 5500 does not require duplicate reporting with respect to compliance with Part 7. An important reason for requiring these groups to file is to collect uniform information on MEWAs that does not rely on the arrangements' assessments of their status as group health plans or their entitlement to claim an exception based on the existence of a collective bargaining agreement. Arrangements which might mischaracterize themselves as group health plans under ERISA or as multiemployer collectively bargained plans (and thus not MEWAs), or in any number of other ways, would otherwise be omitted from the data that would be available to the Department and the States to assess compliance by these arrangements. At the same time, the Department did not wish to require reporting by well established multiemployer plans that have been in operation for several years. As noted earlier, this interim final rule may be modified in the future if changes are needed as a result of the issuance of further guidance with respect to establishing criteria and a process for a finding by the Secretary that an agreement is a collective bargaining agreement for purposes of section 3(40)(A)(i) of ERISA. [11] At present, however, the Department considers it important to obtain complete data on all entities which may be considered MEWAs, including newly originated multiemployer collectively bargained group health plans in their first years of operation.

An ancillary benefit of the availability of complete data on the multiple employer health plan universe will be a significantly enhanced capability to conduct more thorough analysis of the market segment represented by MEWAs. Risk pooling by groups of employers has been considered to offer potential advantages in the purchase of health care coverage by small employers. Timely and complete information on these entities will be of significant utility in evaluating the effectiveness of existing arrangements in providing

[10] *See* note 5.

[11] *See* note 6.

employment-based health benefits. Greater access to information for participants may assist them in exercising their rights under these arrangements in the event of a dispute.

Estimates of the burdens associated with this filing requirement are based on the number of annual filers and the time assumed to be required to complete the form.

The Filer Universe

The entities that will be required to file the annual reporting form will include multiemployer collectively bargained group health plans (entities claiming exception, or ECEs) originated within three years of the filing date, MEWAs which are group health plans under ERISA, and MEWAs which are not group health plans under ERISA. A description of the Department's methods of estimating the number and characteristics of filers in each group follows.

Multiemployer Collectively Bargained Plans

These plans are generally required to file Form 5500, and as such, information is available concerning the number of such plans originated from year to year. For the purpose of estimating the number of potential filers, the Department reviewed the data collected from Form 5500 filings for the 1991 through 1995 plan years for collectively bargained multiemployer welfare plans which provided medical benefits. A period of longer than three years was examined in order to determine whether the numbers were reasonably consistent from year to year, and whether the data indicated a trend over this period. Individual records in this group were examined and adjusted for the purpose of this count for possible errors in filers' characterization of their filing entity (which is selected from a number of codes in the Form 5500 instructions). The resulting number of such plans originated since 1991 was 41, which amounts to an average of about 8 plans per year. The number of participants in those 41 plans was 78,702. This represents about 2% of the total of all multiemployer collectively bargained group health plan filers in 1995 (2,180 plans with 5,957,946 participants).

Examination of origination in each individual year shows that the number of plans established was reasonably similar from year to year. The Department considers a reasonable estimate of the number of new plans that are originated each year is 12, which is the greatest number originated in any single year during the period examined. This would result in approximately 36 filers in this category for each annual filing cycle, assuming that 12 plans are originated each year, and 12 plans will no longer be required to file the form. The average number of participants per plan in the 41 plans originated since 1990 was 1,900, while the greatest average number per plan in a single year was 3,200. Based on these averages, it could be assumed that participation would total between 23,000 and 38,000 for the 12 plans assumed to originate in any year. For purposes of estimating the number of participants in the affected plans in this category, a midpoint of 30,600 per year (2,550 participants per plan) for the 12 new plans, and 91,800 for all 36 filers has been used.

Certain characteristics of this group may also be estimated, based on the characteristics of both the 1995 filers originated since 1990 and all 1995 multiemployer health plan filers. In both groups, no more than 11 percent of plans had fewer than 100 participants, while less than 1 percent of total participants were covered by plans with fewer than 100 participants.

The methods of funding indicated by the filers on Form 5500 differ somewhat between the groups. The funding method categories are defined in the Form 5500 instructions. ''Trust only'' is generally used interchangeably with the more commonly understood terms ''self-funded'' or ''self-insured.'' ''Insured'' is considered to mean fully insured. Where ''Trust and Insurance'' is indicated, it is generally not possible to determine without examination of individual records whether the plan is essentially self-funded with stop-loss insurance, or whether the plan is entirely self-funded except to the extent that it includes specific insured benefits such as life or long term disability insurance. Consequently, this category will include a range of funding methods. For purposes of estimates of the burden of the filing requirement, a distinction is made between fully insured arrangements and all other arrangements. While estimates of the number of fully self-funded arrangements may also be of interest, only fully insured arrangements are segregated for purposes of estimates ultimately developed, due to a difference in form completion time for these entities.

The plan funding methods reported on Form 5500 for the 2,180 multiemployer collectively bargained group health plans (with 5,957,946 participants) filing in 1995 were compared with those for the 41 multiemployer collectively bargained group health plans (with 78,702 participants) established since 1990. The comparison showed that about 63 percent of the 41 plans, and 51 percent of the 2,180 plans reported being fully self-funded. Between 2 and 4 percent of both groups of plans reported being fully insured. The remainder (24 percent of the 41 plans, and 41 percent of the 2,180 plans reported funding through a combination of insurance and self-funding. It is assumed that the newly originated multiemployer collectively bargained group health plans will more closely resemble the group of 41 plans originated since 1990.

Multiple Employer Welfare Arrangements Which Are Group Health Plans Under ERISA

The number of filers in this category may be estimated in a manner similar to that used for estimating the ECE count. In general, most ERISA-covered welfare plans which provide medical benefits are required under the statute and regulations to file a Form 5500 annually unless the plan covers fewer than 100 participants and is either unfunded or fully insured. While data from Form 5500 filings will not include information on small plans due to this exemption from filing requirements, multiple employer plans are considered less likely to be excluded on this basis because the affiliation of at least two employers for the formation of a plan increases the likelihood that participation will exceed 100. However, because plans with fewer than 100 participants will be required to file the annual report for MEWAs, an adjustment would need to be made to account for the excluded plans.

Data from Form 5500 filings for 1995 plan years were reviewed with respect to plans indicating they provided medical benefits that were designated as multiemployer collectively bargained plans, multiple employer non-collectively bargained plans, and group insurance arrangements. Because the Department has been made aware of some multiple employer plan filers' uncertainty as to the appropriate entry for this element of the form, the source data in these categories were also examined. While it is not possible to determine the nature of a filing entity with certainty without reference to the facts and circumstances related to its establishment, a number of plans appeared to have been coded in such a way as to limit the usefulness of this data for the purpose of estimating the number of potential filers. For purposes of this estimate, therefore, entity codes were adjusted where a more appropriate choice was apparent. The resulting data, after exclusion of plans that appeared to

be single employer plans or collectively bargained plans, and inclusion of plans originally categorized as group insurance arrangements, were summarized to arrive at the initial estimate of the number and characteristics of filers. On this basis (and without yet adjusting for small plans exempted from Form 5500 filing requirements), 642 plans in this category covering approximately 1,913,000 participants would be expected to file the MEWA annual reporting form. The average number of participants per plan among this group is approximately 3,000. About 14 percent of these plans report self-funding only, while 31 percent report being fully insured. About 49 percent of these plans report a combination of insurance and self-funding.

Although the number of MEWA report filers which are multiple employer group health plans could be estimated by adjusting the number of Form 5500 filers to allow for plans exempted from Form 5500 filing requirements, the Department is unaware of an appropriate basis for such an adjustment. Instead, these exempt filers have been estimated in conjunction with the estimate of MEWA report filers which are not employee benefit plans under ERISA, as explained below.

Multiple Employer Welfare Arrangements Which Are Not Group Health Plans Under ERISA

The potential number of filers in this category is significantly more difficult to estimate because there is no single source of data on such arrangements. The Department therefore relied on three different data sources to develop an estimate of the number of potential filers. Data reported in the previously cited March, 1992 GAO report (GAO/HRD–92–40) were collected in GAO's survey of State insurance officials conducted in 1991. These data showed 1,034 MEWAs which were headquartered in the State in which the information was collected, and 2,213 MEWAs operating in States in which they were not headquartered.[12] Of the 1,034 MEWAs, 264 (25.5 percent) were characterized as ''fully insured'' and 770 (74.5 percent) were ''not fully insured.'' It was also reported that there were 2,581,438 participants and beneficiaries covered by the 1,034 MEWAs in the respondent States.

The figures may be somewhat understated due to the lack of survey data from a number of large States which reported data for another aspect of the survey indicating that participants has sustained losses as a result of MEWAs' failure to pay claims in the State. The number of these entities may also be expected to have changed during the period since the survey due to small group reforms in the States, the enactment of HIPAA, and a period of relative stability in health care costs that generally reduces economic pressures on employers seeking affordable coverage. It is generally believed that these factors have served to reduce the number of entities that obtain group health coverage through risk pooling arrangements such as MEWAs.

Furthermore, it is unclear whether the survey respondents would have distinguished between MEWAs which are group health plans and those which are not group health plans. Consequently, it is not possible to determine whether the number of MEWAs headquartered in the States may overlap to any degree with the estimate of the number of MEWAs which are ERISA-covered plans. The Department contacted the National Association of Insurance Commissioners and certain State representatives to whom it was subsequently referred to determine whether comparable and more current data were available, and concluded on the basis of these contacts that while several States might maintain certain current data elements, no comparable data set is available to support the updating or refinement of the GAO estimates.

