

UNDERSTANDING YOUR FIDUCIARY RESPONSIBILITIES UNDER A GROUP HEALTH PLAN



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This booklet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Introduction

Offering a group health plan can be one of the most challenging, yet rewarding, decisions an employer can make. The employees who participate in the plan, their beneficiaries, and the employer benefit when a group health plan is in place. Administering a plan and managing its assets, however, require certain actions and involve specific responsibilities.

Employers need to understand some basic rules, specifically the Employee Retirement Income Security Act (ERISA), to meet their responsibilities as plan sponsors. ERISA sets standards of conduct for those who manage employee benefit plans and their assets, called fiduciaries. An ERISA-covered group health plan is an employment-based plan that provides medical care coverage, including hospitalization, sickness, prescription drugs, vision, or dental. It can provide benefits by using funds in a plan trust, purchasing insurance, or self-funding benefits from the employer's general assets. *Understanding Your Fiduciary Responsibilities Under A Group Health Plan* provides an overview of the basic fiduciary responsibilities that apply to group health plans under the law.

This booklet addresses the scope of ERISA's protections for private-sector group health plans. ERISA does not cover public sector or church-sponsored plans. The publication provides a simplified explanation of the law and regulations. It is not a legal interpretation of ERISA, nor is it a substitute for the advice of a health benefits professional. It does not cover Federal tax or state insurance laws that may affect group health plans.

What Are the Essential Elements of a Plan?

Each plan has certain key elements, including:

- A written plan that describes the benefit structure and guides day-to-day operations;
- A trust to hold the plan's assets;¹
- A recordkeeping system to track contribution and benefit payments, maintain participant and beneficiary information, and accurately prepare reporting documents; and
- Documents to provide plan information to participating employees and the government.

Employers often hire outside professionals (sometimes called third-party service providers) or use an internal administrative committee or human resources department to manage some or all of a plan's day-to-day operations. There may be one or a number of officials with discretion over the plan. These are the plan's fiduciaries.

Who Is a Fiduciary?

Many of the actions involved in operating a plan make the person or entity performing them a fiduciary. A person using discretion in administering and managing a plan or controlling the plan's assets is a fiduciary to the extent of that discretion or control. Thus, fiduciary status is based on the functions performed for the plan, not just a person's title.

1. If a plan is set up through an insurance contract, then the contract does not need to be held in trust. If a plan is self-funded (paid from the employer's general assets), those funds are not plan assets except for any participant contributions withheld or received.

Group health plans can be structured in a variety of ways. The structure of the plan affects who has fiduciary responsibilities. Most employers who sponsor fully or partially self-funded group health plans exercise some discretionary authority and therefore are fiduciaries. If the employer sponsors a fully insured plan, fiduciary status depends on whether the employer exercises discretion over the plan.

A plan must have at least one fiduciary (a person or entity) named in the written plan or through a process described in the plan, having control over the plan's operation. The plan can identify the fiduciary by office or by name. Some plans may name an administrative committee or a company's board of directors.

A plan's fiduciaries ordinarily will include plan administrators, trustees, investment managers, all individuals exercising discretion in the administration of the plan, all members of a plan's administrative committee (if it has one), and those who select committee officials. Attorneys, accountants, and actuaries generally are not fiduciaries when they act solely in their professional capacities. Similarly, a third-party administrator, recordkeeper, or utilization reviewer who performs solely ministerial tasks is not a fiduciary; however, that may change if they exercise discretion in deciding on a participant's eligibility for benefits. The key to determining whether individuals or entities are fiduciaries is whether they exercise discretion or control over the plan.

A number of decisions are not fiduciary actions but employer business decisions that ERISA does not govern. For example,

- Establishing a plan,
- Determining the benefit package,
- Including certain features in a plan,
- Amending a plan, and
- Terminating a plan.

When making these decisions, an employer is acting on behalf of its business, not the plan; therefore, the employer is not a fiduciary. However, when an employer (or someone hired by the employer) takes steps to implement these decisions, that person is acting on behalf of the plan and, in carrying out these actions, may be a fiduciary.

