ERISA: Title I, Part 7

U.S. Department of Labor

Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance

Unless otherwise noted, this draft is current as of December 2018. Although EBSA makes every effort to assist the public, these slides are not intended to be, and should not be construed as, legal advice. They are also not a substitute for any regulations or interpretive guidance issued by EBSA. *

Agenda

- Introduction and Background of Part 7 of ERISA
- Affordable Care Act (ACA) Market Reforms
- Mental Health and Substance Use Disorder Parity
  - General Rules
  - FAQs and other Resources

Agenda Continued

- Executive Order 13813 (October 12, 2017)
  - Association Health Plans
  - Short-Term, Limited-Duration Insurance
  - Health Reimbursement Arrangements
- Part 7 Disclosure Requirements
- Additional Compliance Tips and Tools

Introduction and Background of ERISA Part 7

Laws Contained in Part 7 of ERISA

- Health Insurance Portability and Accountability Act (HIPAA Title I)
- Mental Health Parity Act (MHPA)
- Women's Health and Cancer Rights Act (WHCRA)
- Newborns' and Mothers' Health Protection Act (Newborns' Act)

(Continued on next slide)

Laws Contained in Part 7 of ERISA

- Genetic Information Nondiscrimination Act of 2008 (GINA)
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Michelle's Law of 2008
- Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
- Patient Protection and Affordable Care Act of 2010 (Affordable Care Act)
- 21st Century Cures Act (Cures Act)

Development of the Regulations

- Tri-department process
  - Department of Labor, EBSA
  - Department of Health and Human Services, CMS
  - Department of the Treasury, Internal Revenue Service

Arrangements Subject to Part 7

- **Group Health Plan**

  Definition: An employee welfare benefit plan that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise

- **Health Insurance Issuer**

  Definition: An insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance

- **Self-insured v. Fully-insured**

  Collection of premiums or contributions

  Assumption of risk for claims

Arrangements *Not* Subject to Part 7

- **Very Small Group Health Plans**
- **Church Plans**

  However, generally subject to parallel provisions in the Internal Revenue Code
- **Governmental Group Health Plans**

  However, state and local governmental group health plans may be subject to parallel provisions in the Public Health Service Act
- **Excepted Benefits**

Arrangements *Not* Subject to Part 7

- **Excepted Benefits:**
  - Benefits excepted in all circumstances (generally not health coverage);
  - Limited Excepted Benefits. Benefits offered separately (insurance policy, certificate, or contract) or are not an integral part of the plan;
  - Non-coordinated Benefits. Not coordinated with benefits under another group health plan;
  - Supplemental Excepted Benefits. Offered under a separate policy, certificate, or contract of insurance and supplemental to Medicare, Armed Forces health coverage or similar supplemental coverage provided to coverage under a group health plan.

Arrangements *Not* Subject to Part 7

- **Excepted Benefits: Limited-scope Dental and Vision**

  Not an integral part of the plan if:

  - Participants may decline coverage; or
  - Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

Arrangements *Not* Subject to Part 7

- **Excepted Benefits: EAPs**
  - EAP does not provide significant benefits in the nature of medical care (amount, scope, and duration of covered services).
  - The benefits under the EAP are not coordinated with benefits under another group health plan.
  - No employee premiums or contributions are required as a condition of participation in the EAP.
  - No cost sharing under the EAP.

Affordable Care Act Market Reforms

ACA Section 1251 (grandfathered health plans)

PHSA Section 2704 (prohibition of preexisting condition exclusions)

PHSA Section 2705 (wellness programs)

PHSA Section 2708 (90-day waiting period limitation)

PHSA Section 2711 (prohibition on lifetime or annual dollar limits)

PHSA Section 2712 (prohibition on rescissions)

PHSA Section 2713 (coverage of preventive health services)

PHSA Section 2714 (extension of dependent coverage)

PHSA Section 2715 (summary of benefits and coverage and uniform glossary)

PHSA Section 2719 (internal claims and appeals and external review)

PHSA Section 2719A (patient protections provisions)

Wellness Programs

- Under the HIPAA nondiscrimination requirements plans may not require an individual to pay higher premium or contribution rates than other similarly situated individuals based on a health factor.
  - Exception: Rewards for adherence to certain wellness programs

- In June 2013, final wellness program regulations were issued under ERISA section 702 and PHSA section 2705.