Other more recent sources may serve to shed light on the usefulness of the GAO data in developing a current estimate of potential non-ERISA plan MEWA filers. The Department examined reports published by W.F. Morneau & Associates and the American Society of Association Executives[13] (ASAE) concerning membership surveys conducted in 1992 and 1997. The survey respondents were those associations which reported sponsoring health care plans for their members. The respondents would apparently include sponsors of plans covered by ERISA as well as arrangements not covered by ERISA. Respondents also included professional/individual associations, which would not typically be sponsors of ERISA-covered plans due to lack of an employment basis. Coverage sponsored by these types of associations may, however, be considered non-plan MEWAs based on the facts and circumstances surrounding the establishment and maintenance of the arrangement. The report also states that because the response rate to the 1997 survey was somewhat low (974 of 7,169 surveys distributed were returned), it would be conservative to assume that the survey represents no more than 50 percent of the total number of association health plans. On the basis of the 283 plans reported, then, it could be assumed that the number of association sponsored plans could be estimated at 566. The 1992 data were somewhat different, with 2,648 responses to 6,341 surveys distributed, resulting in 799 association sponsored plans being reported. However, the report on the 1997 survey offers many reasons for a decline in the number of plans sponsored, which supports the credibility of the observed decrease.

A different approach may also be taken to estimating the number of non-respondents which sponsor health plans, which results in a somewhat larger estimate of association plans. If it is assumed that the rate of sponsorship of plans among non-respondents is one-half the rate of sponsorship among respondents, it may be estimated that there are approximately 1,200 association sponsored plans. As noted, this estimate would likely include arrangements that would be considered to be plans under ERISA, as well as those that would not. This estimate would also include both trade/corporate association plans and professional/individual association plans. Other data presented in the Morneau/ASAE report indicate that 66 percent of association health plans are sponsored by trade/corporate associations. While this would tend to support reducing the estimate of association plans which might file the annual reporting form, the degree of imprecision already introduced may not support further refinement of this estimate.

If it is assumed, then, that there are 1,200 association plans to be considered among the universe of potential filers, an assumption concerning the funding mechanisms used is also needed. Assuming 75 percent of these plans are fully insured, as indicated by the 1997 report, 900 plans would be fully insured and 300 would not be fully insured.

Findings of an analysis conducted by the RAND Corporation of data from the 1997 Robert Wood Johnson Foundation

[12] According to GAO, comparison of these totals may give an indication of the number of MEWAs operating across State lines. GAO indicates that the numbers should not be added, because MEWAs operating in more than one State may have been counted in each State of operation.

[13] ''Survey of Association Member Health Plans,'' W.F. Morneau & Associates/ American Society of Association Executives, 1993 and 1997.

Employer Health Insurance Survey [14] offer another basis for the development of an estimate of the number of MEWAs. The findings address the prevalence of pooled purchasing among employer health plans through analysis of survey respondents' assessments of whether their establishment purchases insurance through (1) a purchasing cooperative or alliance, (2) a business coalition, (3) a multiple employer trust (MET) or multiple employer welfare arrangement (MEWA), or (4) a trade or professional association or other membership organization. The report concludes that about 25 percent of establishments participate in pooled purchasing in at least one of the forms described.

The survey data as weighted for purposes of the analysis indicate that a total of 394,000 establishments covering 5.7 million employees report offering insurance through a MEWA/MET or a trade association/membership organization. This includes 118,000 establishments which were pooled through a MEWA/MET and 276,000 establishments pooled through a trade association or membership organization. Employees reported to be covered through a MEWA/MET total 3.3 million, while those reported as covered through an association or membership organization total 2.4 million.

The MEWA/MET and trade association/membership association categories appear to include many of the arrangements that would be required to file the MEWA annual reporting form, including collectively bargained arrangements, without regard to whether the arrangement constitutes a plan for purposes of ERISA. It is also likely that potential filers will be found among the establishments reporting purchase through a purchasing alliance or business coalition. The total number of establishments which report purchasing through pooled purchasing arrangements, including business coalitions and purchasing alliances, but excluding known purchasing alliances, is 836,000. Employees of these establishments number 12 million. Known purchasing alliances are excluded because these are not considered likely to be MEWAs. Because these data are collected and presented on an establishment rather than plan basis, other adjustments are required in order to compare them with data reported in other sources.

One possible approach to imputing a estimated number of different arrangements from the employee counts reported in the pooled arrangements would be to simply divide the number of employees by the average number of participants in the multiple employer group health plans which file Form 5500 (between 2,500 and 3,000). Dividing the 12 million employees in this way results in an estimate of 4,000 to 4,800 separate arrangements. When applied to the trade association segment alone, the imputed number of separate arrangements would be between 800 and 1,000. This analysis, although imprecise, appears to support the comparability of the Morneau/ASAE data and the RAND analysis of the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey data.

Because a total based on all pooling arrangements will include collectively bargained multiemployer group health plans and multiple employer non-collectively bargained group health plans, the estimate must be reduced to avoid duplication. Reducing the estimated total of 4,800 arrangements by multiemployer and multiple employer group health plans counts results in a total of 2,200 MEWAs not previously counted, which cover an estimated 4 million employees.

The universe of filers, therefore, can be variously estimated as follows:

- 642 non-collectively bargained multiple employer group health plans which file Form 5500 plus 36 newly originated multiemployer collectively bargained group health plans (ECEs) covering a total of 1,943,551 participants (excludes non-plan MEWAs and small fully insured/unfunded plans exempt from filing) (1995 Form 5500 data);
- 1,034 MEWAs including plans and non-plans covering 2,581,438 participants (likely excludes some arrangements the States would recognize as ERISA covered plans) (1992 GAO report);
- 1,200 association plans including ERISA plans and non-ERISA plans (likely excludes both arrangements which are MEWAs not sponsored by associations and collectively bargained multiemployer plans) (1997 Morneau/ASAE survey); and
- 4,000 to 4,800 multiple employer association plans, collectively bargained plans, and MEWAs covering 12,000,000 participants (or 2,000 non-ERISA plan MEWAs covering 4,100,000 employees, after adjustment for multiemployer collectively bargained group health plans and multiple employer non-collectively bargained group health plans) (1997 RWJF Health Insurance Survey).

On the basis of these estimates, the Department believes a conservative assumption as to the number of MEWAs and entities claiming exception that will be required to file the annual reporting form in any year is 2,678. The method of developing the estimate of filers accounts for some arrangements which would be considered group health plans under ERISA but which are exempt from Form 5500 filing requirements, although their number is not separately identified.

Estimating the proportion of these arrangements which are fully insured, funded through a trust, or a combination of these methods is more problematic. The RAND analysis does not provide specific information on the funding method of the pooled arrangements, and the information reported in the other sources varies significantly. For example, 73 percent of the recently originated multiemployer collectively bargained plans were funded through a trust only, while only 4 percent were fully insured. Of the multiple employer non-collectively bargained ERISA plans which filed Form 5500, 14 percent were self-funded and 31 percent were fully insured. Of the MEWAs reported by the States in the GAO study, 25 percent were fully insured, while 75 percent of the association plans in the Morneau/ASAE survey reported being fully insured.

The funding status of the filers that reported their funding method on Form 5500 has been included as reported. In the absence of additional information as to the funding status of the 2,000 non-plan filers, the Department believes it is reasonable to assume that 50 percent (the midpoint between the 25 percent reported by GAO and the 75 percent reported by Morneau/ASAE) are fully insured. Although this assumption is somewhat arbitrary, it is relied on for purposes of the estimates of annual report filer burden only for estimating a variation in the burden expected in completing the form. The Department welcomes comments on the data and assumptions used in developing these estimates.

The resulting breakdown of arrangements between fully insured and not fully insured is shown below:

	Total	Fully insured	Not fully insured
Total	2,678	1,202	1,476
Multiemployer ECE	36	1	35
Multiple employer non-collectively bargained ERISA plans	642	201	441
Other MEWA	2,000	1,000	1,000

[14] "Pooled Purchasing: Who Are the Players?" Stephen H. Long and M. Susan Marquis, "Health Affairs," July—August 1999.

Completing the MEWA Annual Reporting Form

Completion of this two-page form is expected to require between 2 hours and 50 minutes to 3 hours and 35 minutes. This estimate assumes that all filers will require an average of two hours to familiarize themselves with the form and read the instructions, particularly in the first years following implementation of the filing requirement. The identifying information in Parts I and II of the form and the signature block would be expected to require a limited amount of time to complete.

The most variable portion of the form is expected to be Part III, which includes information concerning the locations in which the arrangement does business, and its funding arrangements and licensing status in those locations. The amount of information to be entered here will vary directly with the number of States in which an entity operates. The degree of this variation is expected to be great, as some of the arrangements which will file are known to be State-specific, while others are national in scope.

Time required to complete this segment of the form is also expected to vary with the funding arrangement of the entity in any given State, and with the State's licensing requirements. Entities which are fully insured in the States in which they operate would be expected to require little time to complete the section because those entities are believed to be least likely to require licensure by a State. Those entities which are either partially or fully self-funded and which operate in States in which they are required to be licensed are expected to require the greatest amount of time to complete this section. The range of completion time assumed for this segment (from 30 minutes to an hour) is intended to allow for this variation.

The Department is aware that the States have implemented a range of regulatory requirements for both MEWAs and health plans sponsored by associations which are self-funded and conducting business in their jurisdictions. These requirements range from registration to full compliance with all of the solvency, rating, and other requirements of the State insurance code. The information that could be provided by the States, if collected directly from them, would include only those arrangements which are aware of the requirements in the State or States in which they do business, and which have elected to comply with those requirements. From time to time States still report being unaware of MEWAs operating within their jurisdictions, or in neighboring States but covering consumers in their jurisdictions, until problems are reported.

With respect to Part IV of the form, the Department assumed a 15 to 30 minute completion time depending again on whether or not an arrangement is fully insured. Fully insured arrangements are expected to be readily aware of their compliance with the specified aspects of Part 7 of ERISA because their insurance contracts will in most cases have been amended to bring them into compliance. Those arrangements which may not have considered the status of their compliance with these requirements may require additional time to answer the questions. No estimate of the time to respond to the question concerning litigation or enforcement proceedings is made because rate of litigation among all plans in general is believed to be low. While positive responses to this question are expected to be useful in assessing compliance with Part 7, the frequency of positive responses among the small group of filers is expected to be very low.