What Is the Significance of Being a Fiduciary?

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of group health plan participants and their beneficiaries. These responsibilities include:

- Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them;
- Carrying out their duties prudently;
- Following the plan documents (unless inconsistent with ERISA);
- Holding plan assets (if the plan has any) in trust; and
- Paying only reasonable plan expenses.

The duty to act prudently is one of a fiduciary's central responsibilities under ERISA. It requires expertise in a variety of areas. A fiduciary who lacks that expertise will want to hire someone with the professional knowledge to carry out those functions. Prudence focuses on the process for making fiduciary decisions, so a fiduciary should document decisions and the basis for those decisions. For instance, when hiring a plan service provider, a fiduciary may want to survey a number of potential providers, asking for the same information and providing the same requirements. By doing so, a fiduciary can document the process and make a meaningful comparison and selection.

Following the terms of the plan document is also an important responsibility. The plan document serves as the foundation for plan operations. Employers should be familiar with their plan document, especially when it is drawn up by a third-party service provider, and periodically review the document to make sure it remains current. For example, if a plan official named in the document changes, the plan document must be updated to reflect that change.

Limiting Liability

With these fiduciary responsibilities, there is also potential liability. Fiduciaries who don't follow the basic standards of conduct may be personally liable to restore any losses to the plan, or to restore any profits made through improper use of the plan's assets resulting from their actions.

However, fiduciaries can limit their liability in certain situations. One way fiduciaries can demonstrate that they carried out their responsibilities properly is to document the processes used to carry out their fiduciary responsibilities.

A fiduciary also can hire service providers to handle fiduciary functions, setting up the agreement so that the provider assumes liability for the selected functions. If an employer contracts with a plan administrator to manage the plan, the employer is responsible for the selection of the service provider, but is not liable for the provider's decisions. However, an employer must monitor the service provider periodically to assure that it is handling the plan's administration prudently.

Other Plan Fiduciaries

A fiduciary must be aware of other fiduciaries to the same plan, because they could be liable for their co-fiduciaries' actions. For example, if a fiduciary knowingly participates in, conceals, or does not act to correct another fiduciary's breach of responsibility, they are also liable.

Bonding

For additional protection for plans, every person, including a fiduciary, who handles plan funds or other plan property generally must be covered by a fidelity bond. A fidelity bond is a type of insurance that protects the plan against loss because of fraudulent or dishonest acts by people that the bond covers. Many persons dealing with group health plans that pay benefits from the general assets of an employer or union (unfunded) or group health plans that are insured (that pay benefits through a group health insurance contract purchased from a licensed insurer) may be eligible for exemptions from the fidelity bonding requirements. For more information, request a copy of ***Protect Your Employee Benefit Plan with an ERISA Fidelity Bond***. See the "Resources" section in the back of this booklet.

How Do These Responsibilities Affect the Operation of the Plan?

Even if employers hire third-party service providers or use internal administrative committees to manage the plan, certain functions can make an employer a fiduciary.

Employee Contributions

If a plan provides for salary reductions from employees' paychecks for contribution to the plan or participants pay directly, such as the payment of COBRA premiums, then the employer must deposit the contributions in a plan trust in a timely manner. The law requires that participant contributions be deposited in the plan as soon as it is reasonably possible to segregate them from the company's assets, but no later than 90 days from the date when the employer withholds or receives them. If employers can reasonably deposit the contributions sooner, they must do so. For plans with fewer than 100 participants, salary reduction contributions deposited with the plan no later than the 7th business day following withholding by the employer will be considered contributed in compliance with the law.

For participant contributions to cafeteria plans (also referred to as (Internal Revenue Code) Section 125 plans), the Department will not assert a violation solely because participant contributions were not held in trust. Other contributory health plan arrangements may get the same relief if the participant contributions are used to pay insurance premiums within 90 days of receipt.