Wellness Programs

- Participatory wellness programs: none of the conditions for obtaining a reward are based on an individual satisfying a standard related to a health factor.
  - Must be available to all similarly situated individuals.
- Health-contingent wellness programs: requires an individual to satisfy a standard related to a health factor in order to obtain a reward.
  - Activity-only
  - Outcome-based

Wellness Programs

Five requirements for health-contingent wellness programs:

1. Must give individuals eligible for the program the opportunity to qualify for the reward at least once per year;

2. Reward does not exceed 30% of the total cost of coverage (increased to 50% for programs designed to prevent or reduce tobacco use).

Wellness Programs

3. Reasonable design:

- Activity-only: must be reasonably designed to promote health and prevent disease. Determination based on all relevant facts and circumstances.
  - Has a reasonable chance of improving the health of, or preventing disease in, participating individuals;
  - Is not overly burdensome;
  - Is not a subterfuge for discriminating based on a health factor; and
  - Is not highly suspect in the method chose to promote health or prevent disease.
- Outcome-based: additional requirement – reasonable alternative standard must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening.

Wellness Programs

4. Uniform availability and reasonable alternative standards:

- Activity-only: reasonable alternative standard if it is unreasonably difficult due to a medical condition or is medically inadvisable to attempt to satisfy the initial standard.
  - Physician verification if reasonable under the circumstances.
- Outcome-based: reasonable alternative standard for any individual who does not meet the initial standard based on a measurement, test, or screening.
  - No physician verification.
  - Requirements for reasonable alternative standard that is, itself, an activity-only program or an outcome-based program.

Wellness Programs

5. Notice of availability of reasonable alternative standard (and, if applicable, possibility of waiver of original standard):

- Disclosure in all plan materials describing terms of program
- Must include contact information and statement that recommendations of individual's personal physician will be accommodated.
- For outcome-based wellness programs - must be included in any disclosure that an individual did not satisfy an initial outcome-based standard.
- Sample language

Summary of Benefits and Coverage and Uniform Glossary

- Unless otherwise permitted by the instructions, plans and issuers must not alter the template.
  - Special Rule for Limitations, Exceptions, and Other Important Information: To the extent that the inclusion of these limitations and exceptions would make compliance with the limit impossible, the plan or issuer should cross reference the pages or identify the sections where they are described in the applicable document.

- The SBC is limited to 4 double-sided pages, with no smaller than 12 point font.

Summary of Benefits and Coverage and Uniform Glossary

- The Uniform Glossary includes all statutorily required terms, as well as additional terms recommended by the NAIC.
- Plans and issuers must make the Uniform Glossary available upon request within seven business days.
- The SBC must include an internet address where the Uniform Glossary can be obtained.

Summary of Benefits and Coverage and Uniform Glossary

Coverage Examples

- The SBC includes coverage examples- a tool to help consumers compare coverage options.

- Plans and issuers are provided the necessary information to simulate how claims would be processed under the scenario, which will generate an estimate of cost sharing the consumer might expect to pay for the scenario under the coverage.

Summary of Benefits and Coverage and Uniform Glossary

Who provides/receives an SBC:

- Issuer to Plan (or plan sponsor)
- Plan/ Issuer to Participants and beneficiaries
  - Plans/issuers must generally provide SBCs for each benefit package for which the P or B is eligible.

Summary of Benefits and Coverage and Uniform Glossary

When an SBC is provided:

- Upon application
  - To Plans – As soon as practicable but no later than 7 business days after a request for application.
  - To Ps and Bs – With written application materials, or if not applicable, no later than the first date the P can enroll.
- First day of coverage (if there are any changes)
  - Must be provided no later than first day of coverage.

