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PEO Health Plans – MEWAs or Not?

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PEO Health Plans – MEWAs or Not?

The focus of this *NAPEO Legal Review*™ is to discuss the status of PEO health plans and the issue of whether or not they fall under the ERISA (Employee Retirement Income Security Act) category called MEWAs (multiple employer welfare arrangements).

Like many PEO issues, the topic is not one with clearly defined answers. As is the case with other PEO situations, the co-employment model finds itself in a gray area with competing interpretations. Given the fact, however, that the U.S. Department of Labor (DOL) has fairly steadfastly placed PEO health plans into the MEWA category, it is crucial for PEOs to understand the issue and its history. The following paper will give an overview of the current regulatory situation, a detailed analysis of the MEWA rules and their origin, and finally will make some observations about practical implications for PEOs.

I. Current Regulatory Situation

On February 11, 2000, when the DOL issued interim final regulations requiring that MEWAs and certain entities claiming an exception (ECEs) file the Form M-1, the question of whether a PEO constitutes a MEWA became more than an academic discussion without monetary consequences.

The Form M-1 is a required filing for all MEWAs and ECEs.[1] The Form M-1 has two purposes. One purpose is to determine whether MEWAs and ECEs are complying with four federal laws: the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, and the Womens' Health and Cancer Rights Act. A second purpose is to create a national registry of MEWAs to aid the DOL and state agencies in their MEWA enforcement efforts.

The Form M-1 is required to be filed each March 1st with information for the prior year.[2] Under ERISA's civil penalty provisions, a PEO deemed to be a MEWA that fails to file a Form M-1 can be assessed a civil penalty as high as $1,000 a day.[3]

Traditionally, PEOs operating under a business model based on a co-employer relationship with the worksite employer in which the PEO is the health benefit sponsor have taken the position that they are entitled to structure their employee benefit plans as if they were sponsored by a single-employer. The National Association of Professional Employer Organizations (NAPEO) filed comments with the DOL articulating this position[4]. In its most recent comment, NAPEO distinguished PEOs from those plans that were the focus of the 1983 MEWA amendments to ERISA:

> When Congress passed the MEWA Act of 1983, it intended to carve out an exception to the ERISA preemption for arrangements whose sponsors were in fact providing welfare benefits to the *employees of others*. It

1 An ECE, is an entity that claims it is not a MEWA because its is excepted from the definition of a MEWA under the Employee Retirement Income Security Act (ERISA) § 3(40)(A)(i), 29 U.S.C. § 1002(40(A)(i). This provision generally exempts from the definition of a MEWA an arrangement that is established or maintained pursuant to one or more agreements the DOL finds to be collectively bargained.

2 One automatic 90-day extension is available for filers and the Form M-1 and instructions are available online at *http://www.dol.gov/ebsa*.

3 See ERISA § 502(c)(5), 29 U.S.C. § 1132(c)(5).

4 NAPEO comment letters to the Pension and Welfare Benefits Administration (then PWBA and now the Employee Benefits Securities Administration, or EBSA) of March 13, 2000, and November 29, 2000.

> was not intended to intrude upon the right of an employer to provide benefits under ERISA to that employer's own employees . . . . The MEWA Act was intended to address arrangements where the only link between the sponsor of the employee benefit plan and the employees receiving benefits was that of a third party sponsor of the plans. It was not designed, nor intended, to address the employment arrangements of PEOs.
>
> We believe that there is a sufficient, distinct, and easily identifiable difference between PEOs and MEWAs that permits the PWBA a legal basis for excluding PEOs from the MEWA filing requirement. In a PEO arrangement, the same sponsoring employer employs all covered employees. The PEO, as an employer, is sponsoring a welfare benefit plan for its own employees. Conversely, a MEWA is established and operated to provide welfare benefits to employees of other employers.[5]

NAPEO suggested the DOL either not consider PEO health plans as MEWAs or develop an alternative reporting mechanism for only those PEO plans that were self-insured or not otherwise regulated. This was based on the position that PEOs should be permitted to structure single-employer plans. To say it has been difficult to persuade federal regulators to agree with NAPEO's position is an understatement.

In prior, company-specific interpretations, the DOL determined that staff leasing company plans constituted MEWAs.[6] NAPEO's efforts concerning the MEWA reporting regulations notwithstanding, the DOL could not find a sufficiently meaningful distinction between PEOs and staff leasing companies such that it could change its earlier advisory opinions addressing the MEWA status of plans sponsored by staff leasing companies versus PEO-sponsored plans. The DOL felt the reasoning in its staff leasing plan advisory opinions applied in the PEO health plan context.

The DOL's conclusion that staff leasing company plans constitute MEWAs is based really on one fundamental factor: their concern that the client continues to be an employer of the worksite employees under a common law test.[7] This and the use of the terminology "co-employment" logically, according to DOL, leads to the conclusion that two or more employers participate in the arrangement.

In one of the DOL opinion letters, the Department stated, in part:

> "[Leasing company] maintains that it acts as a 'fiscal employer' or 'co-employer' of employees with respect to whom it provides management services. All of the documents submitted indicate that employer responsibilities with respect to the employees covered by the [leasing company] program are expected to be divided between [leasing company] and the Client. ...Any Client that in fact exercises employer control and authority over employees covered in the [leasing company] Program would be an 'employer' with respect to such employees for purposes of ERISA ..."[8]

5 NAPEO comment letter of November 29, 2000.

6 See Advisory Opinion (AO) 91-17A to L.J. Darter, III (April 5, 1991); AO 91-47A to Lee P. Jedziniak (December 20, 1991); AO 92-04A to Sandra Milburn (January 27, 1992); AO 93-29A to Alfred W. Gross (November 2, 1993); AO 95-22A to Dale Robinson (August 25, 1995); and AO 95-29A to Kevin W. Ahern (December 7, 1995).

7 *Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318 (1992)(adopting the common law test for determining employee status in the ERISA plan context).

8 DOL, PWBA Office of Regulations and Interpretations AO 93-29A,

The fact that there are two employers and there is an arrangement pursuant to which benefits are provided in turn leads to the conclusion that the arrangement is a MEWA under the definition of a MEWA in ERISA.[9]

While the DOL has not taken the position that the PEO is not an employer, PEOs have long had difficulty asserting employer status under the common law test.

The common law test is fact intensive and requires that "all of the incidents of the relationship" be examined in the context of numerous factors that have been identified by the courts over time, with no one factor being decisive.[10] The Supreme Court has stated that the test can be summarized as a consideration of "the hiring party's right to control the manner and means by which the product is accomplished."[11] The following factors are relevant to the determination of employer status:

> "the skill required; the source of the instrumentalities and tools; the location of the work; whether the hiring party has the right to assign additional projects to the hired party; the extent of the hired party's discretion over when and how long to work; the method of payment; the hired party's role in hiring and paying assistants; whether the work is part of the regular business of the hiring party; whether the hiring party is in business; the provision of employee benefits; and the tax treatment of the hired party."[12]

NAPEO does not assert that the client of a PEO is not a common law employer, but has maintained that PEOs, as co-employers, are also qualified under the test. NAPEO's position is that the common law test is not an "either/or" test to be applied between two employers, but a test to be applied between a worker and employer to determine if the worker is an employee or an independent contractor. In many situations, however, regulatory agencies and the courts have instead applied the common law test as a comparative test to determine who is the "true" employer.