Medical Loss Ratio (MLR) Rebates

Under the Affordable Care Act, insurance companies must rebate a portion of premiums to policyholders, including health plans, when the insurance company's spending for clinical services and health care quality improving activities, in relation to the premiums charged, is less than established medical loss ratio standards. These rebates may be the health plan's assets.

To determine whether any part of the rebate is a health plan's asset, consider factors such as whether the plan or the employer is the policyholder, the terms of the plan documents, and whether plan participants paid any portion of the premiums. If any part of the medical loss ratio rebate is the plan's asset, the decision on how to apply it is a fiduciary function. In deciding how to allocate the rebate (such as distributing to participants, enhancing plan benefits or reducing future participant premiums), a fiduciary must consider each option's costs and benefits. The plan asset, like employee contributions, must be held in a trust.

Hiring a Service Provider

Hiring a service provider in and of itself is a fiduciary function. When considering prospective service providers, give each of them complete and identical information about the plan and the services you are looking for so you can make a meaningful comparison.

Fiduciaries need to consider additional actions when selecting a service provider including:

- Getting information from more than one provider;
- Comparing firms based on the same information, such as services offered, experience, costs, etc.;
- Obtaining information about the firm itself, including its financial condition and its experience with group health plans of similar size and complexity;
- Evaluating information about the quality of the firm's services: the identity, experience, and qualifications of professionals who will be handling the plan or providing medical services; any recent litigation or enforcement action taken against the firm; the firm's experience or performance record; ease of access to medical providers and information about the health care provider's operations; the procedures in place to timely consider and resolve patient questions and complaints; the procedures for patient record confidentiality; and enrollee satisfaction statistics; and
- Ensuring that any required licenses, ratings or accreditations are up to date (insurers, brokers, TPAs, health care service providers).

An employer should document its selection and monitoring process, and, when using an internal administrative committee, should educate committee members on their roles and responsibilities. Read, understand, and keep copies of all contracts.

Fees

Fees are just one of several factors fiduciaries need to consider when deciding on service providers. When the fees for services are paid out of plan assets, fiduciaries need to understand the fees and expenses charged and the services provided. While the law does not specify a permissible level of fees, it does require that fees charged to a plan be "reasonable." After carefully evaluating them when selecting a service provider, the plan's fees and expenses should be monitored to determine whether they are still reasonable.

When comparing estimates from prospective service providers, ask which services the estimated fees cover and which they do not. Some providers offer a number of services for one fee, sometimes referred to as a "bundled" services arrangement. Others charge separately for individual services. Compare all services to be provided with the total cost for each provider. Consider whether the estimate includes services you did not specify or want. Remember, all services have costs.

Some service providers receive additional fees from third parties, such as insurance brokers. Employers should ask prospective providers whether they get any third-party compensation, such as finder's fees, commissions, or revenue sharing.

Who pays the fees? The employer, the plan, or both may pay plan expenses. The plan document should specify how fees are paid, and the fiduciary must ensure that those fees and expenses are reasonable, necessary for the plan's operation, and not excessive for the services provided.

Monitoring a Service Provider

An employer should establish a formal review process and follow it at reasonable intervals to decide if it wants to continue using the current service providers or look for replacements. When monitoring service providers, employers should act to ensure the service providers are performing the agreed upon services including:

- Reviewing the service providers' performance;
- Reading any reports they provide;
- Checking actual fees charged;
- Asking about policies and practices (such as a third-party administrator's claims processing systems);
- Ensuring proper maintenance of plan records; and
- Following up on participant complaints.

Maintaining the Plan's Benefits Claims Procedure

Group health plans must establish and maintain reasonable claims procedures that allow participants and beneficiaries to apply for and receive promised benefits. Fiduciaries must maintain the plan's procedures. Plans (including insured and self-funded plans) must meet the minimum standards for benefit claims determinations set by rules issued by the Department of Labor. While many plans hire benefits professionals or insurance companies to process claims, an employer needs to understand the requirements before selecting a service provider who can comply with the benefit claim standards.