Based upon its experience with many types of multiple employer group health plans and other arrangements, the Department has assumed for its estimates of burden under the Paperwork Reduction Act that 90 percent of plans and arrangements will purchase services to meet the filing requirement rather than complete the form in-house. Because these arrangements by definition include at least two employers which are unrelated by ownership and which may or may not be related by trade or industry, an entity which is separate from the arrangement typically handles administrative duties for the arrangement. This may be the association or subsidiary of the association in the case of a plan sponsored by a trade association, or a third party administrator. This entity is commonly compensated for services such as billing employers, processing claims, or marketing the arrangement to other employers, by the plan or by the participating employers, through an assessment to the premium or other contribution collected from the employers. It is believed that the filing would be completed by this separate entity and that the entity would be compensated for this service. This assumption has no implication with respect to the person or entity obligated to file the form. The assumption is intended to provide an estimate of the cost of filing based on the entity expected as a practical matter to perform the tasks required by the form.

In developing the cost of preparation of the form, the Department has assumed a professional rate for a financial manager of approximately $50 per hour. Copying and mailing is estimated to require 1 minute at a clerical rate of $15 per hour plus $0.38 for mailing and materials. Electronic filing of the form is under consideration, but has not been reflected in these estimates. The Department requests comments on the assumptions used in this analysis.

In the Department's view, the filing requirement will not require the maintenance of records which were not already maintained by the MEWA in the ordinary course of its business.

Type of Review: New.

Agency: U.S. Department of Labor, Pension and Welfare Benefits Administration.

Titles: Annual Report for Multiple Employer Welfare Arrangements and Entities Claiming Exception (Form M–1).

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions.

OMB Number: 1210–NEW.

Frequency of Response: Annually.

Respondents: 2,678.

Responses: 2,678.

Estimated Burden Hours: 874.

Estimated Annual Cost (Operating and Maintenance): $ 394,300.

Comments submitted with respect to this information collection request will be summarized and/or included in the request for OMB approval of the information collection request; they will also become a matter of public record.

Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and likely to have a significant economic impact on a substantial number of small entities. If an agency determines that a proposed rule is likely to have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations, and governmental jurisdictions.

Because these rules are being issued as interim final rules and not as a notice

of proposed rulemaking, the RFA does not apply and the Department is not required to either certify that the rule will not have a significant impact on a substantial number of small businesses or conduct a regulatory flexibility analysis. Nevertheless, the Department has considered the likely impact of this interim rule on small entities, and believes the rule will not have a significant impact on a substantial number of small entities. The reasons for this conclusion are explained in the discussion which follows.

For purposes of this discussion, the Department has deemed a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. For this purpose, it is assumed that arrangements with fewer than 100 participants and which are (1) multiemployer collectively bargained group health plans originated within the last three years, (2) non-collectively bargained multiple employer group health plans, or (3) other multiple employer arrangements which provide medical benefits, are small plans.

PWBA believes that assessing the impact of this proposed rule on small plans is an appropriate substitute for evaluating the effect on small entities as that term is defined in the RFA. As explained earlier, it is estimated that 2,678 plans and arrangements will file the MEWA annual reporting form. Of the total number of Form 5500 filers included in this total, the number of plans with fewer than 100 participants is estimated at 257, or about 11 percent. This number may be slightly understated because data from Form 5500 filings were used to develop the estimate of multiple employer group health plans which fall within the definition of a ''welfare plan'' for purposes of ERISA. That data generally excludes welfare plans with fewer than 100 participants which are either unfunded or fully insured due to this group's exemption from filing requirements.

Consideration of the number of small plans affected by this filing requirement is more meaningful in the context of the total number of small private group health plans estimated to exist. Based on the health coverage reported in the Employee Benefits Supplement to the 1993 Current Population Survey, and a 1993 Small Business Administration survey of retirement and other benefit coverages in small firms, it is estimated that there are approximately 2.6 million private group health plans with fewer than 100 participants. As such, even if all of the potential filers of this form were small plans, only one-tenth of one percent of small group health plans would be affected by this requirement.

It is expected, however, that a very small number of these arrangements will have fewer than 100 participants. By their nature, the affected arrangements must involve at least two employers, which decreases the likelihood of coverage of fewer than 100 participants. Also, underlying goals of the formation of these arrangements, such as gaining purchasing and negotiating power through economies of scale, improving administrative efficiencies, and gaining access to additional benefit design features, are not as readily accomplished if the group of covered lives remains small. Finally, although an average provides no insight into the number of arrangements which have fewer than 100 participants, it may still be noted that the average number of participants per arrangement in the data examined to estimate the number of potential filers appeared to be between 2,500 and 3,000.

It is known, however, that the *employers* typically involved in these arrangements *are* small (that is, have fewer than 500 employees, which is generally consistent with the definition of small entity found in regulations issued by the Small Business Administration (13 CFR § 121.201)). For example, RWJF data referenced earlier show that 12 million employees at 836,000 establishments indicated they obtained coverage through pooled purchasing arrangements. This averages just over 14 employees per establishment. Further, while some employers of 500 or more employees may be included in multiple employer arrangements providing health benefits, groups of this size are typically considered large enough to realize the advantages of economies of scale on their own. It can generally be assumed, therefore, that nearly all employers participating in these arrangements are small. The number of small employers assumed to be affected is 836,000.

The total annual cost of the filing requirement is estimated at $437,400. The filing requirement applies to the administrator of the estimated 2,678 plans or arrangements, and is expected to cost an average of about $164 per plan or arrangement. If this amount were passed on directly to the employers assumed to participate in these arrangements, their additional cost would amount to about $0.50 per year on average.

It is expected that this requirement will be satisfied by professional staff of an entity that provides administrative services to the group health plan or arrangement under an existing agreement. Entities with expertise in management, accounting, and benefits administration are often either formed by the group of employers for the purpose of managing a group health plan, or are responsible for establishing the plan or arrangement and making it available to the employers.

No federal rules have been identified that duplicate, overlap, or conflict with this interim final rule. The Department has considered a number of reporting formats, and has proposed a form intended to collect only the information necessary to assess compliance with Part 7 of ERISA as simply as possible, given the complexities of these arrangements and the regulatory framework in which they operate. The design of the form, which requires reporting by arrangements rather than employers participating in the arrangements, limits the number of filers which will be required to comply with the requirement. Compliance guides have been made part of the report package for the purpose of lessening the time required to assess compliance, and assisting the arrangements in achieving compliance where additional action is required.

Small Business Regulatory Enforcement Fairness Act

The interim final rule being issued here is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to Congress and the Comptroller General for review.

Unfunded Mandates Reform Act

Because these rules are issued as interim final rules and not as a notice of proposed rulemaking, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) does not apply. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, this interim final rule does not include any federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of $100 million.

Statutory Authority

Sec. 29 U.S.C. 1024, 1027, 1059, 1132(c)(5), 1135, 1171–1173, 1181–1183, 1191–1194; Sec. 101, Pub. L. 104–191, 101 Stat. 1936 (29 U.S.C. 1181); Secretary of Labor's Order No. 1–87, 52 FR 13139, April 21, 1987.

List of Subjects in 29 CFR Part 2510

Employee benefit plans, Employee Retirement Income Security Act, Multiple Employer Welfare Arrangements, Pension and Welfare Benefit Administration, Reporting and recordkeeping requirements.

For the reasons set out in the preamble, Part 2520 of Chapter XXV of Title 29 of the Code of Federal Regulations is amended as follows:

PART 2520—[AMENDED]

1. The authority for Part 2520 is revised to read:

Authority: Secs. 101, 102, 103, 104, 105, 109, 110, 111(b)(2), 111(c), 502(c)(5), 505, 701–703, 711–713, 731–734 Pub. L. 93–406, 88 Stat. 840–852 and 894 (29 U.S.C. 1021–1025, 1029–1031, 1135, 1171–1173, 1181–1183, 1191–1194), as amended by Pub. L. 104–191, 101 Stat. 1936 and Pub. L. 104–204, 101 Stat. 2944; Secretary of Labor's Order No. 27–74, 13–76, 1–87, and Labor Management Services Administration Order 2–6.

Sections 2520.102–3, 2520.104b–1 and 2520.104b–3 are also issued under sec. 101(a), (c) and (g)(4) of Pub. L. 104–191, 110 Stat. 1936, 1939, 1951 and 1955 and sec. 603 of Pub. L. 104–204, 110 Stat. 2935 (29 U.S.C. 1185 and 1191c).

2. Part 2520 is amended by adding § 2520.101–2 to read:

§ 2520.101–2 Annual reporting by multiple employer welfare arrangements and certain other entities offering or providing coverage for medical care to the employees of two or more employers.

(a) *Basis and scope.* Section 101(g){h} [1] of the Act permits the Secretary of Labor to require, by regulation, multiple employer welfare arrangements (MEWAs) providing benefits that consist of medical care (within the meaning of section 733(a)(2) of the Act), and that are not group health plans, to report, not more frequently than annually, in such form and manner as the Secretary may require, for the purpose of determining the extent to which the requirements of part 7 of the Act are being carried out in connection with such benefits. Section 734 of the Act provides that the Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of part 7 of the Act. This section sets out requirements for annual reporting by MEWAs that provide benefits that consist of medical care and by certain entities that claim not to be a MEWA solely due to the exception in section 3(40)(A)(i) of the Act (Entities Claiming Exception or ECEs). These requirements apply regardless of whether the MEWA or ECE is a group health plan.

(b) *Definitions.* As used in this section, the following definitions apply:

Administrator means—

(1) The person specifically so designated by the terms of the instrument under which the MEWA or ECE is operated;

(2) If the MEWA or ECE is a group health plan and the administrator is not so designated, the plan sponsor (as defined in section 3(16)(B) of the Act); or

(3) In the case of a MEWA or ECE for which an administrator is not designated and a plan sponsor cannot be identified, the person or persons actually responsible (whether or not so designated under the terms of the instrument under which the MEWA or ECE is operated) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent, custodian, or trustee designated by such person or persons.

Entity Claiming Exception (ECE) means an entity that claims it is not a MEWA due to the exception in section 3(40)(A)(i) of the Act. (In general, this exception is for entities that are established and maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements).