Without assessing each individual relationship, it is virtually impossible to make a conclusive finding on the employment relationship in the PEO context. Thus, to date no regulatory agency has made such a definitive finding. At least one court has reviewed the question in the context of a PEO pension plan and concluded that the PEO was not the "true" employer and its pension plan was subject to disqualification.[13] Subsequently, however, the same circuit also affirmed that a leased employee could be an employee both of the agency and of the client under that same common law test.[14]

On April 9, 2003, when the DOL issued final Form M-1 regulations, it officially declined to accept the NAPEO suggestion that an alternative reporting for PEOs might be appropriate.[15] In the preamble, the agency stated it was unable to "conclude

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9 With exceptions, ERISA states that any group health plan arrangement in which two or more employers participate constitutes a MEWA. ERISA § 3(40), 29 U.S.C. § 1002(40).

10 *Id.* at 323.

11 *Id.*, (quoting *Community for Creative Non-Violence v. Reid*, 490 U.S. 730, 740 (1989).

12 *Id.* at 323-324.

13 *Professional and Executive Leasing, Inc. v. Commissioner*, 89 T.C. 225 (1987), aff'd 862 F.2d 751 (9th Cir. 1988).

14 *Vizcaino v. District Court*, 173 F3d 713 (9th Cir 1999 at Part IV).

15 The DOL's consideration of this issue was not helped by an earlier Internal Revenue Service (IRS) ruling. On April 24, 2002, the Internal Revenue Service released Rev. Proc. 2002-21, which requires that PEO pension plans structured as single-employer plans convert to multiple-employer plans or that the plans be terminated by a certain date. A PEO plan that fails to comply with these requirements is subject to disqualification. In the Rev. Proc., the IRS concluded that, although it could not find that a PEO would never meet the common law definition of "employer," it nonetheless could also not conclude that all PEOs met the test.

that the group health plans maintained by PEOs, like the plans maintained by employee leasing companies, do not cover the employees of more than one employer."[16] Therefore, although the DOL did not find that PEO plans constituted MEWAs, it nonetheless would not exempt PEOs from the requirement of the Form M-1 filing.

Although both the IRS in its revenue procedure on 401(k) plans and the DOL in its regulation on MEWA reporting reached their positions, in part, on their inability to determine who is the "true" employer of the worksite employees, their concerns with respect to the plans are very different. The IRS focus was upon whether PEO plans might be evading qualification rules involving discrimination testing and top heavy rules. The DOL's concerns, on the other hand, were much broader than concerns about individual plans.

ERISA's broad preemptions with regard to state law and the states' authorities to regulate and DOL's past experience with fraudulent "ERISA plans" were prime motivators in the DOL's hesitance in granting a PEO exemption to the filing requirement, even a limited one. The agency was faced with the fearful specter that in so doing the DOL might inadvertently create a window through which unscrupulous entrepreneurs might market fraudulent healthcare coverage below the radar screen of state regulators.

Two of the three key ERISA enforcement agencies – the DOL and the IRS – have dodged the issue of conclusively stating whether or not a PEO can be deemed the employer of worksite employees. However, both have imposed a regulatory regime that applies to the world of multiple-employer plans rather than single employers.[17]

Given this regulatory environment, PEOs need to deepen their knowledge of the regulatory world of MEWAs, because unlike the world of multiple-employer pension plans, MEWAs are governed by both state insurance laws and ERISA. The purpose of this article is demystify MEWAs and their regulations.

II. An Overview of the History of MEWA Regulation

A. The Origins of MEWAs

To say that MEWAs have had a checkered history in the marketplace is an understatement. When MEWAs were first marketed shortly after the passage of ERISA, they were called multiple employer trusts (METs). METs quickly developed a bad reputation because they were often insufficiently funded or had inadequate reserves with which to pay legitimate medical claims. The assets of the most abusive METs were often drained by operators who simply embezzled the money for their own use. In 1992, the General Accounting Office reported that between 1988 and 1990, "MEWAs left at least 398,000 participants and their beneficiaries with over $123 million in unpaid claims."[18]

The basic concept of a MEWA or MET is simple. MEWAs offer small employers the opportunity to band together and negotiate rates from an insurance company lower than that which each individual small employer could purchase on its own. Alternatively, by banding together, small employers are able to create or join a self-funded trust through which benefits are paid, thereby avoiding insurance companies altogether. In essence, MEWAs allow small employers greater price and design flexibility than would otherwise be available to them through traditional insurance sources.

16 See 68 *Fed. Reg.* 17497 (2003) (to be codified at 29 C.F.R. pt. 2520).

17 The third agency is the Pension Benefits Guaranty Corporation, which primarily governs distressed defined benefit plans.

18 GAO, *Employer Based Health Plans, Issues, Trends and Challenges Posed by ERISA*, p.39 (July 1995).

Historically, states have controlled insurance regulation. ERISA governs pension and welfare employee benefit plans. Welfare plans are defined to include employee benefit plans that provide health benefits.[19] Accordingly, the jurisdictional distinction that historically existed between state and federal government over insurance regulation was blurred when ERISA was enacted in 1974. MEWAs or METs have always tried to take advantage of the jurisdictional blur to avoid state regulation, and, therefore, a central issue in the debate involving MEWAs historically has involved which government – state or federal – regulates them.

B. An Introduction to ERISA's Preemption Provision and Other Relevant ERISA Terms

Although ERISA contains a broad preemption provision, it allows states to continue to regulate the business of insurance.[20] ERISA's preemption provision is qualified by the "insurance savings clause" which provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance. . . ."[21] The "insurance savings clause," however, is qualified by the so-called "deemer clause" which prohibits a state from deeming an employee benefit plan an insurance company for purposes of state insurance regulation.[22] ERISA defines an employee welfare benefit plan as any plan, fund, or program established or maintained by an employer, employee organization, or both to the extent that the plan, fund, or program was established for the purpose of providing *inter alia* medical coverage.[23] ERISA broadly defines the term "employer" as any "person acting directly as an employer, or indirectly in the interest of an employer in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity."[24] The term "employee association" is also broadly defined and includes any labor union.[25] As originally enacted, ERISA did not define the term MET.

The abusive METs or MEWAs were generally not employee benefit plans because they were not established or maintained by an employer, or an employee organization, or both for the purpose of providing medical benefits to their members and employees.[26] The abusive METs or MEWAs historically have been sponsored by third party entrepreneurs who marketed the medical coverage to disparate groups of employers with whom the MET sponsors had no previous relationship. Accordingly, these enterprises lack the essential element which distinguishes an ERISA-covered employee welfare plan from an insurance company: an employer/employee relationship.