A claim for benefits is a request for a plan benefit made in accordance with the plan's procedures by a claimant (participant or beneficiary) or their authorized representative. Questions about plan benefits, coverage, and eligibility, and casual inquiries generally are not considered claims for benefits.

Fiduciaries must become familiar with the timeframes to decide claims, the contents of benefit denial notices, and the standards for appeals of benefit denials.

Once a plan receives a claim, the timeframe for a plan to make a determination and provide notice of the claim determination varies based on the type of claim filed:

- Urgent care, as soon as possible, and no later than **72 hours** after receiving the claim;
- Pre-service claims, within a reasonable time period, and no later than **15 days** after receiving the claim;
- Post-service claims, within a reasonable time period, and no later than **30 days** after receiving the claim; and
- Disability claims, within a reasonable time period, and no later than **45 days** after receiving the claim.

Fifteen-day extensions may be available for pre- and post-service claims. Up to 30-day extensions may be available for disability claims.

The timeframe for a plan to review appeals also varies based on the type of claim –

- Urgent care claims, as soon as possible, taking into account the patient’s medical needs, and no later than **72 hours** after receiving the request to review a denied claim;
- Pre-service claims, within a reasonable time period appropriate to the medical circumstances, and no later than **30 days** after receiving the request to review a denied claim;
- Post-service claims, within a reasonable time period, and no later than **60 days** after receiving the request to review a denied claim; and
- Disability claims, within a reasonable time period, and no later than **45 days** after receiving the request to review a denied claim.

The plan cannot extend the deadline without the claimant’s consent.

If a plan denies a claim, it must send a denial notice to the claimant, either in writing or electronically. The notice must include:

- Specific reasons for denial (for example, not medically necessary, not covered by the plan, or reached maximum amount of treatment permitted under the plan);
- A reference to the specific plan provisions relied upon for the denial;
- If denied for a lack of information, a description of any additional material needed and an explanation of why it’s necessary;
- A description of the plan’s review procedures (for example, how appeals work and/or how to initiate an appeal);
- If denied based on rules, guidelines, or protocols, either a description of rules, guidelines, or protocols relied upon in denying the claim, or a statement that a copy of such items will be provided upon request;
- If denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant’s medical circumstances, or a statement that an explanation will be provided for free upon request; and
- A description of the claimant’s right to go to court to recover benefits due under the plan.

The notice of a claim denial on appeal must include the same information as noted above (except the description of the plan’s appeal process) as well as:

- An explanation of the claimant’s right to receive documents relevant to the benefit claim (documents and records upon which the decision is based and other documents prepared or used during the process), free of charge;
- A description of any voluntary processes the plan offers to resolve claims disputes; and
- A description of the claimant’s rights to seek judicial review of the plan’s decision.

The plan’s claims procedure must provide for a full and fair review of a benefit claim if a claimant files an appeal of the denial. The minimum standards for appeals are:

- Plans must give claimants at least 180 days to file an appeal;
- Appeals must be reviewed by someone new. The reviewer cannot be the same person who made the initial decision or that person’s subordinate, and the reviewer must give no consideration to the initial decision;

- The reviewer must consult with a qualified health professional (and others as needed) when the denial is based on a determination of whether a particular treatment, drug or other item is experimental, investigational, or not “medically necessary”;
- Plans can require no more than two levels of review; and
- Mandatory binding arbitration of claims is generally prohibited. However, non-binding arbitration is permissible if done within the required timelines.

For more information on disability claims and appeals, request a copy of the publication ***An Employer’s Guide to Health and Disability Benefit Claims***. See “Resources” in the back of this booklet for information on obtaining copies.