Group health plan means a *group health plan* within the meaning of section 733(a) of the Act and § 2590.701–2.

Health insurance issuer means a *health insurance issuer* within the meaning of section 733(b)(2) of the Act and § 2590.701–2.

Medical care means *medical care* within the meaning of section 733(a)(2) of the Act and § 2590.701–2.

Multiple employer welfare arrangement (MEWA) means a multiple employer welfare arrangement within the meaning of section 3(40) of the Act.

Origination means the occurrence of any of the following three events (and a MEWA or ECE is considered to have been *originated* when any of the following three events occurs)—

(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals);

(2) The MEWA or ECE begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals) after a merger with another MEWA or ECE (unless all of the MEWAs or ECEs that participate in the merger previously were last originated at least three years prior to the merger); or

(3) The number of employees receiving coverage for medical care under the MEWA or ECE is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless the increase is due to a merger with another MEWA or ECE under which all MEWAs and ECEs that participate in the merger were last originated at least three years prior to the merger).

(c) *Persons required to report*—(1) *General rule.* Except as provided in paragraph (c)(2) of this section, the following persons are required to report under this section—

(i) The administrator of a MEWA that offers or provides benefits consisting of medical care, regardless of whether the entity is a group health plan; and

(ii) The administrator of an ECE that offers or provides benefits consisting of medical care during the first three years after the ECE is originated.

(2) *Exception.* Nothing in this paragraph (c) shall be construed to require reporting under this section by the administrator of a MEWA or ECE if the MEWA or ECE is licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees.

(3) *Construction.* For purposes of this section, the following rules of construction apply—

(i) Whether or not an entity is a MEWA or ECE is determined by the administrator acting in good faith. Therefore, if an administrator makes a good faith determination at the time when a filing under this section would otherwise be required that the entity is maintained pursuant to one or more collective bargaining agreements, the entity is an ECE, and the administrator of the ECE is not required to file if its most recent origination was more than three years. Even if the entity is later determined to be a MEWA, filings are not required prior to the determination that the entity is a MEWA if at the time the filings were otherwise due, the administrator made a good faith determination that the entity was an ECE. However, filings are required for

[1] Section 1421(d)(1) of the Small Business Job Protection Act of 1996 (Pub. L. 104–188) created a new section 101(g) of ERISA relating to Simple Retirement Accounts. Subsequently, section 101(e)(1) of HIPAA also created a new section 101(g) of ERISA relating to MEWA reporting. Accordingly, when referring to section 101(g) of ERISA relating to MEWA reporting, this document cites section 101(g){h} of ERISA.

years after the determination that the entity is a MEWA.

(ii) In contrast, while an administrator's good faith determination that an entity is an ECE may eliminate the requirement that the administrator of the entity file under this section for more than three years after the entity's origination date, the administrator's determination, nonetheless, does not affect the applicability of State law to the entity. Accordingly, incorrectly claiming the exception may eliminate the need to file under this section, if the claiming of the exception is done in good faith. However, the claiming of the exception for ECEs under this filing requirement does not prevent the application of State law to an entity that is later determined to be a MEWA. This is because the filing, or the failure to file, under this section does not in any way affect the application of State law to a MEWA.

(d) *Information to be reported* (1) The annual report required by this section shall consist of a completed copy of the Form M–1 ''Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)'' (Form M–1) and any additional statements required in the instructions to the Form M–1. This report is available by calling 1–800–998–7542 and on the Internet at http://www.dol.gov/dol/pwba.

(2) The Secretary may reject any filing under this section if the Secretary determines that the filing is incomplete, in accordance with § 2560.502c–5.

(3) If the Secretary rejects a filing under paragraph (d)(2) of this section, and if a revised filing satisfactory to the Secretary is not submitted within 45 days after the notice of rejection, the Secretary may bring a civil action for such relief as may be appropriate (including penalties under section 502(c)(5) of the Act and § 2560.502c–5).

(e) *Timing*—(1) *Period to be Reported.* A completed copy of the Form M–1 is required to be filed for each calendar year during all or part of which the MEWA or ECE offers or provides coverage for medical care to the employees of two or more employers (including one or more self-employed individuals).

(2) *Filing deadline*—(i) *General March 1 filing due date.* Subject to the transition rule described in paragraph (e)(2)(ii) of this section, a completed copy of the Form M–1 is required to be filed on or before each March 1 that follows a period to be reported (as described in paragraph (e)(1) of this section). However, if March 1 is a Saturday, Sunday, or federal holiday, the form must be filed no later than the next business day.

(ii) *Transition rule for Year 2000 filings.* For the year 1999 period to be reported, a completed copy of the Form M–1 is required to be filed no later than May 1, 2000.

(iii) *Special rule requiring a 90–Day Origination Report when a MEWA or ECE is originated*—(A) *In general.* Subject to paragraph (e)(2)(ii)(B) of this section, when a MEWA or ECE is originated, the administrator of the MEWA or ECE is also required to file a completed copy of the Form M–1 within 90 days of the origination date (unless 90 days after the origination date is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the next business day).

(B) *Exceptions.* (*1*) Paragraph (d)(2)(ii)(A) of this section does not apply if the origination occurred between October 1 and December 31.

(*2*) Paragraph (d)(2)(ii)(A) of this section does not apply before May 1, 2000. Therefore, for an entity that is originated, for example, on January 1, 2000, no 90–day origination report is required. Nonetheless, for an entity originated, for example, on April 1, 2000, a 90–day origination report is required to be completed and filed no later than June 30, 2000.

(iv) *Extensions.* An extension may be granted for filing a report if the administrator complies with the extension procedure prescribed in the Instructions to the Form M–1.

(f) *Filing address.* A completed copy of the Form M–1 is filed with the Secretary by sending it to the address prescribed in the Instructions to the Form M–1.

(g) *Civil penalties and procedures.* For information on civil penalties under section 502(c)(5) of the Act for persons who fail to file the information required under this section (including a transition rule applicable to filings due in the year 2000), see § 2560.502c–5. For information relating to administrative hearings and appeals in connection with the assessment of civil penalties under section 502(c)(5) of the Act, see § 2570.90 *et seq.*

(h) *Examples.* The rules of this section are illustrated by the following examples:

Example 1. (i) MEWA *A* began offering coverage for medical care to the employees of two or more employers July 1, 1989 (and continuous to offer such coverage). MEWA *A* does not claim the exception under section 3(40)(A)(i) of ERISA.

(ii) In this *Example 1,* the administrator of MEWA *A* must file a completed copy of the Form M–1 by May 1, 2000. Furthermore, the administrator of MEWA *A* must file the Form M–1 annually by every March 1 thereafter.

Example 2. (i) ECE *B* began offering coverage for medical care to the employees of two or more employers on January 1, 1992. ECE *B* has not been involved in any mergers and in 1999 the number of employees to which ECE *B* provides coverage for medical care is not at least 50 percent greater than the number of such employees on December 31, 1998.

(ii) In this *Example 2,* ECE *B* was originated was on January 1, 1992 has not been originated since then. Therefore, the administrator of ECE *B* is not required to file a Form M–1 on May 1, 2000 because the last time the ECE *B* was originated was January 1, 1992 which more than 3 years prior to May 1, 2000.

Example 3. (i) ECE *C* began offering coverage for medical care to the employees of two or more employers on July 1, 1998.

(ii) In this *Example 3,* the administrator of ECE *C* must file a completed copy of the Form M–1 by May 1, 2000 because the last date *A* was originated was July 1, 1998, which is less than 3 years prior to the May 1, 2000 due date. Furthermore, the administrator of ECE *C* must file a year 2000 annual report by March 1, 2001 (because July 1, 1998 is less than three years prior to March 1, 2001). However, if ECE *C* is not involved in any mergers that would result in a new origination date and if ECE *C* does not experience a growth of 50 percent or more in the number of employees to which ECE *C* provides coverage from the last day of the previous calendar year to any day in the current calendar year, then no Form M–1 report is required to be filed after March 1, 2001.

Example 4. (i) MEWA *D* begins offering coverage to the employees of two or more employers on January 1, 2000. MEWA *D* is licensed or authorized to operate as a health insurance issuer in every State in which it offers coverage for medical care to employees.

(ii) In this *Example 4,* the administrator of MEWA *D* is not required to file Form M–1 on May 1, 2000 because it is licensed or authorized to operate as a health insurance issuer in every State in which it offers coverage for medical care to employees.

Example 5. (i) MEWA *E* is originated on September 1, 2000.

(ii) In this *Example 5,* because MEWA *E* was originated on September 1, 2000, the administrator of MEWA *E* must file a completed copy of the Form M–1 on or before November 30, 2000 (which is 90 days after the origination date). In addition, the administrator of MEWA *E* must file a completed copy of the Form M–1 annually by every March 1 thereafter.

(i) *Compliance dates*—(1) Subject to paragraph (i)(2) of this section, reports filed pursuant to this reporting requirement are first due by May 1, 2000. (Therefore, on May 1, 2000, filings are due with respect to MEWAs or ECEs that provided coverage in calendar year 1999.)

(2) 90-Day Origination Reports (described in paragraph (e)(2)(ii) of this section) are first due by May 1, 2000. Therefore, for an entity that is

originated, for example, on January 1, 2000, no 90-day origination report is required. Nonetheless, for an entity originated, for example, on April 1, 2000, a 90-day origination report is required to be completed and filed no later than June 30, 2000.

Signed at Washington, DC, this 4th day of February 2000.

Leslie B. Kramerich,

Acting Assistant Secretary, Pension and Welfare Benefits Administration, U.S. Department of Labor.

BILLING CODE 4510–29–P

1999 Form M-1 MEWA/ECE Form This Form is Open to Public Inspection	**Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)** This report is required to be filed under section 101(g){h} of the Employee Retirement Income Security Act of 1974 and 29 CFR 2520.101-2. ➤ See separate instructions before completing this form.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

PART I ANNUAL REPORT IDENTIFICATION INFORMATION

Complete either Item **A** or Item **B**, as applicable.