METs nonetheless promoted themselves as ERISA–covered plans in an effort to escape state insurance laws through ERISA's preemption provision. Until the passage of HIPAA, ERISA contained few substantive provisions governing welfare plans. For example, unlike pension plans, ERISA does not include funding or vesting requirements for welfare funds. By arguing that they were ERISA governed plans, METs were able to operate as unlicensed and unregulated health insurance vehicles.[27]

19 29 U.S.C. § 1002(1).
20 29 U.S.C. 1144(a).
21 29 U.S.C. § 1144(b)(2)(A).
22 29 U.S.C. § 1144(b)(2)(B).
23 29 U.S.C. 1002(1).
24 29 U.S.C. 1002(5).
25 29 U.S.C. 1002(4).
26 U.S.C. § 1002(1); and see 128 *Cong. Rec.* 30356-58 (1982) (remarks of Rep. Erlenborn).
27 128 *Cong. Rec.* 30356-58 (1982) (remarks of Rep. Erlenborn).

In response to the market abuses created by METs, Congress enacted the Erlenborn-Burton Act in 1983, which amended ERISA by introducing and defining the term MEWA to include both employee welfare benefit plans and other arrangements (so-called METs) established and maintained for the purpose of offering welfare benefits to the employees of two or more employers.[28] The definition of a MEWA excluded *inter alia*, an arrangement that was established or maintained "pursuant to one or more agreements the Secretary [of Labor] finds to be collective bargaining agreements."[29] Accordingly, plans sponsored by a union pursuant to a legitimate collective bargaining agreement are governed exclusively by ERISA.[30]

The 1983 amendments also clarified that state insurance laws applied to MEWAs that were employee benefit plans, provided that the state law was not inconsistent with ERISA.[31] The amendments further clarified that state insurance laws, without reservation, applied to MEWAs that were not employee benefit plans.[32] As Representative Erlenborn stated, "[t] he amendment removes any potential obstacle that might exist under current law which could hinder the ability of the states to regulate multiple employer welfare arrangements to assure the financial soundness and timely payment of benefits under such arrangements."[33]

The federal government, of course, also retained jurisdiction over ERISA-covered MEWAs and arrangements which failed to meet the definition of an employee benefit plan. In the latter context, ERISA governed if it could be proved that the MEWA contained plan assets. To establish that a MEWA contains plan assets, the proof consists of demonstrating that the subscribing employers create ERISA-covered plans.[34]

The Erlenborn-Burton amendments were intended to remove any doubt that state laws did not apply to all MEWAs to make it impossible for METs to assert that ERISA preempted state insurance laws and thus escape state regulation. The effect of the amendments was to confer concurrent jurisdiction over MEWAs so that MEWA sponsors could not play state and federal regulators against each other and the public would be better protected against fraud and abuse in the healthcare arena. The public harm that results from fraudulent healthcare schemes is severe. When a MEWA fails, individuals are left holding the bag for their unpaid health claims. Most, if not all, state association guarantee funds exclude coverage for failed MEWAs, and the federal government does not have a bail-out program.

28 29 U.S. C. § 1002(40)(A).

29 29 U.S.C. § 1002(40)(A)(i).

30 On April 9, 2003, the DOL issued final regulations on providing guidance on what constitutes a bona fide collective bargaining agreement for purposes of the exemption and an administrative process by which entities can request a hearing to obtain an official DOL determination as to the entities' status. See 68 *Fed. Reg.* 17484 (April 9, 2003), (concerning administrative hearings); and 68 *Fed. Reg.* 17471 (April 9, 2003) (setting forth criteria for what constitutes a bona fide collective bargaining agreement).

31 The Department of Labor takes the position that a state insurance law or regulation would be inconsistent with ERISA only if the state law "would abolish or abridge an affirmative protection or safeguard otherwise available to plan participants and beneficiaries" or conflict with an ERISA provision. See, e.g. Opinion Letter 90-01 8A. By way of example, the Department's Advisory Opinion described as inconsistent with ERISA a state law that would require an ERISA-covered MEWA to make imprudent investments. In general, the Department has not found that any state law that imposes more protection by way of solvency standards or licensing requirements to be inconsistent with ERISA. For good reason, there are no substantive provisions that govern welfare plans with which state laws could possibly conflict.

32 29 U.S.C. § 1144(6).

33 12 *Cong. Rec.* 30356 (1982) (remarks of Rep. Erlenborn).

34 See, e.g., *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (*en banc*).

III. If a PEO Plan Were Deemed to Be a MEWA, What Type of MEWA Would it Be?

ERISA broadly defines the term MEWA. The definition captures arrangements that meet the definition of an employee welfare benefit plan under ERISA and those that don't. Under ERISA a MEWA means:

> 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 any benefit described in [ERISA § 3(1)] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries. . . . 35

As indicated by the statutory definition, MEWAs can be of two types. One type of MEWA is the type referred to by the statute as a MEWA that falls within ERISA's definition of "employee welfare benefit plan." This type of MEWA is also referred to as a "Title I MEWA" and sometimes it is called an "association plan MEWA."36 The other type of MEWA is the kind that falls under what the statute defines as "any other arrangement." PEO's would likely be deemed a MEWA that falls under the definition of "any other arrangement." In other words, the PEO's MEWA would likely not be deemed to constitute an employee welfare benefit plan as that term is defined by ERISA, in part, because of the problems determining that a PEO is a an "employer" of the worksite employees.

In the analogous staff leasing context, for example, the DOL has issued a number of advisory opinions where it determined that the presence of even one client employer who retains sufficient indices of control over his or her employers was sufficient to render the arrangement a MEWA.37 Unless there was a finding that the PEO constituted the "true" employer for all its worksite employees, a finding that to date in the analogous staff leasing context the DOL has not made, the arrangement would likely constitute a MEWA of the type that falls under the "any other arrangement" clause of the MEWA definition.

From a regulatory perspective, the distinctions between employee benefit plan MEWAs and MEWAs that constitute "any other arrangement" are negligible because ERISA and state insurance laws govern both arrangements, albeit in varying degrees. Complete preemption of state insurance laws under ERISA only applies to single-employer plans and even then only to self-funded single-employer plans. State insurance laws would nevertheless govern the insurance policy issued to a single-employer plan.

A. State Law Application to MEWAs

As noted above, the 1983 amendments to ERISA's preemption provision were intended to clarify that state insurance law applies, as permitted under ERISA § 514(b)(6)(A), to MEWAs that met the definition of an employee benefit plan and that

35 ERISA § 3(40), 29 U.S.C. § 1002(40). The following three types of arrangements are expressly excluded from the definition of a MEWA: An arrangement that is established or maintained pursuant to one or more agreements that the Secretary of Labor finds to be collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association. Also excluded are arrangements that include more than one employer, all of whom are members of the same "control group" as defined in ERISA and the Internal Revenue Code.

36 The reference to "Title I" refers to Title I of ERISA, which governs fiduciary standards of conduct and is where the definition of employee benefit plans and MEWAs, among other, are found.