Summary of Benefits and Coverage and Uniform Glossary

When an SBC must be provided:

- Renewal, Reissuance or Re-enrollment
  - If written application is required for renewal, must be provided no later than the date application materials are distributed.
  - If renewal is automatic - No later than 30 days prior to the first day of the new plan or policy year.
    - If renewal or reissuance has not occurred before this date, no later than 7 business days after the issuance of the new policy, certificate or contract of insurance.

Summary of Benefits and Coverage and Uniform Glossary

When an SBC must be provided:

- Upon request
  - As soon as practicable but no later than 7 business days following receipt of a request for an SBC or summary information about the health coverage.
- Special enrollment
  - Must be provided to special enrollees no later than the timeframe required to provide an SPD, which is 90 days from enrollment.

Summary of Benefits and Coverage and Uniform Glossary

Special Rules to Prevent Unnecessary Duplication

- Requirement to provide SBC is satisfied if another party provides it
- Providing SBC to last known address
- Upon renewal, only provide SBC for benefit package in which individual is enrolled

Summary of Benefits and Coverage and Uniform Glossary

Notice of Modification

- Only if plan or issuer makes any material modification in any terms that affect the content of the SBC other than in connection with a renewal or reissuance of coverage.
- Notice must be provided to enrollees not later than 60 days prior to the date the modification will be effective.

  Note: This notice is in advance of timing for SMM notice in other ERISA rules.

Summary of Benefits and Coverage and Uniform Glossary

Electronic Delivery

- The Departments generally allow electronic delivery of the SBC and Uniform Glossary in accordance with the regulations.

Culturally and Linguistically Appropriate Manner

- The SBC and Uniform Glossary must be provided in a culturally and linguistically appropriate manner.
  - These rules are located in the regulations on Internal Claims and Appeals; External Review PHSA Section 2719.

Internal Claims and Appeals and External Review

- Plans and issuers must initially incorporate the internal claims and appeals processes set forth in the Department of Labor Claims Procedure Regulation (See 29 CFR 2560.503-1) and update such processes in accordance with standards established by the Secretary of Labor.

- 7 additional requirements added to Claims Procedure Regulation by these regulations.

1. Adverse benefit determinations (ABD). An ABD eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

Internal Claims and Appeals

2. Notice of urgent care determinations. Must notify a claimant of an initial ABD on an urgent care claim as soon as possible, but generally not later than 72 hours after the receipt of the claim.

3. Full and Fair Review. Must provide claimants (free of charge) with any new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with a claim as, well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.

4. Avoiding conflicts of interest. All claims and appeals must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Internal Claims and Appeals

5. Notices – Form and Manner. Must be provided in a culturally and linguistically appropriate manner.

- Applicable non-English language. With respect to an address to which a notice is sent, if 10% or more of the population residing in the county is literate only in the same non-English language.

- See CLAS data at http://www.cciio.cms.gov/resources/factsheets/clas-data.html

- If threshold is met, plans and issuers are required to provide, in any applicable non-English language:
  - Oral language services.
  - Assistance with filing claims and appeals.
  - In English versions of notices, a prominently displayed statement indicating how to access the language services provided.

Internal Claims and Appeals

6. Notices - Content. Notices must provide broader content and specificity.

- Provide sufficient information to identify the claim involved (Date of service, health care provider and claim amount)
- Notice to participants of their right to diagnosis and treatment code information upon request
- A description of the reasons for denial and of the standard that was used in denying the claim.
- A description of available internal appeals and external review processes, including how to initiate an appeal.
- The availability and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- Model notices available at: http://www.dol.gov/ebsa/healthreform

Internal Claims and Appeals

7. Deemed exhaustion. If a plan or issuer fails to adhere to all the requirements of the internal claims and appeals process, the claimant will be deemed to have exhausted internal appeals, and will be able to initiate an external review and pursue any available remedies.