A If this is an annual report, specify whether it is for:
(*1*) ☐ The 1999 calendar year; or
(*2*) ☐ The fiscal year beginning _____, _____ and ending _____, _____.

B If this is a special filing, specify whether it is:
(*1*) ☐ A 90-day origination report;
(*2*) ☐ An amended report; or
(*3*) ☐ A request for an extension.

PART II MEWA OR ECE IDENTIFICATION INFORMATION

1a Name and address of the MEWA or ECE	**1b** Telephone number of the MEWA or ECE
	1c Employer Identification Number (EIN)
	1d Plan Number (PN)
2a Name and address of the administrator of the MEWA or ECE	**2b** Telephone number of the administrator
	2c Employer Identification Number (EIN)
3a Name and address of the entity sponsoring the MEWA or ECE	**3b** Telephone number of the sponsor
	3c Employer Identification Number (EIN)

PART III REGISTRATION INFORMATION

4 Specify the most recent date the MEWA or ECE was originated . . . . . ➤ _____

5 Complete the following chart. (See Instructions for **Item 5**)

5a	5b	5c	5d	5e	5f	5g
Enter all States where the entity offers or provides coverage.	Is the entity a licensed health insurance issuer in this State?	If you answer "yes" to **5b**, list any NAIC number.	If you answer "no," to **5b**, is the entity fully-insured?	If you answer "yes" to **5d**, enter the name of the insurer and its NAIC number.	Does the entity purchase stop-loss coverage?	If you answer "yes" to **5f**, enter the name of the stop-loss insurer and its NAIC number.
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	

You may attach additional pages if necessary.

For Paperwork Reduction Act Notice, see page 1 of the instructions.

6 Of the States identified in **Item 5a**, list those States in which the MEWA or ECE conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care under the MEWA or ECE).

7 Total number of participants covered under the MEWA or ECE . . . . . ➤ _____

PART IV INFORMATION FOR COMPLIANCE WITH PART 7 OF ERISA

8a Has the MEWA or ECE been involved in any litigation or enforcement proceeding in which noncompliance with any provision of Part 7 of Subtitle B of Title I of ERISA was alleged? Answer for the year to which this filing applies and any time since then up to the date of completing this form. Answer "Yes" for any State, federal, administrative litigation or enforcement proceeding, whether the allegation concerns a provision under Part 7 of ERISA, a corresponding provision under the Internal Revenue Code or Public Health Service Act, a breach of any duty under Title I of ERISA if the underlying violation relates to a requirement under Part 7 of ERISA, or a breach of a contractual obligation if the contract provision relates to a requirement under Part 7 of ERISA. (The instructions to this form contain additional information that may be helpful in answering this question.) . . . . . ➤ ☐ Yes ☐ No

8b If you answered "Yes" to **Item 8a**, identify each litigation or enforcement proceeding. With respect to each, include: (1) the case number (if any), (2) the date, (3) the nature of the proceedings, (4) the court, (5) all parties (for example, plaintiffs and defendants or petitioners and respondents), and (6) the disposition. You may answer this question by attaching a copy of the complaint with the disposition of the case noted in the upper right corner. If you need additional space, you may attach additional pages.

9 Complete the following. (Note: The instructions to this form contain four detailed worksheets which may be helpful in completing this item. Please read the instructions carefully before answering the following questions.)

9a	Is the MEWA or ECE in compliance with the portability provisions of the Health Insurance Portability and Accountability Act of 1996 and the Department's regulations issued thereunder? (See Worksheet A)	➤ ☐ Yes ☐ No ☐ N/A
9b	Is the MEWA or ECE in compliance with the Mental Health Parity Act of 1996 and the Department's regulations issued thereunder? (See Worksheet B)	➤ ☐ Yes ☐ No ☐ N/A
9c	Is the MEWA or ECE in compliance with the Newborns' and Mothers' Health Protection Act of 1996 and the Department's regulations issued thereunder? (See Worksheet C)	➤ ☐ Yes ☐ No ☐ N/A
9d	Is the MEWA or ECE in compliance with the Women's Health and Cancer Rights Act of 1998? (See Worksheet D)	➤ ☐ Yes ☐ No ☐ N/A

IF MORE SPACE IS REQUIRED FOR ANY ITEM, ATTACH ADDITIONAL SHEETS THE SAME SIZE AS THIS FORM.

Caution: *Penalties may apply in the case of a late or incomplete filing of this report.*

Under penalty of perjury and other penalties set forth in the instructions, I declare that I have examined this report, including any accompanying attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of administrator ➤ _____ Date ➤ _____

Type or print name of administrator ➤ _____

Department of Labor
Pension and Welfare Benefits Administration

Instructions for Form M-1

Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)

ERISA refers to the Employee Retirement Income Security Act of 1974

Paperwork Reduction Act Notice

We ask for the information on this form to carry out the law as specified in ERISA. You are required to give us the information. We need it to determine whether the MEWA or ECE is operating according to law. You are not required to respond to this collection of information unless it displays a current, valid OMB control number.

The average time needed to complete and file the form is estimated below. These times will vary depending on individual circumstances.

Learning about the law or the form	Preparing the form
2 hrs.	50 min. - 1 hr and 35 min.

Contents

The instructions are divided into three main sections.

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SECTION 1

1.1 Introduction

This form is required to be filed under section 101(g){h}* and section 734 of the Employee Retirement Income Security Act of 1974, as amended (ERISA) and 29 CFR 2520.101-2.

The Department of Labor, Pension and Welfare Benefits Administration (PWBA) is committed to working together with administrators to help them comply with this filing requirement. Filer's guides, which may be helpful in filing this report are available by calling the PWBA toll-free publication hotline at 1-800-998-7542 and on the Internet at: http://www.dol.gov/dol/pwba. If you have any questions (such as whether you are required to file this report) or if you need any assistance in completing this report, please call the PWBA help desk at (202) 219-8818.

All Form M-1 reports are subject to a computerized review. It is, therefore, in the filer's best interest that the responses accurately reflect the circumstances they were designed to report.

* Both the Small Business Job Protection Act of 1996 (Pub. L. 104-188) and the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) created a new section 101(g) of ERISA. Accordingly, section 101(g) of ERISA that relates to reporting by certain arrangements is referred to in this document as section 101(g){h} of ERISA.

1.2 Who Must File

General rules

The "administrator" (defined below) of a "multiple employer welfare arrangement" (MEWA, defined below) generally must file this report for every calendar year, or portion thereof, that the MEWA offers or provides benefits for medical care to the employees of two or more employers (including one or more self-employed individuals). The administrator of an "entity claiming exception" (ECE, defined below) must file the report each year for the three years after the ECE is "originated" (defined below). (Warning: An ECE may be "originated" more than once. Each time an ECE is "originated," more filings are triggered.)

However, in no event is reporting required by the administrator of a MEWA or ECE if the MEWA or ECE is licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees.

Accordingly, subject to the exception described above for licensed or authorized health insurance issuers, the administrator of a MEWA is required to file annually. By contrast, the administrator of an ECE is required to file for three years following an origination. Whether or not an entity is a MEWA or ECE is determined by the administrator acting in good faith. Therefore, if an administrator makes a good faith determination at the time of the filing that the entity is maintained pursuant to one or more collective bargaining agreements, the entity is an ECE, and the ECE is not required to file because its most recent origination was more than three years ago, then a filing is not required. Even if the entity is later determined to be a MEWA, filings are not required prior to the determination that the entity is a MEWA if at the time the filings were due, the administrator made a good faith determination that the entity was an ECE. However, filings are required for years after the determination that the entity is a MEWA.

In contrast, while an administrator's good faith determination that an entity is an ECE may eliminate the requirement that the administrator of the entity file under this section for more than three years after the entity's origination date, the administrator's determination does not affect the applicability of State law to the entity. Accordingly, incorrectly claiming the exception may eliminate the need to file under this section, if the claiming of the exception is done in good faith. However, the claiming of the exception for ECEs under this filing requirement does not prevent the application of State law to an entity that is later determined to be a MEWA. This is because the filing, or the failure to file, under this section does not in any way affect the application of State law to a MEWA.

Definition of "Administrator"

For purposes of this form, the "administrator" is the person specifically designated by the terms of the MEWA or ECE. However, if the MEWA or ECE is a group health plan and the administrator is not so designated, the plan sponsor (as defined in section 3(16)(B) of ERISA) is the administrator. Moreover, in the case of a MEWA or ECE for which an administrator is not designated and a plan sponsor cannot

be identified, the administrator is the person or persons actually responsible (whether or not so designated under the terms of the MEWA or ECE) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent or trustee designated by such person or persons.

Definition of "Multiple Employer Welfare Arrangement" or "MEWA"
In general, a multiple employer welfare arrangement (MEWA) is an employee welfare benefit plan or other arrangement that is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that the term does not include any such plan or other arrangement that is established or maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association. See ERISA section 3(40).

Definition of "Entity Claiming Exception" or "ECE"
For purposes of this report, the term "entity claiming exception" or "ECE" means any plan or other arrangement that is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, and that claims it is not a MEWA because the plan or other arrangement claims the exception relating to plans established or maintained pursuant to one or more collective bargaining agreements (contained in section 3(40)(A)(i) of ERISA).

The administrator of an ECE must file this report each year for the first three years after the ECE is "originated". (Warning: An ECE may be "originated" more than once. Each time an ECE is "originated," more filings are triggered.)

Definition of "Originated"
For purposes of this report, a MEWA or ECE is "originated" each time any of the following events occur:

(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals),

(2) The MEWA or ECE begins offering or providing such coverage after any merger of MEWAs or ECEs (unless all MEWAs or ECEs involved in the transaction have been offering or providing coverage for at least three years prior to the transaction), or

(3) The number of employees to which the MEWA or ECE offers or provides coverage for medical care is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless such increase is due to a merger with another MEWA or ECE under which all MEWAs and ECEs that participate in the merger were last originated at least three years prior to the merger).

Therefore, a MEWA or ECE may be originated more than once. Each time an ECE is originated, filings are triggered.