37 See, e.g., A.O. 92-04A to Sandra Milburn (January 27, 1992); and AO 93-29A to Fred W. Gross (November 2, 1993).

MEWAs that were not employee benefit plans were fully governed by state insurance laws.[38] One purpose of the amendments was to ensure that state regulators could move aggressively against fraudulent MEWAs unimpeded from an ERISA preemption defense because irrespective of the MEWA's status as an employee benefit plan, state insurance regulation of MEWAs was not preempted to the extent permitted by ERISA § 514(b)(6)(A). In the case of a MEWA that did not constitute an employee benefit plan, state insurance laws would be fully applicable. Hence, if a PEO's plan were deemed to constitute a MEWA that itself was not an employee benefit plan, its plan, whether self-funded or fully-insured, would be subject to all state insurance laws.

Even if a PEO's plan were found to constitute an employee benefit plan MEWA, it would nonetheless be subject to state regulation as prescribed under ERISA § 514(b)(6)(A). Although, ERISA's preemption provisions appear to make a distinction in how state laws apply to a fully-insured versus a self-funded employee benefit plan MEWA, in practice the distinction is not that significant and neither is the difference between an employee benefit plan MEWA and one that is not.

In practice, state insurance laws, for the most part, apply to employee benefit plan MEWAs, theoretically, unimpeded by ERISA preemption. With respect to fully-insured MEWAs, ERISA § 514(b)(6)(A) provides that state laws setting insurance standards and reserves and any state law provisions to enforce these standards and reserves are not preempted. With respect to self-funded MEWAs, only state laws that do not conflict with ERISA are not preempted. The DOL, however, has narrowly interpreted what constitutes a state law that is "inconsistent" with ERISA. It has stated, for example, that a state law is inconsistent with ERISA "to the extent that compliance with such law would abolish or abridge an affirmative protection" or make compliance with ERISA impossible.[39] The DOL has also stated that it would not consider state laws that impose standards higher than those required under ERISA to conflict with ERISA or state laws setting reserves and specified levels of contributions.[40]

In practice, there are few real distinctions in a state's ability to regulate MEWAs, irrespective of their status as an employee benefit plan. In the MEWA context, only a very rare state insurance law would be preempted by ERISA. The reality is that most state insurance laws would apply to MEWAs, irrespective of their status as an employee benefit plan.

B. ERISA Jurisdiction Over MEWAs

1. ERISA-Covered Plans

An employee benefit plan MEWA is governed by all ERISA provisions. This includes compliance with ERISA's reporting and disclosure requirements and fiduciary standards. It also includes compliance with ERISA's prohibited transaction provisions.

38 ERISA § 514(b)(6)(A) provides that in the case of an employee benefit plan that is a fully insured MEWA any law of any state that regulates insurance may apply to the arrangement to the extent:

(i) Standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(ii) Provisions to enforce such standards.

In the case of any other employee benefit plan MEWA, "any law of any state which regulates insurance may apply to the extent not inconsistent" with the Title I of ERISA.

39 U. S. Department of Labor, Employee Benefits Security Administration "Multiple Employer Welfare Arrangements Under ERISA, A Guide to Federal State Regulation" at *17 (June 1, 2003). (Attached as Appendix A).

40 *Id.* at *18 and DOL AO 1990-18A to Texas State Board of Insurance (July 2, 1990).

The basis of ERISA jurisdiction in the case of an employee benefit plan MEWA is that the plan meets the definition of an employee welfare benefit plan in ERISA § 3(1), and therefore, logically, ERISA governs.[41]

2. ERISA Jurisdiction Over MEWAs That Are Not Employee Benefit Plans

As noted, if PEOs were deemed a MEWA, they would likely fall into the category of MEWAs that do not constitute an employee benefit plan. This section will both elaborate on the reasons for this and discuss ERISA jurisdiction in the more relevant context of these types of arrangements.

In order to fully understand why a PEO MEWA would likely not constitute an employee benefit plan, it is necessary to detour through the thicket of ERISA's definitional provisions.

The main distinction between an ERISA-covered MEWA and one that constitutes "any other arrangement" is that an employer establishes or maintains the arrangement for the exclusive benefit of plan participants. ERISA broadly defines the term "employer" to include " a group or association of employers acting for a [single employer].[42] The term "participant" is defined as, *inter alia*, "an employee of an employer," a definition the Supreme Court has called "completely circular and explains nothing."[43]

ERISA's broad definition of employer might lead some to conclude that a PEO plan if deemed a MEWA should constitute a Title I MEWA. The DOL, however, has consistently taken the position that a Title I MEWA exists only where the arrangement is created by concerted action on the part of the sponsoring parties. To assure the presence of concerted employer activity, the DOL has interpreted the term "group or association of employers" in ERISA § 3(5) to mean a cognizable, bona fide organization of employers, controlled by its members, and acting in a settlor capacity with respect to the plan.[44]

Informally, the DOL has stated that in determining whether a *bona fide* group or association of employers exists, the following factors should be considered: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed; the purposes for which it was formed and what, if any, were the pre-existing relationships of its members; the powers, rights, and privileges and operations of employer-members; and who actually controls and directs the activities and operations of the benefit program.[45] In practice, Title I MEWAs have been limited to MEWAs sponsored by a trade association because these types of entities are usually able to meet the six-factor test.[46]

Where no *bona fide* group or association of employers exists, the arrangement itself would not be considered an ERISA-covered welfare plan. It does not follow, however, that ERISA does not govern the arrangement. ERISA will govern this arrangement if it can be demonstrated that the participating employers established an ERISA-covered plan. *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (*en banc*). In most cases, this is not a problem.

ERISA plans are easily created. The lack of a formal written document will not deter a court from finding that a plan exists. In *Dillingham*, the court developed a two-step process for determining the existence of an ERISA plan. This test has been

41 See Footnote 15 and accompanying text.

42 ERISA § 3(5), 29 U.S.C.§ 1002(5).

43 *Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318, 323 (1992).

44 See, e.g. DOL AO 2001-04A (March 22, 2001) to John E. Mosberg regarding the Wisconsin Automobile and Truck Dealers; and DOL AO 79-41A (June 29, 1979) to Western Employers Security Trust.

45 See Employee Benefits Security Administration, U.S. Department of Labor "Multiple Employer Welfare Arrangements Under ERISA, A Guide to Federal and State Regulation." (June 1, 2003).

46 See, e.g. DOL AO 2001-04A (March 22, 2001) to John E. Mosberg regarding the Wisconsin Automobile and Truck Dealers.

applied by virtually every circuit court in the country that has been asked to decide the question. The first step requires that a court determine whether a plan, fund, or program of benefits exists. The second requires that the court decide whether the plan was established and maintained by an employer for the benefit of its employees.