Plans not grandfathered under the Affordable Care Act (those established, or that have made certain significant changes, after March 23, 2010) must comply with additional internal claims procedure requirements. The claims and appeal process must cover rescissions (retroactive cancellations) of coverage, as well as other denials of benefits. They, or their insurers, also must:

- Provide claimants with new or additional evidence or rationale, and a reasonable opportunity to respond to it, before making a final decision on the claim;
- Ensure that claims and appeals are adjudicated in an independent and impartial manner;
- Provide detail in all claims denial notices on the claim involved, the reason for denial (including the denial code and meaning), any available internal and external appeals processes, and consumer assistance information;
- Provide, on request, diagnosis and treatment codes (and their meanings) for any denied claim;
- Provide notices in a culturally and linguistically appropriate manner;
- Allow claimants to begin the external review process if the plan fails to follow the internal claims requirements (unless the plan’s violation is minimal); and
- Allow claimants to resubmit a claim through the internal claims process if a request for immediate external review is rejected by the external reviewer under specific circumstances.

In addition, plans not grandfathered under the Affordable Care Act must provide for external review of claim denials by an independent party. Plans that are grandfathered must also provide external review if the claims are within the protections of the No Surprises Act (discussed below). The external review process used by the plan depends on whether the plan is self-funded or provides benefits through an insurance company.

Self-funded plans generally must comply with the procedures set by the Department of Labor. A plan may choose to refer requests for external review to an accredited Independent Review Organization, or may voluntarily comply with a state external review process if the state allows access. For more information, visit the Department of Labor’s **[web page on internal claims and appeals and external review](#)**.

Insured plans and insurance companies generally must comply with their state’s external review process, if the state process includes minimum consumer standards set by the Department of Health and Human Services (HHS). If the state process does not meet these standards, group health plans and insurers may use either the accredited Independent Review Organization process or an HHS-administered Federal external review process. For the status of your state’s external process, see **[HHS’s website](#)**.

Are There Some Transactions That Are Prohibited? Is There a Way to Make Them Permissible if the Actions Will Benefit the Plan?

Some transactions are prohibited under the law to prevent dealings with parties who may be in a position to exercise improper influence over the plan. In addition, fiduciaries cannot engage in self-dealing and must avoid conflicts of interest that could harm the plan.

Prohibited Transactions

Who is prohibited from doing business with the plan? Prohibited parties (called parties in interest) include the employer, the union, plan fiduciaries, service providers, and statutorily defined owners, officers, and relatives of parties in interest.

Prohibited transactions include:

- A sale, exchange, or lease between the plan and party in interest;
- Lending money or other extension of credit between the plan and party in interest; and
- Furnishing goods, services, or facilities between the plan and party in interest.

Other prohibitions relate solely to fiduciaries who use plan assets in their own interest or who act on both sides of a transaction involving the plan. Fiduciaries cannot receive money or any other consideration for their personal account from any party doing business with the plan related to that business.

Exemptions

There are a number of exceptions (exemptions) in the law that provide protections for the plan while conducting necessary transactions that otherwise would be prohibited. The Labor Department may grant additional exemptions.

The law provides exemptions for many dealings that are essential to ongoing plan operations. One exemption allows the plan to hire a service provider as long as the services are necessary to operate the plan and the contract or arrangement for providing the services and the compensation paid is reasonable.

The exemptions issued by the Department can involve transactions available to a class of plans or to one specific plan. Both class and individual exemptions are available at [DOL's exemptions page](#). For more information on applying for an exemption, see [Exemption Procedures Under Federal Pension Law](#).

How Do Employees Get Information About the Plan? How Are Employers Required to Report Plan Activities?

Plan administrators must furnish plan information to participants and beneficiaries and submit reports to government agencies.

Informing Participants and Beneficiaries

The following documents must be furnished automatically to participants and beneficiaries.

The **Summary Plan Description (SPD)** – the basic descriptive document – is a plain language explanation of the plan and must be comprehensive enough to apprise participants of their rights and responsibilities under the plan. It also informs participants about the plan features and what to expect of the plan. Among other things, the SPD must include basic information such as:

- Plan name, address, and contact information;
- Plan benefits;
- How to file a claim for benefits; and
- Duties of the plan and/or employee.