1.3 When to File

General Rule
The administrator of a MEWA or ECE that is required to file must file the Form M-1 no later than March 1 following any calendar year for which a filing is required.

*** Transition Rule for Year 2000 Filings:
For the 1999 Year to be Reported, the administrator of a MEWA or ECE that is required to file must file the Form M-1 no later than May 1, 2000.

90-Day Origination Report
In general, an expedited filing is required after a MEWA or ECE is originated. To satisfy this requirement, the administrator must complete and file the Form M-1 within 90 days of the date the MEWA or ECE is originated (unless the last day of the 90-day period is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the following business day).

Exceptions to the 90-Day Origination Report Requirement
(1) No 90-Day Origination Reports are due before May 1, 2000. (Therefore, for an entity that is originated, for example, on January 1, 2000, no 90-day origination report is required. Nonetheless, for an entity that is originated, for example, on April 1, 2000, a 90-Day Origination Report is required to be completed and filed no later than June 30, 2000.)

(2) No 90-Day Origination Report is required if the entity was originated in October, November, or December.

Extensions
A one-time extension of time to file will automatically be granted if the administrator of the MEWA or ECE requests an extension. To request an extension, the administrator must complete and file Parts I and II of the Form M-1 (and check **Box B(3)** in Part I) no later than the normal due date for the report. In such a case, the administrator will have an additional 60 days to file a completed Form M-1. A copy of the request for extension must be attached to the completed Form M-1 when filed.

1.4 Where to File

Completed copies of the Form M-1 should be sent to:

Public Documents Room, Pension and Welfare Benefits Administration
Room N-5638, U.S. Department of Labor
200 Constitution Avenue, NW.
Washington, DC 20210

1.5 Penalties

Good Faith Safe Harbor for Filings Due in Year 2000. The Department of Labor, Pension and Welfare Benefits Administration is committed to working together with administrators to help them comply with this filing requirement. In this regard, the Department does not intend to assess penalties in cases where there has been a good faith effort to comply with a filing due in the Year 2000.

However, in instances where there has not been a good faith effort to comply with a filing due in the Year 2000, and for any filing due after the Year 2000 (whether or not the administrator has made a good faith effort to comply), please be aware that ERISA provides for the assessment or imposition of a penalty for failure to file a report, failure to file a completed report, and late filings. In the event of no filing, an incomplete filing, or a late filing, a penalty may apply of up to $1,000 a day for each day that the administrator of the MEWA or ECE fails or refuses to file a complete report. In addition, certain other penalties may apply.

SECTION 2

2.1 Year to be Reported

General rule
The administrator of a MEWA or ECE that is required to file should complete the form using the previous calendar year's information. (Thus, for example, for a filing that is due by May 1, 2000, calendar year 1999 information should be used.)

Fiscal year exception
The administrator of a MEWA or ECE that is required to file may report using fiscal year information if the administrator of the MEWA or ECE has at least six continuous months of fiscal year information to report. (Thus, for example, for a filing that is due by May 1, 2000, fiscal year 1999 information may be used if the administrator has at least six continuous months of fiscal year 1999 information to report.) In this case, the administrator should check **Box A(2)** and specify the fiscal year.

2.2 The 90-Day Origination Report

When a MEWA or ECE is originated, a 90-Day Origination Report is generally required. (See section 1.3 on When to File). When filing a 90-Day Origination Report, the administrator is required to complete the Form M-1 using information based on at least 60 continuous days of operation by the MEWA or ECE.

Remember, there are two exceptions to the 90-Day Origination Report requirement: (1) No 90-Day Origination Reports are due before May 1, 2000. (Nonetheless, for an entity that is originated, for example, on April 1, 2000, a 90-Day Origination Report is required to be completed and filed by June 30, 2000.); and (2) No 90-Day Origination Report is required if the entity was originated in October, November, or December.

2.3 Signature and Date

The administrator must sign and date the report. The signature must be original. The name of the individual who signed as the administrator must be typed or printed clearly on the line under the signature line.

2.4 Amended Report

To correct errors and/or omissions on a previously filed Form M-1, submit a completed Form M-1 with Part I, **Box B(2)** checked and an original signature. When filing an amended report, answer all questions and circle the amended line numbers.

SECTION 3

Important: "Yes/No" questions must be marked "Yes" or "No," but not both. "N/A" is not an acceptable response unless expressly permitted in the instructions to that line.

3.1 Line-By-Line Instructions

Part I - Annual Report Identification Information

Complete either **Item A** or **Item B**, as applicable.

Item A: If this is an annual report, check either box A(1) or box A(2).
Check **box A(1)** if calendar year information is being used to complete this report. (See Section 2.1 on Year to be Reported.)
Check **box A(2)** if fiscal year information is being used to complete this report. Also specify the fiscal year. (For example, if fiscal year 1999 information is being used instead of calendar year 1999 information, specify the date the fiscal year begins and ends.) (See Section 2.1 on Year to be Reported.)

Item B: If this is a special filing, check either box B(1), box B(2), or box (B)(3).
Check **box B(1)** if this form is a 90-Day Origination Report. (See Section 1.2 on Who Must File, Section 1.3 on When to File, and Section 2.2 on 90-Day Origination Reports.)
Check **box B(2)** if this form is an Amended Report. (See Section 2.4 on Amended Reports.)
Check **box B(3)** if the administrator of the MEWA or ECE is requesting an extension. (See Section 1.3 on When to File.)

Part II - MEWA or ECE Identification Information

Items 1a through 1d: Enter the name and address of the MEWA or ECE, the telephone number of the MEWA or ECE, and any employer identification number (EIN) and plan number (PN) used by the MEWA or ECE in reporting to the Department of Labor or the Internal Revenue Service. If the MEWA or ECE does not have any EINs associated with it, leave **Item 1c** blank. If the MEWA or ECE does not have any PNs associated with it, leave **Item 1d** blank. In answering these questions, list only EINs and PNs used by the MEWA or ECE itself and not by group health plans or employers that purchase coverage through the MEWA or ECE.

Items 2a through 2c: Enter the name and address of the administrator of the MEWA or ECE, the telephone number of the administrator, and any employer identification number (EIN) used by the administrator in reporting to the Department of Labor or the Internal Revenue Service. For this purpose, use only an EIN associated with the administrator as a separate entity. Do not use any EIN associated with the MEWA or ECE itself.

Items 3a through 3c: Enter the name and address of the entity sponsoring the MEWA or ECE, the telephone number of the sponsor, and any employer identification number (EIN) used by the sponsor in reporting to the Department of Labor or the Internal Revenue Service. For this purpose, use only an EIN associated with the sponsor. Do not use any EIN associated with the MEWA or ECE itself. If the MEWA or ECE is a group health plan, the sponsor is the "plan sponsor," which is defined in ERISA section 3(16)(B) as (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. If the MEWA or ECE is not a group health plan, the administrator should enter the name, address, or telephone number of the entity that establishes or maintains the MEWA or ECE. If there is no such entity, leave **Item 3** blank and skip to **Item 4**.

Part III - Registration Information

Item 4: Enter the date the MEWA or ECE was most recently "originated." For this purpose, a MEWA or ECE is "originated" each time any of the following events occur:
(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals);
(2) The MEWA or ECE begins offering or providing such coverage after any merger of MEWAs or ECEs (unless all MEWAs or ECEs involved in the transaction have been offering or providing coverage for at least three years prior to the transaction); or
(3) The number of employees to which the MEWA or ECE offers or provides coverage for medical care is at least 50 percent greater than the number of such employees during the previous calendar year (unless such increase is due to a merger with another MEWA or ECE under which all MEWAs and ECEs that participate in the merger were last originated at least three years prior to the merger).

Item 5: Complete the chart. If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with

information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Item 5a. Under **Item 5a**, enter all States in which the MEWA or ECE offers or provides benefits for medical coverage.

In answering this question, a "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the pertinent areas and installations of the Canal Zone.

Item 5b. Under **Item 5b**, specify whether the MEWA or ECE is licensed or otherwise authorized to operate as a health insurance issuer in each such State. (A "health insurance issuer" is defined, in pertinent part, in § 2590.701-2 of the Department's regulations, "an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law which regulates insurance . . . . Such term does not include a group health plan.")

Item 5c. If the answer to Item 5b is "yes," under **Item 5c**, enter the National Association of Insurance Commissioners (NAIC) number.

Item 5d. If the answer to Item 5b is "no," under **Item 5d** specify whether the MEWA or ECE is fully-insured by a health insurance issuer in each State.

Item 5e. If the answer to Item 5d is "yes," under **Item 5e** enter the name of the insurer and its NAIC number.

Item 5f. Under **Item 5f**, specify whether the MEWA or ECE has purchased any stop-loss coverage. For this purpose, stop-loss coverage includes any coverage defined by the State as stop-loss coverage. For this purpose, stop-loss coverage also includes any financial reimbursement instrument that is related to liability for the payment of health claims by the MEWA or ECE, including reinsurance.

Item 5g. If the answer to Item 5f is "yes," under **Item 5g** enter the name of the stop-loss insurer and its NAIC number.

If more space is needed to complete **Item 5**, additional pages may be attached. These pages must indicate "Item 5 Attachment" in the upper right corner and must be in a format similar to that of **Item 5**.

Item 6: Of the States identified in **Item 5a**, identify all States in which the MEWA or ECE conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care under the MEWA or ECE).

For example, consider a MEWA that offers or provides coverage to the employees of six employers. Two employers are located in State X and 70 employees of the two employers receive coverage through the MEWA. Three employers are located in State Y and 30 employees of the three employers receive coverage through the MEWA. Finally, one employer is located in State Z and 200 employees of the employer receive coverage through the MEWA. In this example, the administrator of the MEWA should specify State X and State Z under Item 6 because the MEWA conducts 23⅓% of its business in State X (70÷300 = 23⅓%) and 66⅔% of its business in State Z (200÷300 = 66⅔%). However, the administrator should not specify State Y because the MEWA conducts only 10% of its business in State Y (30÷300 = 10%)

If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Item 7: Identify the total number of participants eligible to receive coverage for benefits under the MEWA or ECE.