In *Dillingham*, the court stated that a plan, fund, or program could exist if from the surrounding circumstances a reasonable person could ascertain the intended benefits, a class of beneficiaries, the source of financing, and the procedures for receiving benefits.[47] The determination that a plan, fund, or program exists, does not end the inquiry. For a plan to qualify as an ERISA plan, *Dillingham* requires evidence that employers established or maintained the plan with the intent of providing benefits to their employees and that the arrangement does not fall within ERISA's safe harbor provision.[48]

In the context of a group health plan, the DOL has issued safe harbor regulations setting forth four criteria that, if present in the aggregate, will exempt a group insurance program from ERISA coverage. The regulations provide that an insurance program will not constitute an ERISA plan if: the employer makes no contributions; participation in the program is completely voluntary; the employer merely advertises the program, without endorsement; and the employer receives no consideration, other than reimbursement for plan administration expenses, in connection with the program.[49]

How courts weigh and apply the four criteria to determine whether an employer has established or maintained a plan varies from jurisdiction to jurisdiction. As an example of how courts weigh the criteria, the Ninth Circuit takes the position that the absence of any one of the four criteria is sufficient to preclude the availability of the safe harbor exemption.[50] Most circuits agree that a plan has been established if the participants include "employees" and the employer pays in whole or in part for the coverage. The absence of employer contributions standing alone, however, will be insufficient for courts to decide that an ERISA plan does not exist.[51]

In practice, as long as the plan participants include more than just the owner and his or her spouse, and the employer endorses the program in almost any manner, most courts will conclude that an employer established a plan. Therefore, in most cases an arrangement that itself does not constitute an employee benefit plan will nonetheless be governed by ERISA because in all likelihood the participating employers established plans. The MEWA operators would be deemed to be exercising discretion over the plan or its assets. In general, persons who exercise discretionary authority or control over ERISA-covered plans or

47 See also *Salameh v. Provident Life & Accident Ins. Co.*, 23 F Supp 2d 704 (SD Tex 1998) (applying *Dillingham* test in the context of a long-term disability plan); *Modzeleuski v. Resolution Trust Corp.*, 17 EBC (BNA) 2298 (9th Cir 1994) (applying *Dillingham* test in the context of retirement benefits); *Williams v. Wright*, 13 EBC (BNA) 2137 (11th Cir 1991) (same); *McNeil v. Time Ins. Co.*, 205 F 3d 179, 189-90 (5th Cir 2000); *Johnston v. Paul Revere Life Ins. Co.*, 241 F 3d 623, 629 (8th Cir 2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 US 1, 11-12 (1987) (no single action constitutes the establishment of a plan; however, a plan must embody a "set of administrative practices"))

48 See *Dillingham*, 688 F 2d at 1372-73; see also *Crull v. Gem Ins. Co.*, 58 F 3d 1386, 1390 (9th Cir 1995); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F 2d 489 (9th Cir 1988), *cert denied*, 492 US 906 (1989).

49 See DOL Reg § 2510.3-1(j); see also, e.g., *McNeil v. Time Ins. Co.*, 205 F 3d 179, 189-90 (5th Cir. 2000).

50 See, e.g., *Stuart v. Unum Life Ins. Co. of America*, 217 F 3d 1145 (9th Cir. 2001) (reviewing 9th Cir. cases and holding that an employer who was named administrator for the plan under the facts of the case could still satisfy all four criteria and come within the safe harbor regulations); *Qualls v. Saddleback*, 22 F. 3d 839, 843 (9th Cir. 1994); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988), *cert denied*, 492 U.S. 906 (1989).

51 See, e.g., *Hansen v. Continental Ins. Co.*, 940 F 2d 971 (5th Cir. 1991).

their assets are considered fiduciaries within the meaning of ERISA and therefore subject to ERISA's fiduciary standard provisions.[52] Thus, in the context of a MEWA that is not an employee benefit plan, ERISA jurisdiction is conferred because the MEWA managers are in all likelihood exercising discretion over the plans established, albeit perhaps unknowingly, by employers participating in the arrangement.

3. ERISA Provisions that Apply to MEWAs that Are Not Employee Benefit Plans

In general, all of ERISA's fiduciary standards apply to managers of MEWAs that are not employee benefit plans. Those standards are set forth in ERISA § 404(a)(1)(A) and (B) and generally are referred to as ERISA's loyalty and prudence provision.[53] ERISA §§ 404(a)(1)(A)and (B) impose what one court has referred to as "three different although overlapping standards."[54] In *Donovan v. Bierwirth*, the court stated that "a fiduciary must discharge his duties 'solely in the interest of the participants and beneficiaries.' He must do this 'for the exclusive purpose' of providing benefits to them. And he must comply 'with the care, skill, prudence, and diligence under the circumstances then prevailing' of the traditional 'prudent [person].'"[55] These basic requirements constitute ERISA's duty of undivided loyalty and prudence.

The duty of undivided loyalty forbids a fiduciary not only from using the assets of the plan for his or her personal interest but also from favoring the interests of a third party over the interests of a plan participant, even if the fiduciary's own interests are not implicated.[56]

Whether a fiduciary acted prudently in any given situation depends on the facts and circumstances of each case. "The scope of the fiduciary's duty of prudence is . . . limited to those factors and circumstances that a prudent person having similar duties and familiar with such matters would consider relevant, whether the context is one of plan investments or otherwise."[57] The prudence standard under ERISA "is not that of a prudent lay person, but rather of a prudent fiduciary with experience dealing with a similar enterprise."[58]

ERISA's prudence standard is by necessity a "flexible standard" because fiduciaries of employee benefit plans are charged with making decisions that range from the investment of plan assets to the selection of service providers.[59] A fiduciary act is

52 ERISA defines a "fiduciary" in functional terms. Under ERISA a person is a fiduciary "to the extent" he: exercises discretionary authority over an employee benefit plan or its assets; provides investment advice within certain parameters; or has any discretionary control over a plan or its assets whether or not the discretion is exercised. See ERISA § 3(21)(A), 29 U.S.C. § 1002(3)(21)(A).

53 ERISA § 404(a)(1)(A) and (B) provide that "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and:

(i) For the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan;

(ii) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

54 *Donovan v. Bierwirth*, 680 F.2d 263 (2d. Cir), *cert denied*, 459 US 1069 (1982).

55 *Id.*, at 271.

56 *Marshall v. Kelly*, 465 F. Supp 341, 350 (WD Okla 1978).

57 44 Fed. Reg. 37,222-23 (DOL release accompanying DOL Reg § 2550.404a-1(b))

58 *Whitfield v. Cohen*, 682 F.Supp 188, 194 (S.D.N.Y. 1988) (quoting *Marshall v. Snyder*, 1 EBC (BNA) 1878, 1886 (EDNY 1979)).

59 *Donovan v. Cunningham*, 716 F.2d 1455, 1467 (5th Cir. 1983).

judged by the standard of one "familiar with such matters."[60] A trustee's lack of familiarity with an issue does not excuse a fiduciary breach.[61] As noted in *Cunningham*, a "pure heart and an empty head are not enough."[62]

In addition, to ERISA's prudence and loyalty standards, § 404 also requires that a fiduciary diversify investments so as to minimize the likelihood of large losses and that the plan be governed in accordance with the documents and instruments governing plan documents.

In practice and, as a very general matter, there are probably three broad areas in the PEO/MEWA context where ERISA's prudence provisions will be constantly tested: selecting plan service providers, monitoring service providers, and using plan assets to pay service providers.