More specific information must also be provided, including:

- The plan's claims procedure (either in the document or as separate attachment);
- Participants' basic rights and responsibilities under ERISA (model language is provided in the SPD rules);
- Information on premiums, cost-sharing, deductibles, co-payments, etc.;
- Procedures for using network providers and composition of network;
- Conditions regarding pre-certification;
- A description of plan procedures governing Qualified Medical Child Support Orders (see below); and
- Notices and descriptions of certain rights under the Health Insurance Portability and Accountability Act (HIPAA) and other health coverage laws, described below.

A plan must give employees a summary plan description within 90 days after they are covered by the plan and within 30 days of a request. Generally, summary plan descriptions also must be redistributed every 5th year. The SPD must be current within 120 days.

The **Summary of Material Modification (SMM)** appraises participants and beneficiaries of changes made to the plan or to the information required to be in the SPD. The SMM or an updated SPD for a group health plan must be furnished automatically to participants not later than 210 days after the end of the plan year in which the change was adopted. If the change is a material reduction in covered services or benefits, the plan administrator must furnish the SMM within 60 days after the reduction is adopted. A material reduction is any plan change that:

- Eliminates benefits,
- Reduces benefits payable,

- Increases premiums, deductibles, coinsurance or co-payments,
- Reduces the service area an HMO covers, or
- Establishes new conditions or requirements (such as pre-authorization) for obtaining services or benefits.

A **Summary of Benefits and Coverage (SBC)** is a uniform template that uses plain language to summarize the key features of a plan, such as covered benefits, cost-sharing provisions and coverage limitations. It must include an internet address where an individual can review a Uniform Glossary of medical and insurance-related terms designed to help consumers compare the terms of their coverage and the extent of medical benefits, as well as contact information for obtaining a paper copy. Plans and insurance companies must provide the summary of benefits and coverage to participants and beneficiaries with the plan’s enrollment or application materials, upon renewal or reissuance of coverage, or within 90 days of special enrollment. The summary of benefits and coverage and a copy of the Uniform Glossary also must be provided within seven business days of a request. A **template for the summary of benefits and coverage and the Uniform Glossary** is available.

A **Summary Annual Report (SAR)** outlines in narrative form the financial information in the plan’s annual return/report, the Form 5500, filed with the Federal Government (see “Reporting to the Government” for those plans required to file this report). The plan administrator must furnish it annually to participants in plans that are required to file the Form 5500.

Other Group Health Plan Notices

ERISA requires notices under other provisions, such as:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA),
- The Health Insurance Portability and Accountability Act (HIPAA),
- The Affordable Care Act,
- The Newborns’ and Mothers’ Health Protection Act, and
- The Women’s Health and Cancer Rights Act.

The SPD may include some of these notices, and others must be provided separately due to the timeframes when they must be provided. For more information on these notices, see the publication **Reporting and Disclosure Guide for Employee Benefit Plans**. For more information on COBRA, HIPAA, the Affordable Care Act, and the other health plan-related provisions in ERISA, see the resources in the back of this booklet.

Note: If an employer offers Individual Coverage Health Reimbursement Arrangements (HRAs) to reimburse employees (and sometimes their family members) for their medical care expenses, the HRA must provide a notice to eligible employees. They also have to substantiate that participating employees and their families have enrolled in individual insurance. You can find a model notice and model attestation form, as well as more information about Individual Coverage HRAs [here](#).

Disclosures upon Request

In addition to the summary plan description, participants can request the plan document, insurance contracts, and other documents governing the plan's operations. These documents might include, for instance, the criteria for determining whether benefits are medically necessary, as well as the comparative analyses required under the Mental Health Parity and Addiction Equity Act (MHPAEA). A reasonable copying fee may be charged.