Exception if violation of procedural rules was:

- De minimis;
- Non-prejudicial;
- Attributable to good cause or matters beyond the plan/issuer control;
- In the context of an ongoing good faith exchange of information; AND
- Not reflective of a pattern or practice of non-compliance.

External Review

- Section 2719 of the PHS Act requires plans and issuers to implement an effective external review process that meets minimum standards established by the Secretary.
- The statute, final regulations and a series of technical releases provide a basis for determining when plans and issuers must comply with the Federal or State External Review Processes as well as guidelines for these processes.
- Guidance issued has established guidelines for the following External Review Processes:
  - Federal Processes
    - Independent Review Organization (IRO) process
    - HHS-administered process
  - State Process
    - NAIC Uniform Model Act parallel or similar processes

Mental Health Parity

Mental Health Parity Act of 1996 (MHPA)

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

21st Century Cures Act (Cures Act)

Mental Health Parity

- Only applicable to plans offering both:
  - medical/surgical (med/surg) benefits; and
  - mental health or substance use disorder (MH/SUD) benefits
- Anti-abuse provision: look at all possible combinations of med/surg and MH/SUD benefits
- Does not apply to employers with 50 or fewer employees (but non-grandfathered, small group market coverage must include coverage for MH/SUD benefits for plan years beginning or after January 1, 2014).
- Increased cost exemption

Mental Health Parity

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

- General Rule: financial requirements or quantitative treatment limitations applicable to MH/SUD benefits can be no more restrictive than the predominant financial requirements or quantitative treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

Mental Health Parity

SUMMARY - GENERAL RULE ANALYSIS

1. Within a classification
2. Substantially all med/surg benefits
3. Predominant level applied to substantially all
4. Requirements or limitations that can be applied to MH/SUD benefits

Mental Health Parity

- General rule is applied within each of six classifications of benefits.
- Six Classifications:

  -Inpatient, in-network

  -Inpatient, out-of-network

  -Outpatient, in-network*

  -Outpatient, out-of-network*

  -Emergency care

  -Prescription drugs

- Classifications are mutually exclusive and must be used.
- If a plan provides benefits for a MH/SUD, the plan must provide MH/SUD benefits in all classifications in which medical/surgical benefits are offered (including out-of-network classifications).

Mental Health Parity

Nonquantitative Treatment Limitations (NQTLs)

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness
- Formulary design
- Network tier design
- Standards for provider admission to participate in a network, including reimbursement rates
- Plan methods for determining UCR
- Fail-first policies or step therapy protocols
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits

Mental Health Parity

Nonquantitative Treatment Limitations (NQTLs)

- Processes, strategies, evidentiary standards, or other factors used in applying nonquantitative treatment limitations to MH/SUD benefits must be comparable to, and applied no more stringently than, those used with respect to med/surg benefits.

Mental Health Parity

Disclosure Requirements:

Availability of Plan Information

- Criteria for Medical Necessity Determinations
- Reason for any Denial
- Disclosure Provisions Under Other Law Generally Applicable to Claims, Including Mental Health
  - Plans cannot refuse to disclose information they are otherwise required to disclose on the grounds that it is “proprietary” or “of commercial value.”

Mental Health Parity

Revised Draft Model Disclosure Template

- Issued on April 23, 2018 (available on EBSA's website).
- Tool designed to help request information from employer-sponsored health plan/ insurer regarding limitations that may affect MH/SUD benefits.
  - Both general information about coverage/ treatment limitations or specific information about limitations that may have resulted in denial of benefits can be requested using the template.

Mental Health Parity

- Recent MHPAEA FAQs
  - ACA FAQs Part XXIX
  - ACA FAQs Part 31
  - ACA FAQs Set 34
  - ACA FAQs Set 38
  - Proposed ACA FAQs Set 39

Mental Health Parity

- *Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*
  - Purpose: to identify provisions that require further inquiry beyond the plan/policy terms to determine compliance
  - Provides examples of plan provisions that should trigger analysis including:
    - Preauthorization & pre-service notification requirements
    - Fail-first protocols
    - Probability of improvement
    - Written treatment plan required

Mental Health Parity

- Enforcement
  - MHPAEA Enforcement Fact Sheets issued January 2016, January 2017, and April 2018.
  - EBSA relies on its investigators to review plans for compliance.
  - Benefits Advisors pursue voluntary compliance from plans on behalf of participants and beneficiaries.