4. Selecting Service Providers

The following are guidelines for establishing a prudent selection process:

- Check credentials of the service provider. Ask how long has the service provider been in business, ask what educational degrees or training its employees have, and check references.
- Investigate the service provider's financial stability.
- Engage in competitive bids.
- Understand the compensation structure and be sure the compensation is reasonable for the services provided.
- Determine whether the service provider is a party in interest to the plan or whether there are any other relationships between the service provider and the plan that should be considered.

In the fully insured welfare benefit context, selecting an insurance carrier is likely the most critical service provider selection a fiduciary will make. In this context, price considerations should be compared to the quality and accessibility of the healthcare providers. For example, a fiduciary may compare two health insurance carriers that provide similar coverage for comparable cost, but if one of the carriers requires that participants use only their network for the quoted price, ease of accessibility to the network in relation to where the majority of participants live should be considered. An additional consideration may include timeliness of the insurer in paying claims to the providers. An insurer with a history of chronic late payments to providers may be an indication that the insurer is not financially stable, or, as a result of paying the providers chronically late, the insurer may have a network of unhappy doctors and medical facilities. In other words, the quality of services is a critical factor to consider as well as price when selecting a service provider.

5. Monitoring Service Providers

After the service provider is retained, a fiduciary is under a continuing duty to monitor the service provider's performance. In *Whitfield v. Cohen*, the court held that the fiduciary "had a duty to monitor [the investment manager's] performance with reasonable diligence and to withdraw the investment if it became clear or should have been clear that the investment was no longer proper for the plan."[63] In *Cohen*, the fiduciary never received information about the nature of the investments. The monthly

60 *Marshall v. Glass/Metal Ass'n. & Glaziers & Glassworkers Pension Plan*, 507 F.Supp 378, 384 (D. Haw. 1980).

61 *Katsaros v. Cody*, 744 F.2d 270, 279 (2d Cir.), *cert denied*, 469 US 1072 (1984).

62 *Cunningham*, 716 F.2d 1455, 1467 (5th Cir. 1983).

63 682 F. Supp. 188, 194 (S.D.N.Y. 1988).

statements only included the original amount invested by the plan, an accrued interest figure, and the sum of those two amounts. The court concluded that, given the dearth of information contained in the monthly statements, the fiduciary should have been on notice that further investigation and inquiry was necessary. By the time the fiduciary took any action, the plan had suffered significant losses and the court held that he had failed to prudently monitor the investment manager.

In *Arakelian v. National Western Life insurance Co.*, the trustees argued that they were not fiduciaries because they never exercised their fiduciary powers, and that they had delegated plan administration to the insurance company from which they had purchased a group annuity contract.[64] The court held that "[t]he fact that all administrative functions of the plan were delegated to the plan administrator (National Western) did not and does not absolve the trustees of their duty to review and insure that the administrator was acting in the best interests of the participants."[65]

Both cases demonstrate that even in situations where the fiduciaries have delegated fiduciary duties to someone else, the delegating fiduciary retains a monitoring function over the fiduciary that he or she appointed. Accordingly, it is not sufficient to just prudently select a service provider. A fiduciary must keep a watchful eye on the service provider to ensure that the participants are being properly serviced. The process and manner by which this is done, depends on the facts and circumstances of each case.

6. The Matter of Costs

Lastly, it should be noted that a fiduciary is under a duty to determine that a plan is paying reasonable compensation in light of the services provided to its vendors. This does not mean that the fiduciary must select the least expensive option. A fiduciary must consider the quality of the services provided in light of the fees paid to the provider and sometimes this means the more expensive choice. The U. S. Department of Labor has made this point at least twice. In response to an inquiry from a multiple-employer welfare fund, the DOL explained that:

> because numerous factors necessarily will be considered by a fiduciary when selecting healthcare service providers, the fiduciary need not select the lowest bidder . . . . because "quality of services" is a factor relevant to selection of a service provider, it is the view of the Department that a plan fiduciary's failure to take quality of services into account in the selection process would constitute a breach of the fiduciary's duty under ERISA when, in the case of a Taft-Hartley or other plan, the selection involves the disposition of plan assets.[66]

In *PWBA: A Look at 401(k) Plan Fees*, the Department also noted that "higher investment management fees do not necessarily mean better performance. Nor is cheaper necessarily better."[67]

The requirement simply is that if plan assets are used to pay the service provider, "no more than reasonable compensation [be] paid" to the service provider.[68] If a service provider is paid more than reasonable compensation, then the fiduciary may have caused the plan(s) to engage in a prohibited transaction.

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64 755 F. Supp. 1080 (D.D.C. 1990)

65 *Id.* at 1084.

66 See DOL AO to Diana Orantes Ceresi, SEIU, (February 19, 1998).

67 See also Study of 401(k) Plan Fees and Expenses, available on DOL's web site at *http://www.dol.gov/dol/ebsa*.

68 ERISA § 408(b)(2), 29 U.S.C. § 1108(b)(2).

ERISA § 406(a) and (b) create prohibitions against certain transactions involving a plan and specified related parties, unless a statutory or administrative exemption is available.[69] The prohibited transaction provisions of ERISA § 406 were designed to prevent certain categories of insider transactions that Congress believed offered a high potential for abuse of plan assets. The specified related parties that may not participate in a transaction involving a plan are called *parties in interest* and are defined in ERISA § 3(14). ERISA defines about 16 categories of parties in interest, including plan sponsors, fiduciaries, and service providers.

Exemptions from an otherwise prohibited transaction under ERISA § 406(a) are provided in ERISA § 408. In addition to the statutory exemptions, ERISA § 408(a) authorizes the Secretary of Labor to issue administrative exemptions for prohibited transactions. A detailed discussion of ERISA's prohibited transaction and exemption provisions are beyond the scope of this article. However, at least two provisions are relevant for a discussion involving reasonable compensation in the service provider context.

ERISA § 406(a)(1)(C), prohibits a party in interest from receiving fees for services provided to a plan, unless ERISA § 408(b)(2) is available to allow the transaction. ERISA § 408(b)(2) allows a plan to contract or make reasonable arrangements with a party in interest provided that the services are necessary for the operation of the plan, pursuant to a reasonable arrangement, and for reasonable compensation.

Department of Labor regulations state that services are necessary to the plan "if the service is appropriate and helpful to the plan . . . in carrying out the purpose for which the plan is established or maintained."[70] The arrangement is reasonable if it allows the plan to terminate the arrangement on "reasonably short notice" without a penalty.[71] A minimal fee to recapture start-up costs or an early termination penalty on a lease to recapture any losses resulting from reasonably foreseeable expenses related to vacancy and reletting the space is permissible.[72]

The regulations are completely unhelpful with respect to what is reasonable compensation and ERISA does not define the term.[73] This, of course, is the issue that gets the most attention in litigation. Courts struggling with this question typically look to market conditions in the specific geographic area for comparable services, taking into account any special characteristics that might add or detract value from the particular service. Thus, compensation will be considered reasonable if it is competitive in the geographic area for the services offered. Provided that a service provider is paid reasonable compensation, the engagement will not be prohibited.