If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Part IV - Information for Compliance with Part 7 of ERISA

Background Information on Part 7 of ERISA: On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. On September 26, 1996, both the Mental Health Parity Act of 1996 (MHPA) and the Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act) were enacted. On October 21, 1998, the Women's Health and Cancer Rights Act of 1998 (WHCRA) was enacted. All of the foregoing laws amended Part 7 of ERISA with new requirements for group health plans. With respect to most of these requirements, corresponding provisions are contained in Chapter 100 of Subtitle K of the Internal Revenue Code (Code) and Title XXVII of the Public Health Service Act (PHS Act). These provisions generally are substantively identical.

The Departments of Labor, the Treasury, and Health and Human Services first issued interim final regulations implementing HIPAA's portability, access, and renewability provisions on April 1, 1997 (published in the Federal Register on April 8, 1997, 62 FR 16893). Two clarifications of the HIPAA regulations were published in the Federal Register on December 29, 1997 at 62 FR 67687. Regulations implementing the MHPA provisions were published in the Federal Register on December 22, 1997 at 62 FR 66931. Also, regulations implementing the substantive provisions of Newborns' Act were published in the Federal Register on September 9, 1998 at 63 FR 48372 and on October 27, 1998 at 63 FR 57545. Moreover, the notice requirements with respect to group health plans that provide coverage for maternity or newborn infant coverage are described in the Department's summary plan description (SPD) content regulations at 29 CFR 2520.102-3(u), 63 FR 48372 (September 9, 1998). Finally, on November 23, 1998, the Department issued informal guidance on WHCRA in the form of questions and answers. All of the above-mentioned guidance is available on the Department's website at www.dol.gov/dol/pwba and via the Pension and Welfare Benefits Administration's toll-free publications hotline at 1-800-998-7542.

General Information Regarding the Applicability of Part 7: In general, the foregoing provisions apply to group health plans and health insurance issuers in the group market. A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. A health insurance issuer or issuer means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance. Such term does not include a group health plan. Group market generally means the market for health insurance coverage offered in connection with a group health plan.

Many MEWAs and ECEs are group health plans or health insurance issuers. However, even if the MEWA or ECE is neither a group health plan nor a health insurance issuer, if the MEWA or ECE offers or provides coverage in the group market, the coverage is required to comply with Part 7 of ERISA.

Relation to Other Laws:
States may, under certain circumstances, impose stricter laws with respect to health insurance issuers. Generally, questions concerning State laws should be directed to the State Insurance Commissioner's Office.

For More Information: To obtain copies of the Department of Labor's booklet, "Questions and Answers: Recent Changes in Health Care Law," which includes information on HIPAA, MHPA, the Newborns' Act, and WHCRA, you may call the Department's toll-free publication hotline at 1-800-998-7542. This booklet is also available on the Internet at : www.dol.gov/dol/pwba. If you have any additional questions concerning Part 7 of ERISA, you may call the Department of Labor office nearest you or the Department's health care question hotline at 202-219-8776.

Items 8a and 8b: With respect to **Item 8a**, check "yes" or "no" as applicable. For this purpose, do not include any audit that does not result in required corrective action. If you answer "yes" under **Item 8a**, identify, in **Item 8b,** any such litigation or enforcement proceeding. If you need more space, you may attach additional pages. These pages must read "Item 8b Attachment" in the upper right corner.

Item 9a: The portability requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) comprise sections 701, 702, and 703 of ERISA, sections 9801, 9802, and 9803 of the Internal Revenue Code of 1986 (Code), and sections 2701 and 2702 of the Public Health Service Act (PHS Act).

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Similarly, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet A may be helpful.

Item 9b: The Mental Health Parity Act of 1996 (MHPA) provisions are in section 712 of ERISA, section 9812 of the Code, and section 2705 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Second, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Third, if you are the administrator of a MEWA or ECE that does not provide both medical/surgical benefits and mental health benefits, you may answer "N/A." Finally, if you are the administrator of a MEWA or ECE that offers or provides coverage only to small employers (as described in the small employer exemption contained section 712(c)(1) of ERISA and § 2590.712(e) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder) or if the coverage satisfied the requirements for the increased cost exemption (described in section 712(c)(2) of ERISA and § 2590.712(f) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet B may be helpful.

Item 9c: The Newborns' and Mothers' Health Protection Act of 1996 (Newborn's Act) provisions are in section 711 of ERISA, section 9811 of the Code, and section 2704 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A."

Moreover, if you are the administrator of a MEWA or ECE that does not provide benefits for hospital lengths of stay in connection with childbirth, you may answer "N/A." Finally, if you are the administrator of a MEWA or ECE that is subject to State law regulating such coverage, instead of the federal Newborns' Act requirements, in all States identified in **Item 5a**, in accordance with section 711(f) of ERISA and § 2590.711(e) of the Department's regulations (and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet C may be helpful.

Item 9d: The Women's Health and Cancer Rights Act of 1998 (WHCRA) provisions are in section 713 of ERISA and section 2706 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the PHS Act and the regulations issued thereunder), you may answer "N/A." Similarly, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Lastly, if you are the administrator of a MEWA or ECE that does not provide medical/surgical benefits with respect to a mastectomy, you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet D may be helpful.

3.2 Voluntary Worksheets

Voluntary worksheets, which may be used to help assess an entity's compliance with Part 7 of ERISA, are included on the following pages of these instructions. These worksheets may also be helpful in answering **Items 9a** through **9d** of the Form M-1.

Worksheet A (Form M-1)	Determining Compliance with the HIPAA Provisions in Part 7 of Subtitle B of Title I of ERISA Do NOT file this worksheet.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the HIPAA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to any of the questions below, you should review your entity's operations because the entity may not be in full compliance with the HIPAA provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

(1) Does the MEWA or ECE issue certificates of creditable coverage automatically to individuals who lose coverage under the MEWA or ECE and to individuals upon request? ..... ➤ ☐ Yes ☐ No

- Section 701(e) of ERISA and § 2590.701-5 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) require group health plans and group health insurance issuers to issue, free of charge, certificates of creditable coverage automatically to individuals who lose coverage and to any individual upon request.
- In the case of a certificate issued automatically, the certificate should reflect the most recent continuous period of creditable coverage. In the case of a certificate issued upon request, the certificate should reflect all creditable coverage that the individual had in the 24 months prior to the date of request. However, in no event is a certificate required to reflect more than 18 months of creditable coverage.
- Most health coverage is creditable coverage. However, coverage consisting solely of excepted benefits is not creditable coverage. Examples of benefits that may be excepted benefits include limited-scope dental benefits, limited-scope vision benefits, hospital indemnity benefits, and Medicare supplemental benefits.
- If you have a question whether health coverage offered by a MEWA or ECE is creditable coverage or is coverage consisting solely of excepted benefits, contact the Department of Labor office nearest you or call the Department's health care question hotline at 202-219-4377. This is not a toll-free number.

(2) Has the MEWA or ECE made available a procedure for individuals to request and receive certificates? ..... ➤ ☐ Yes ☐ No

- Section 2590.701-5(a)(4)(ii) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires group health plans and group health insurance issuers to establish a procedure for individuals to request and receive certificates.

(3) If the MEWA or ECE imposes a preexisting condition exclusion period, does it issue a notice informing individuals of the exclusion, the terms of the exclusion, and the right of individuals to demonstrate creditable coverage to reduce the period of the exclusion? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 2590.701-3(c) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires that a group health plan, and a group health insurance issuer, may not impose a preexisting condition exclusion with respect to a participant or a dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage.
- The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(4) If the MEWA or ECE imposes a preexisting condition exclusion period, does it issue letters of determination and notification of creditable coverage within a reasonable time after the receipt of individuals' creditable coverage information? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 2590.701-5(d) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) states that, within a reasonable time following receipt of evidence of creditable coverage, a plan or issuer seeking to impose a preexisting condition exclusion with respect to an individual is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied.

- In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage.

(5) If the MEWA or ECE imposes a preexisting condition exclusion period, does it comport with HIPAA's limitations on preexisting condition exclusion periods? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 701(a)(1) of ERISA and § 2590.701-3(a)(1)(i) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a plan or issuer may impose a preexisting condition exclusion period only if it relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the individual's enrollment date in the plan or coverage. (Therefore, genetic information is not treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.) The enrollment date, for purposes of the HIPAA limitations on preexisting condition exclusion periods, is the first day of coverage or, if there is a waiting period, the first day of the waiting period. (For health insurance issuers, State law may prescribe a shorter period than the 6-month period that generally applies.)

- Section 701(a)(2) of ERISA and section § 2590.701-3(a)(1)(ii) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that any preexisting condition exclusion period is limited to 12 months (18 months for late enrollees) after an individual's enrollment date in the plan or coverage. (For health insurance issuers, State law may prescribe a shorter period.)

- Section 701(a)(3) of ERISA and § 2590.701-3(a)(1)(iii) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that any preexisting condition exclusion period is reduced by the number of days of an individual's creditable coverage prior to his or her enrollment date.

- When determining the number of days of creditable coverage, the plan or issuer is not required to take into account any days that occur prior to a significant break in coverage. The federal law defines a significant break in coverage as a break of 63 days or more. However, State law applicable to health insurance coverage offered or provided by health insurance issuers may provide for a longer period.

- In any case, section 701(d) of ERISA and § 2590.701-3(b) provide that a group health plan, and a group health insurance issuer, may not impose any preexisting condition exclusion period with regard to a child who enrolls in a group heath plan within 30 days of birth, adoption, or placement for adoption and who does not incur a subsequent significant break in coverage. In addition, a group health plan, and a group health insurance issuer, may not impose a preexisting condition exclusion relating to pregnancy. (For health insurance issuers, State law may further restrict the extent to which a preexisting condition exclusion may be imposed.)

(6) Does the MEWA or ECE issue notices of special enrollment rights to individuals who are eligible to enroll in the plan or coverage? ..... ➤ ☐ Yes ☐ No

- Section 2590.701-6(c) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires that, on or before the time an employee is offered the opportunity to enroll in a group health plan or coverage, the plan or issuer provide the employee with a description of the plan's special enrollment rules.