Executive Order 13813

- Association Health Plans (AHPs)
- Short-Term, Limited-Duration Insurance (STLDI)
- Health Reimbursement Arrangements (HRAs)

Executive Order 13813

- On October 12, 2017, President Trump issued Executive Order 13813.

- Directs the Departments to consider proposing regulations or revising guidance to:
  - Expand access to Association Health Plans (AHPs)
  - Expand the availability of Short-Term, Limited-Duration Insurance (STLDI)
  - Expand the availability and permitted use of Health Reimbursement Arrangements (HRAs)

Association Health Plans

- AHP Final Rule published June 21, 2018.
  - The Final Rule provides an alternate pathway for employer groups or associations to sponsor an AHP.
  - State of New York et al. v. U.S. Department of Labor et al., No. 18-1747 (D.C. March 28, 2019)—portions of rule struck down.
  - The U.S. Department of Justice issued a statement that the administration disagrees with the District Court's rulings and is considering all available options.
  - More information on the AHP Final Rule available on the EBSA website at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85

Short-Term, Limited-Duration Insurance and Health Reimbursement Arrangements

- STLDI Final Rule
  - Final Rule published August 3, 2018 and applicable October 2, 2018
- HRA Proposed Rule
  - Proposed Rule published October 29, 2018
  - Comments were due December 28, 2018

Short-Term, Limited-Duration Insurance (STLDI)

- Final rule published on August 3, 2018.
- Applicable October 2, 2018.
- Background
  - A type of health insurance primarily designed to fill temporary gaps in coverage.
  - Not subject to the requirements of the ACA.
  - Historically limited to less than 12 months.
  - 2016 regulation limited this to less than 3 months and added notice requirements.

Short-Term, Limited-Duration Insurance

Final rule:

- Maximum initial contract term of STLDI is limited to less than 12 months (the original standard under HIPAA).
- Can be renewed for a total maximum duration of up to 36 months.
- Must provide notice that coverage does not have to comply with certain ACA protections.

Health Reimbursement Arrangements (HRAs)

Background

- HRAs are group health plans funded by employer contributions that reimburse an employee solely for medical expenses incurred by the employee or their family up to a maximum dollar amount.
- These reimbursements are excludable from the employee's income and wages for Federal income tax and employment tax purposes.

Health Reimbursement Arrangements

Background (cont.)

- Current regulations allow the use of HRAs integrated with other employer group health plans, Medicare Parts B and D and Tricare.
- However, current regulations prohibit the use of HRAs to reimburse individual market premiums.
- 21st Century Cures Act allows employers with fewer than 50 employees to establish a qualified small employer HRA (QSEHRA), provided certain conditions are met. (IRS Notice 2017-67)

Proposed Rule published October 29, 2018.

- Comments were due by Dec. 28, 2018.

Health Reimbursement Arrangements

Proposed individual integration HRA requirements:

- Participants and dependents are enrolled in individual health insurance coverage.
- No traditional group health plan is offered to the same participants.
- HRA has reasonable procedures to verify and substantiate coverage.
- HRA allows participants to opt-out from the HRA annually and on termination of employment
- HRA must provide a notice.

Health Reimbursement Arrangements (cont)

Proposed Individual integration HRA requirements (cont.):

- Must offer the HRA on the same terms to all employees within a class, subject to certain exceptions.
- Permitted classes (classes may be combined):
  - Full-time employees
  - Part-time employees
  - Seasonal employees
  - Employees covered by a Collective Bargaining Agreement
  - Employees who have not satisfied a waiting period
  - Employees who have not attained age 25
  - Nonresident aliens with no US based income
  - Employees working in the same rating area

Health Reimbursement Arrangements (cont)

Proposed Excepted benefit HRA requirements:

- Must not be an integral part of the plan.
  - Other group health plan coverage is made available to the participant.
- Limited in amount.
  - The amounts newly made available for a plan year may not exceed $1,800 per year, indexed for inflation.
- Made available on the same terms to all similarly situated individuals (as defined in the HIPAA nondiscrimination rules), regardless of health status.