Before moving off the compensation topic completely, it is worth mentioning that a fiduciary to a plan may also receive compensation for providing services to a plan. The receipt of compensation by a fiduciary for legitimate services to a plan, however, raises the possibility of fiduciary self-dealing. Because a PEO, if deemed to be a MEWA, may be found to be a fiduciary to the worksite employer plans, any payment of fees to the PEO from plan assets needs to be treated with great care. Accordingly, these issues should be considered before a PEO receives payment for services provided to the plan.

69 29 U.S.C. §§ 1106(a) and (b).

70 DOL Reg. § 2550.408b-2(1)(b).

71 DOL Reg. § 2550.408b-2(1)(c).

72 DOL Reg. § 2550.408b-2(1)(c).

73 DOL Reg. § 2550.408b-2(1)(d) (stating that regulations at 2550.408c-2 contain provisions relating to what is reasonable compensation.)

Fiduciary self-dealing can occur if a service provider were deemed to be selecting itself as the provider to the plan, setting its own compensation, and/or negotiating the terms of the contract for itself and the plan. All these acts together or singly might be deemed a violation of ERISA § 406(b)(1) and/or (2).[74] In general, as long as a second fiduciary independent from the service provider fiduciary retains, for the plan, the services of the fiduciary service provider, the fiduciary service provider will not have violated ERISA's self-dealing provisions.[75] In the context herein being discussed, the best way to insulate from an allegation of self-dealing if a PEO is going to charge the plan for a service is to disclose the service and the fee and allow the worksite employer to make the decision.

The Department of Labor historically has taken the position ERISA § 408(b)(2) is unavailable to exempt a transaction involving fiduciary self-dealing, even where the compensation is reasonable.[76] In such situations, the Department's position is that the self-dealing aspect of the transaction is a separate violation that is not exempt under ERISA § 408(b)(2).[77] The typical facts raising this type of issue are where a plan fiduciary selects itself and sets its own compensation for an additional service to a plan.

In cases such as these, ERISA § 408(c)(2) also has been invoked as a potential exemption. Section 408(c)(2) provides that:

> Nothing in § 406 shall be construed to prohibit any fiduciary from:
>
> (2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full-time pay from an employer . . . shall receive compensation from such plan. . . . .

Department of Labor regulations, however, provide that ERISA § 408(c)(2) is not a separate exemption, but rather that it only clarifies the meaning of reasonable compensation for purposes of ERISA § 408(b)(2). Thus, historically, ERISA § 408(c)(2) has not been relied on to exempt a self-dealing violation.[78]

The Eighth Circuit, however, recently refused to give the Department's interpretation of § 408(c)(2) any deference.[79] The court held that the plain language of ERISA § 408(c)(2) supports the conclusion that § 408(c)(2) is a separate exemption available to insulate a fiduciary from liability when the fiduciary's compensation is reasonable, even if the violation involves fiduciary self-dealing. The court held that at least in situations where the compensation is reasonable, ERISA § 408(c)(2) "sensibly insulates a fiduciary from liability...." *Id.* It is too early to predict whether other circuits will follow *Harley*. Predictably, however, if

74 ERISA § 406(b)(1), 29 U.S.C. 1106(b)(1) states that a fiduciary shall not deal with the assets of a plan in his or her own interest or his or her account. ERISA § 406(b)(2), 29 U.S.C § 1106(b)(2) provides that a fiduciary shall not represent the plan in a transaction involving the plan and represent a party whose interests are adverse to the plan.

75 DOL Reg. § 2550.408b-2 provides that if a second fiduciary retains the services of a first fiduciary and the first fiduciary did not use the influence or authority that makes it a fiduciary to obtain the assignment, then the first fiduciary has not engaged in self-dealing. *Id.* at (f) Example 1.

76 DOL Reg. § 2550.408b-2(a) and (e).

77 DOL Reg. § 2550.408b-2(e).

78 See *Lowen v. Tower Asset Management, Inc.*, 829 F.2d 1209 (2d Cir. 1987)(§ 408(c)(2) only clarifies the meaning of reasonable compensation); *LaScala v. Scrufari*, 96 F. Supp.2d 233 (W.D.N.Y. 2000)(§ 408(c)(2) does not provide exemptive relief for a self-dealing violation); *Whitfield v. Tomasso*, 682 F. Supp. 1287 (E.D.N.Y. 1988) (same); *Gilliam v. Edwards*, 492 F. Supp 1255 (D.N.J.)(same).

79 *Harley v. Minnesota, Mining and Manufacturing Company*, 284 F.3d 901, 909 (8th Cir. 2002).

the facts of the case involve an inadvertent technical violation of ERISA § 406(b) because there was a failure to consult with an independent fiduciary, but the compensation was nonetheless reasonable, courts will be tempted to follow *Harley* and they should.

IV. Any Hope for Relief From All These Regulations?

Legislation pending in both chambers of Congress would federalize association health plan MEWAs.[80] The legislation broadens the definition of an "association" plan beyond the DOL's current narrower view, and arguably, some PEOs might fall under the legislation's definition. In short, the plan sponsor must be a bona fide trade industry or professional association, be able to demonstrate its existence has a purpose other than to provide health benefits, and receive some form of membership dues from its participating employers.[81]

The key features of the legislation include preemption of state mandates and laws forbidding a MEWA from operating in its state. The legislation provides that the sponsor must meet strict financial standards. Federal certification would be required and the legislation would give the DOL cease and desist powers similar to those exercised by states when they need to shut down an insurance company or similar entity operating illegally. An entity would have to be in existence for at least three years before it could claim to be an AHP.

The White House supports this legislation, but it faces stiff opposition. Legislation similar to this has been introduced in every Congress for probably more than 10 years and it never passes. This particular rendition was approved in the House in the last Congress, but was defeated in the Senate. The expectation is that the legislation will once again pass in the House, but will face stiff opposition in the Senate, where Democratic opposition is strong and Republican support has been divided.

Proponents of the bill believe that the legislation will allow small business to band together and purchase health insurance with greater bargaining power similar to the bargaining power now available to large employers. The leading opponents are the insurance companies who fear that AHPs will "fracture risk pools" and undermine their ability to serve the small group health markets.

80 The legislation in both chambers is titled "Small Business Health Fairness Act of 2003." The bill number in the House is H.R. 660 and in the Senate it is S. 545.

81 Under both versions of the legislation, an association health plan (AHP) is defined as a group health plan whose sponsor meets the following criteria:

(i) Is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, bona fide industry association, . . . a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of § 1381 of the Internal Revenue Code of 1986), for substantial purposes other than that of obtaining or providing medical care;

(ii) Is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

(iii) Does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

If this bill were ever to be enacted and PEO plans could fit within the definition of an AHP, a prospect that looks positive, at least PEO plans could have some certainty that the only law governing their plans would be ERISA. Unfortunately, the prospects for passage in the Senate are not optimistic.