Qualified Medical Child Support Orders (QMCSO)

Plans may receive either private medical child support orders (MCSOs) or an order from a state agency about an employee's medical child support obligations. Plans must have procedures to receive, process, and implement qualified medical child support orders. If a plan receives an MCSO, the plan administrator has to provide notice to the participant and any named child (and the child's representative) of the receipt of the MCSO and the plan administrator's determination whether the MCSO is qualified. The plan administrator must provide the notice within a reasonable time period after receipt of the MCSO. For more information on QMCSOs and the standards plans must use to determine whether MCSOs are qualified, request a copy of **Qualified Medical Child Support Orders** (see "Resources" in the back of the booklet).

Reporting to the Government

Plan administrators generally are required to file a Form 5500 Annual Return/Report with the Federal Government. The Form 5500 provides information about the plan, its finances, and its operation. This information is used by the U.S. Department of Labor, the Internal Revenue Service (IRS), other government agencies, organizations, and the public. Participants and beneficiaries can receive a copy of the Form 5500 from the plan upon request. Depending on the number of participants covered and the plan design, there may be exemptions from the full filing requirements. A group health plan with fewer than 100 participants that is either fully insured or self-funded (or a combination of both) does not need to file an annual report. Plans with 100 or more participants that are fully insured or self-funded (or a combination) can file a limited report. Plans that have relief from the trust requirement discussed in "Employee Contributions" above are considered self-funded.

The form is filed and processed under EFAST2. For more information on the forms, their instructions, and the filing requirements, see **DOL's EFAST2 website**. See the "Resources" section to obtain a copy of the publication **Reporting and Disclosure Guide for Employee Benefit Plans**.

Administrators of multiple employer welfare arrangements (MEWAs) generally must file a Form M-1 Report with the Federal Government. The Form M-1 provides information on a MEWA's compliance with the requirements of Part 7 of ERISA, including HIPAA, the Newborns' Act, the Womens' Health and Cancer Rights Act, the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act. The form must be filed electronically every year. For more information on the Form M-1, see **DOL's website on reporting and filing**.

Plans required to file the Form M-1 must file the Form 5500. There are penalties for not filing required reports and not providing required information to participants.

How Do Other Laws Affect Fiduciary Responsibilities?

As noted above, other ERISA provisions, as well as other Federal and state laws, affect group health plans. A fiduciary must make sure the plan complies with ERISA, which includes COBRA, HIPAA, the Affordable Care Act and other group health plan provisions.

COBRA requires that participants and their covered dependents have the opportunity to maintain their group health plan coverage for a limited time period if certain qualifying events occur that otherwise would result in a loss of coverage. A plan may require individuals to pay for coverage. For a more detailed discussion of COBRA requirements, see [*An Employer's Guide to Group Health Continuation Coverage Under COBRA*](#) (See “Resources” to obtain a copy).

HIPAA provides special enrollment rights for certain events and prohibits discrimination in eligibility, benefits, or premiums based on a health factor.

The Affordable Care Act provisions include the:

- Extension of dependent coverage until age 26,
- Prohibition of preexisting condition exclusions,
- Prohibition on waiting periods of more than 90 days, and
- A ban on lifetime and annual coverage limits for most benefits.

Additional protections apply to non-grandfathered health plans (those established or that have made certain significant changes after March 23, 2010). These include:

- The internal claims and appeal and external review standards discussed above,
- Coverage for certain preventive services without cost sharing, and
- Certain patient protections, including coverage for emergency services at a hospital outside of a plan's network without prior plan approval.

For more information on the Affordable Care Act, see [DOL's website](#).

ERISA's other group health plan provisions include:

- The Newborns' and Mothers' Health Protection Act, which provides protections for minimum hospital lengths of stay for mothers and their newborns following childbirth;
- The Women's Health and Cancer Rights Act, which provides protections for individuals who have breast reconstruction or certain other follow-up care after a mastectomy;
- The Mental Health Parity and Addiction Equity Act, which provides for parity in mental health benefits and medical/surgical benefits;
- The No Surprises Act, which restricts excessive out-of-pocket costs (known as surprise billing) for receiving out-of-network care for emergency services, non-emergency services from out-of-network providers at in-network facilities in certain circumstances, and air ambulance services; and
- The Genetic Information Nondiscrimination Act, which prohibits discrimination in group health plan coverage based on genetic information.