Health Reimbursement Arrangements (cont)

Proposed Excepted benefit HRA requirements (continued):

- Does not reimburse premiums for certain health insurance coverage.
  - **Cannot** reimburse premiums for
    - individual health insurance coverage,
    - Medicare parts B or D, or
    - a group health plan (generally).
  - **Can** reimburse premiums for
    - Continuation coverage
    - Short-term, limited-duration coverage or
    - Excepted benefits.

Health Reimbursement Arrangements (cont)

- DOL also proposed to clarify that individual health insurance coverage integrated with an HRA is not part of a group health plan if:
  - Purchase of individual insurance is completely voluntary
  - Plan sponsor does not select or endorse coverage
  - Reimbursement for nongroup health insurance premiums is limited solely to individual health insurance coverage.

Health Reimbursement Arrangements (cont)

- DOL proposed clarification requirements (cont.):
  - Plan sponsor receives no consideration in connection with the employee's selection or renewal of any individual health insurance coverage.
  - Each plan participant is notified annually that the individual health insurance coverage is not subject to Title I of ERISA.

Part 7 Disclosure Requirements

Review of Part 7 Disclosure Requirements

- Notice of special enrollment rights
- Summary of Benefits & Coverage (SBC)
- Uniform glossary
- Wellness program disclosures
- Newborns' Act disclosure
- WHCRA notices (enrollment & annual)
- Michelle's Law notice
- CHIPRA notice
- MHPAEA disclosure

Review of Part 7 Disclosure Requirements

- Disclosure for grandfathered plans
  - Grandfathered plan disclosure
- Disclosure for non-grandfathered plans
  - Internal claims and appeals
  - External review
  - Designation of primary care provider

Additional Compliance Tips and Tools

Additional Compliance Tips and Tools

- Use EBSA's Part 7 Compliance Tool to help evaluate compliance.
  - Summarizes regulations and other guidance used by the Department to implement applicable provisions of Part 7.
  - Provides detailed examples and tips for to help plan sponsors review for compliance.

Additional Compliance Tips and Tools

- Where to look to ensure compliance? The Summary Plan Description is a good place to start but be sure to check:
  - Other plan documents
  - Wellness program materials
  - Certificates or evidence of coverage (COC/EOC)
  - SBC, SMM, CBAs, service provider contracts
  - Form 5500 and financial statements
  - Claims processing policies and procedures
  - Audit reports

Additional Compliance Tips and Tools

- Work to ensure the plan is in compliance both as documented and in operation.
- If you have questions or concerns, contact EBSA.

Resources

Subscribe to the DOL, EBSA website for updates:
https://www.dol.gov/agencies/ebsa

Other Good Affordable Care Act Resources:

IRS website:
https://www.irs.gov/affordable-care-act

HHS website:
www.healthcare.gov

Resources (continued)

Compliance Assistance for Health Plans:

https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans

Affordable Care Act:

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers

Mental Health and Substance Use Disorder Parity:

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity

Subscribe for Updates!!!

Resources

- **AHP Final Rule:**
  https://www.gpo.gov/fdsys/pkg/FR-2018-06-21/pdf/2018-12992.pdf

- **AHP Fact Sheet, FAQs and Compliance Assistance Publication**
  https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85

- **DOL MEWA Booklet:**
  https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf

Contact Information

- **EBSA website:**
  https://www.dol.gov/agencies/ebsa

- **EBSA web inquiries:**
  https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa

- **EBSA (questions and publications):**
  866-444-EBSA (3272)

- **OHPSCA (Problematic Part 7 questions):**
  202-693-8335

QUESTIONS?