VII. Conclusion and Some Practical Guidance

As indicated at the outset, the operation of the ERISA MEWA provisions in a PEO context is not crystal clear. However, the recent regulations of the Department of Labor bring in to focus two clear issues. First, it is certain now that DOL expects PEOs to file under the MEWA reporting rules (the annual Form M-1). Second, given the fact that the DOL has routinely treated PEO plans as MEWAs, PEOs must be cognizant of both state and federal regulations applying to MEWAs.

While NAPEO and many in the industry continue to maintain – and with some justification – that the ERISA MEWA provisions were not designed with PEOs in mind, it is increasingly clear that without legislation to the contrary the DOL is unlikely to budge from its position that a PEO arrangement under which worksite employees receive health benefits is a MEWA.

What are the practical consequences of this position?

A. MEWA Reporting

Whether or not the PEO believes its plan is a MEWA, the existing rules contemplate that PEOs will file a Form M-1. These reports are public documents and are available to the public and state regulators over the Internet. While PEOs may continue to file the required form and information with a cover letter protesting that they believe the MEWA rules should not apply to a PEO plan,[82] it is clear that reporting is required and a significant penalty can attach for failure to file.

B. Potential Impact of MEWA Status

1. Fully-Insured Plans

In practice, the burden upon a fully insured PEO plan will not be great. As explained above, the focus of both federal and state regulators has been on self-funded plans. Nonetheless, a fully insured plan may be subject to state registration and reporting.[83]

Some insurance providers have required statements from PEOs that they are not MEWAs during the process of securing coverage. PEOs should consult with counsel with regard to the PEO's representations to the carrier and on the Form M-1.

2. Self-Insured or Partially Self-Insured Plans

A self-funded PEO should review state law regarding MEWAs and the PEO should try to comply. This may pose a difficulty when the PEO's operations are multi-state. At a minimum, PEOs should try to comply with any state MEWA law in its state of domicile. The more compliant a PEO is with respect to both state and federal laws, the fewer problems it is likely to encounter with state or federal regulators.

82 See: "Form M-1 Reporting for MEWAs" by Rufus Wolff, *PEO Insider*, May 2000. It should be noted that the publicly available M-1 filing will include any such disclaimer letter.

83 Virginia, for example, requires both fully insured and self-insured MEWAs to register. However, the registration requirements for self-insured programs are significantly more burdensome.

Another potentially negative side effect of MEWA status is the interplay of the PEO plan with state small group health requirements. The reason that some carriers required a statement of non-MEWA status from PEOs has been a carrier's desire to avoid participation in the small group health market. This becomes less significant if either the carrier is already in the small group market or the state has specific provisions that define a PEO plan as being a single-employer plan and not a MEWA for state law purposes.[84]

C. Practical Steps

A PEO needs to review with counsel knowledgeable about ERISA and MEWA law its existing benefit programs, the impact of the ERISA MEWA provisions with regard to those plans, state MEWA or insurance rules governing MEWAs in jurisdictions where the PEO does business, and the PEO's reporting under the MEWA Form M-1 requirements.

84 See, for example the recently passed registration bill in New York that provides: "5. A registered professional employer organization shall be deemed for purposes of state law an employer for purposes of sponsoring welfare benefit plans for its worksite employees. Worksite employees participating in that professional employer organization's fully insured welfare benefit plan or plans shall be considered employees participating in a single-employer welfare benefit plan or plans. A fully insured welfare benefit plan or plans offered by a registered professional employer organization to its employees and/or worksite employees shall not be considered for purposes of state law a multiple employer welfare arrangement." New York Consolidated Laws, Art. 31, § 922(5)

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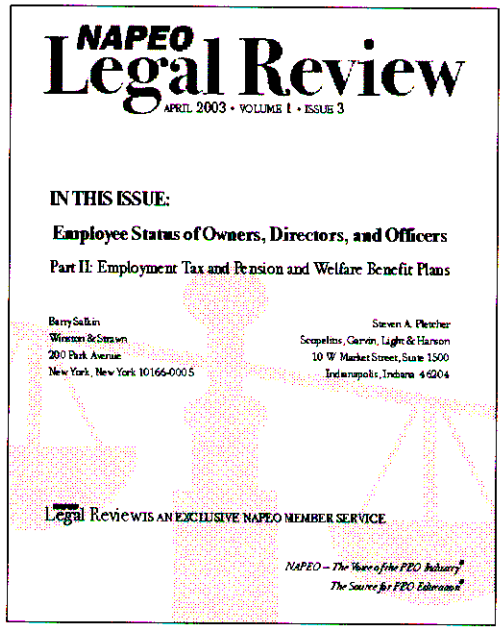
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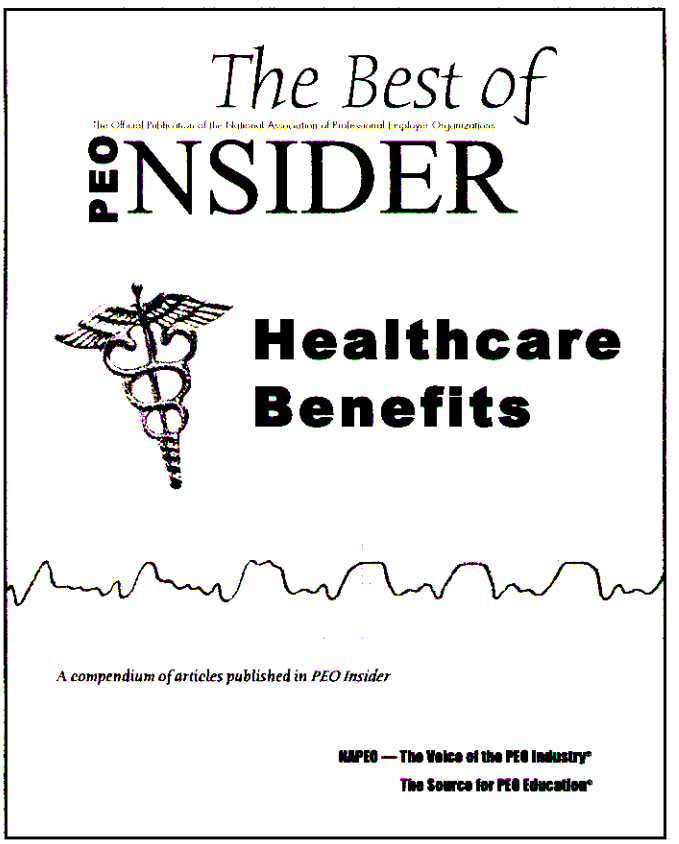

Healthcare Benefits

The ability to provide and administer employer-based healthcare benefits has always been a tremendous challenge. These challenges have many PEOs wanting to abandon healthcare benefits. However, healthcare benefits are fundamental to a PEO's ability to attract and retain a solid book of clients, and many PEOs have been able to develop sound healthcare plans that are flexible, meeting the needs of clients, co-employees, and the PEOs themselves. Fortunately, this compendium offers much of the help you need to understand the issues, options, and alternatives.

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