- For this purpose, the plan may use the following model description of special enrollment rules:

> If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(7) Does the MEWA or ECE provide special enrollment rights to individuals who lose other coverage and to individuals who acquire a new dependent, if they request enrollment within 30 days of the loss of coverage, marriage, birth, adoption, or placement for adoption? . . . . . ➤ ☐ Yes ☐ No

- Section 701(f) of ERISA and § 2590.701-6 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) require group health plans, and group health insurance issuers, if certain conditions are met, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the individual loses other coverage or acquires a new dependent through marriage, birth, adoption, or placement for adoption.

- For State laws applicable to health insurance issuers that may provide individuals with additional special enrollment rights, check with an attorney or the Insurance Commissioner's Office in your State.

(8) Do the MEWA's or ECE's rules for eligibility (including continued eligibility) comply with the nondiscrimination requirements that prohibit discrimination against any individual or a dependent of an individual based on any health factor? . . . . . ➤ ☐ Yes ☐ No

- Section 702(a) of ERISA and § 2590.702(a) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a group health plan, and a group health insurance issuer, may not establish rules for eligibility (including continued eligibility, rules defining any applicable waiting periods, and rules relating to late and special enrollment) of any individual to enroll under the terms of the plan based on a health factor.

- The health factors are: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

- However, nothing requires a plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the plan or coverage. In addition, nothing prevents a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(9) Does the MEWA or ECE comply with the nondiscrimination requirements that prohibit requiring any individual (as a condition of enrollment or continued enrollment) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor? . . . . . ➤ ☐ Yes ☐ No

- Section 702(b) of ERISA and § 2590.702(b) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a group health plan, and a group health insurance issuer, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor (defined above).

- However, nothing restricts the amount that an employer may be charged for coverage under a group health plan and nothing prevents a plan or issuer from establishing premium discounts or rebates or modifying applicable copayments or deductibles in return for adherence to bona fide wellness programs.

(10) If the entity is a multiemployer plan or a MEWA, does it comply with the guaranteed renewability requirements, which generally prohibit it from denying an employer whose employees are covered under a group health plan continued access to the same or different coverage under the terms of the plan? . . . . . ➤ ☐ Yes ☐ No ☐ N/A

- Section 703 of ERISA (as well as the corresponding provisions in the Code) provides that a group health plan that is a multi-employer plan or a MEWA may not deny an employer whose employees are covered under the plan continued access to the same or different coverage under the terms of the plan, other than for nonpayment of contributions; for fraud or other intentional misrepresentation of material fact by the employer; for noncompliance with material plan provisions; because the plan is ceasing to offer any coverage in a geographic area; in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan acts without regard to the claims experience of the employer or any health factor in relation to those individuals or their dependents; and for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

- For other laws applicable to health insurance issuers that may provide additional guaranteed renewability requirements, check with an attorney or the Insurance Commissioner's Office in your State.

Worksheet B (Form M-1)	**Determining Compliance with the Mental Health Parity Act (MHPA) Provisions in Part 7 of Subtitle B of Title I of ERISA** Do NOT file this worksheet.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the MHPA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the question below, you should review your entity's operations because the entity may not be in full compliance with the MHPA provisions in Part 7 of ERISA. If you need help answering this question or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

Q. If the MEWA or ECE offers or provides both mental health benefits and medical/surgical benefits, does the MEWA or ECE comply with the requirements of the MHPA provisions, which are contained in section 712 of ERISA (as well as the corresponding provisions of the Code and the PHS Act)? . . . . . ➤ ☐ Yes ☐ No ☐ N/A

- Section 712 of ERISA and § 2590.712 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) generally provide for parity in the application of aggregate lifetime dollar limits and in the application of annual dollar limits between benefits for medical and surgical care and benefits for mental health coverage.
- However, these provisions do not require a group health plan or group health insurance coverage to provide any mental health coverage. And, MHPA does not apply to benefits for substance abuse or chemical dependency.
- In addition, there are exemptions for small employers and certain plans or coverage with increased costs.
- Finally, MHPA does not apply to benefits for services furnished on or after September 30, 2001.
- Contact the Department of Labor Office nearest you or call the Department's health care hotline at 202-219-4377 to find out more about these provisions.

Worksheet C (Form M-1)	**Determining Compliance with the Newborns' and Mothers' Health Protection Act (Newborns' Act) Provisions in Part 7 of Subtitle B of Title I of ERISA** Do NOT file this worksheet.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the Newborns' Act provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the questions below, you should review your entity's operations because the entity may not be in full compliance with the Newborns' Act provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

(1) If the MEWA or ECE offers or provides benefits for hospital stays in connection with childbirth and is subject to the Newborns' Act, does the MEWA or ECE comply with the Newborns' Act's substantive requirements, which are contained in section 711 of ERISA (as well as the corresponding provisions of the Code and the PHS Act)? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 711 of ERISA and § 2590.711 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) generally provide that a group health plan, and a group health insurance issuer, that offers benefits for hospital lengths of stay in connection with childbirth may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or her newborn child, following a vaginal delivery to less than 48 hours, and following a cesarean section to less than 96 hours, unless the attending provider, in consultation with the mother, decides to discharge earlier.

- In addition, such a plan or issuer may not require that the provider obtain authorization from the plan or issuer for prescribing any length of hospital stay up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section. Nor may such a plan or issuer penalize an attending provider for complying with this law or provide incentives to an attending provider to provide care in a manner that is inconsistent with this law. Nor may such a plan or issuer deny the mother or newborn eligibility or continued eligibility, or provide incentives to mothers to encourage them to accept less than the minimum length of stay required. Nor may such a plan or issuer restrict benefits for any portion of a period within a hospital length of stay required by this law in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

- The Newborns' Act's requirements apply to all self-insured benefits offered in connection with childbirth. However, State law rather than federal law may apply to health insurance coverage offered in connection with childbirth if the State law meets certain criteria specified in section 711(d) of ERISA and § 2590.711(d) of the Department's regulations. (These criteria are also specified in the Code and the PHS Act and the regulations issued thereunder.) Based on a preliminary review of State laws as of July 1, 1998, State law rather than federal law applies to health insurance coverage offered in connection with childbirth in the following States:

  Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, and West Virginia. Health insurance coverage offered in connection with childbirth in other States should also comply with the federal Newborns' Act requirements.

  Moreover, the following States appear to have a State law applicable to health insurance coverage that references the federal Newborns' Act provisions:

  Delaware, Idaho, and Oregon.

  Finally, the following States and other jurisdictions do not appear to have a law regulating coverage for newborns and mothers that would apply to health insurance coverage. Therefore, the federal Newborns' Act provisions appear to apply to health insurance coverage in the following States:

  Hawaii, Michigan, Mississippi, Nebraska, Utah, Vermont, Wisconsin, Wyoming, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the pertinent areas and installations of the Canal Zone.

(2) If the MEWA or ECE or provides benefits in connection with childbirth and is a group health plan, does the MEWA or ECE comply with the disclosure requirements under the Newborn's Act? . . . . . ➤ ☐ Yes ☐ No ☐ N/A

- Section 711(d) of ERISA and § 2520.102-3(u) require group health plans providing maternity benefits to include a statement in their summary plan descriptions advising individuals of the Newborns' Act's requirements.

- For this purpose, a MEWA or ECE that is subject to the Newborns' Act disclosure requirements through ERISA may use the following sample language:

  > Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- MEWAs and ECEs that are nonfederal governmental plans are subject to a similar disclosure requirement. For mandated language required to be used by such plans, see 45 CFR § 146.130(d)(2) (published in the **Federal Register** at 63 CFR 57561 on October 27, 1998).

Worksheet D (Form M-1)	Determining Compliance with the Women's Health and Cancer Rights Act (WHCRA) Provisions in Part 7 of Subtitle B of Title I of ERISA Do NOT file this worksheet.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the WHCRA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the questions below, you should review your entity's operations because the entity may not be in full compliance with the WHCRA provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

(1) If the MEWA or ECE offers or provides mastectomy coverage, does the MEWA or ECE comply with WHCRA's substantive requirements, which are contained in section 713 of ERISA (as well as the corresponding provisions of the PHS Act)? . . . . . ➤ ☐ Yes ☐ No ☐ N/A

- Section 713 of ERISA (as well as the corresponding provisions in the PHS Act) generally provides that a group health plan, and a group health insurance issuer, that offers mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- In addition, a plan or issuer may not deny a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of WHCRA. Nor may a plan or issuer penalize or otherwise reduce or limit the reimbursement of an attending provider; or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to furnish care to an individual participant or beneficiary in a manner inconsistent with WHCRA.
- Plans and issuers may impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.
- State law protections may apply to certain health insurance coverage if the State law was in effect on October 21, 1998 (the date of enactment of WHCRA) and the State law requires at least the coverage for reconstructive breast surgery that is required by WHCRA.

(2) If the MEWA or ECE offers or provides mastectomy coverage, does the MEWA or ECE comply with the disclosure requirements under WHCRA? . . . . . ➤ ☐ Yes ☐ No ☐ N/A

- Section 713(b) of ERISA (as well as the corresponding provisions of the PHS Act) establishes a one-time notice requirement under which group health plans, and their health insurance issuers, must furnish a written description of the benefits that WHCRA requires. This notice is required to be furnished as part of the next general mailing (made after October 21, 1998) by group health plans, and their health insurance issuers, or in the yearly information packet sent out regarding the plan, but, in any event, the one-time notice is required to be furnished not later than January 1, 1999.
- Section 713(a)(3) of ERISA (as well as the corresponding provisions of the PHS Act) establishes a disclosure requirement under which group health plans, and their health insurance issuers, must again describe the benefits required under WHCRA, but the notice is to be provided upon enrollment in the plan and annually thereafter.
- Both notices must indicate that, in the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. The notice must also describe any deductibles and coinsurance limitations applicable to such coverage. (Under WHCRA, coverage of breast reconstruction benefits may be subject to deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage.)

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