For more detailed information on these provisions, visit the [Employee Benefits Security Administration's website](#).

ERISA generally supersedes state laws as they relate to employee benefit plans. However, state insurance laws often continue to apply. Therefore, if your plan offers health coverage through an HMO or insurance policy, check with your state insurance department for more information on the insurance laws.

Can a Fiduciary Terminate Its Fiduciary Duties?

Yes, but there is one final fiduciary responsibility. Fiduciaries who no longer want to serve in that role cannot simply walk away from their responsibilities, even if the plan has other fiduciaries. They need to follow plan procedures and make sure that another fiduciary is carrying out the responsibilities left behind. It is critical that a plan has fiduciaries in place so it can continue operations and participants have a way to interact with the plan.

What Help Is Available for Employers Who Make Mistakes in Operating a Plan?

The Department of Labor's Voluntary Fiduciary Correction Program (VFCP) encourages employers to comply with ERISA by voluntarily self-correcting certain violations. The program covers 19 transactions, including failure to timely remit participant contributions and some prohibited transactions with parties in interest. It includes a description of how to apply, as well as acceptable ways to correct violations. In addition, the Department gives applicants immediate relief from payment of excise taxes under a class exemption.

In addition, the Department's Delinquent Filer Voluntary Compliance Program (DFVCP) helps late or non-filers of the Form 5500 come up to date with corrected filings.

For an overview of both programs, visit [DOL's website](#).

Tips for Employers with Group Health Plans

Understanding fiduciary responsibilities is important for a group health plan's security and compliance with the law. The following tips may help as a starting point:

- Have you identified your plan fiduciaries, and are they clear about the extent of their fiduciary responsibilities?
- If you are hiring third-party service providers, have you looked at a number of providers, given each potential provider the same information, and considered whether the fees are reasonable for the services provided? Have you documented the hiring process?
- Are you prepared to monitor your plan's service providers?

- Are you aware of the schedule to deposit participant contributions and payments by participants to the plan and forward them to the insurance company? Have you made sure it complies with the law?
- Have you reviewed your plan document in light of current plan operations and made necessary updates? After amending the plan, have you provided participants with an updated summary plan description or summary of material modifications?
- Does your plan have a reasonable claims procedure that plan fiduciaries follow?
- Does your plan have a procedure for handling QMCSOs?
- Have you identified parties in interest to the plan and taken steps to monitor transactions with them?
- Are you aware of the major exemptions under ERISA that permit transactions with parties in interest, especially those important to plan operations (such as hiring service providers)?
- Have you filed required reports, such as the Form 5500, with the government in a timely manner?

Resources

The U.S. Department of Labor’s Employee Benefits Security Administration offers more information on its [website](#) and in its publications. To order publications or to request assistance from a benefits advisor, contact EBSA [electronically](#) or call toll free 1-866-444-3272.

For Employers

- *An Employer’s Guide to Group Health Continuation Coverage Under COBRA*
- *An Employer’s Guide to Health and Disability Benefit Claims*
- *Reporting and Disclosure Guide for Employee Benefit Plans*
- *Protect Your Employee Benefit Plan with an ERISA Fidelity Bond*
- *Qualified Medical Child Support Orders*
- *VFCP Fact Sheet | FAQs*
- *DFVCP Fact Sheet | FAQs*

For Employees

- *Top 10 Ways to Make Your Health Benefits Work for You*
- *Life Changes Require Health Choices...Know Your Benefit Options*
- *Work Changes Require Health Choices...Protect Your Rights*
- *An Employee’s Guide to Health Benefits Under COBRA*
- *Filing a Claim for Your Health Benefits*
- *Filing a Claim for Your Disability Benefits*
- *Understanding Your Mental Health and Substance Use Disorder Benefits*



EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

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