MEWAs

Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): **A Guide to Federal and State Regulation**

U.S. Department of Labor
Employee Benefits Security Administration

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U.S. Department of Labor
Employee Benefits Security Administration
Revised September 2004

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Foreword

This booklet was prepared by the Employee Benefits Security Administration of the U.S. Department of Labor in an effort to address many of the questions that have been raised concerning the effect of the Employee Retirement Income Security Act (ERISA) on Federal and State regulation of "multiple employer welfare arrangements" (MEWAs). It is the hope of the Department that the information contained in this booklet will not only provide a better understanding of the scope and effect of ERISA coverage, but also will serve to facilitate State regulatory and enforcement efforts, as well as Federal-State coordination, in the MEWA area.

Introduction

For many years, promoters and others have established and operated multiple employer welfare arrangements (MEWAs), also described as "multiple employer trusts" or "METs," as vehicles for marketing health and welfare benefits to employers for their employees. Promoters of MEWAs have typically represented to employers and State regulators that the MEWA is an employee benefit plan covered by the Employee Retirement Income Security Act (ERISA) and, therefore, exempt from State insurance regulation under ERISA's broad preemption provisions.

By avoiding State insurance reserve, contribution and other requirements applicable to insurance companies, MEWAs are often able to market insurance coverage at rates substantially below those of regulated insurance companies, thus, in concept, making the MEWA an attractive alternative for those small businesses finding it difficult to obtain affordable health care coverage for their employees. In practice, however, a number of MEWAs have been unable to pay claims as a result of insufficient funding and inadequate reserves. Or in the worst situations, they were operated by individuals who drained the MEWA's assets through excessive administrative fees and outright embezzlement.

Prior to 1983, a number of States attempted to subject MEWAs to State insurance law requirements, but were frustrated in their regulatory and enforcement efforts by MEWA-promoter claims of ERISA-plan status and Federal preemption. In many instances MEWAs, while operating as insurers, had the appearance of an ERISA-covered plan — they provided the same benefits as ERISA-covered plans, benefits were typically paid out of the same type of tax-exempt trust used by ERISA-covered plans, and, in some cases, filings of ERISA-required documents were made to further enhance the appearance of ERISA-plan status. MEWA-promoter claims of ERISA-plan status and claims of ERISA preemption, coupled with the attributes of an ERISA plan, too often served to impede State efforts to obtain compliance by MEWAs with State insurance laws.

Recognizing that it was both appropriate and necessary for States to be able to establish, apply and enforce State insurance laws with respect to MEWAs, the U.S. Congress amended ERISA in 1983, as part of Public Law 97-473, to provide an exception to ERISA's broad preemption provisions for the regulation of MEWAs under State insurance laws.

While the 1983 ERISA amendments were intended to remove Federal preemption as an impediment to State regulation of MEWAs, it is clear that MEWA promoters and others have continued to create confusion and uncertainty as to the ability of States to regulate MEWAs by claiming ERISA coverage and protection from State regulation under ERISA's preemption provisions. Obviously, to the extent that such claims have the effect of discouraging or delaying the application and enforcement of State insurance laws, the MEWA promoters benefit and those dependent on the MEWA for their health care coverage bear the risk.

This booklet is intended to assist State officials and others in addressing ERISA-related issues involving MEWAs. The Employee Benefits Security Administration has attempted in this booklet to provide a clear understanding of ERISA's MEWA provisions, and the effect of those provisions on the respective regulatory and enforcement roles of the Department of Labor and the States in the MEWA area. Such understanding should not only facilitate State regulation of MEWAs, but should also enhance Federal-State coordination efforts with respect to MEWAs and, in turn, ensure that employees of employers participating in MEWAs are afforded the benefit of the safeguards intended under both ERISA and State insurance laws.

The first part of this booklet, **Regulation of Multiple Employer Welfare Arrangements under ERISA,** focuses on what constitutes an ERISA-covered plan and the regulatory and enforcement authority of the Department of Labor over such plans. The second part of the booklet, **Regulation of Multiple Employer Welfare Arrangements under State Insurance Laws,** focuses on what is and what is not a MEWA and the extent to which States are permitted to regulate MEWAs that are also ERISA-covered welfare benefit plans.

Regulation of Multiple Employer Welfare Arrangements under ERISA

The U.S. Department of Labor, through the Employee Benefits Security Administration (EBSA), is responsible for the administration and enforcement of the provisions of Title I of ERISA (29 U.S.C. §1001 et seq.). In general, ERISA prescribes minimum participation, vesting and funding standards for private-sector pension benefit plans and reporting and disclosure, claims procedure, bonding and other requirements which apply to both private-sector pension plans and private-sector welfare benefit plans. ERISA also prescribes standards of fiduciary conduct which apply to persons responsible for the administration and management of the assets of employee benefit plans subject to ERISA.

ERISA covers only those plans, funds, or arrangements that constitute an "employee welfare benefit plan," as defined in ERISA Section 3(1), or an "employee pension benefit plan," as defined in ERISA Section 3(2). By definition, MEWAs do not provide pension benefits; therefore, only those MEWAs that constitute "employee welfare benefit plans" are subject to ERISA's provisions governing employee benefit plans.

Prior to 1983, if a MEWA was determined to be an ERISA-covered plan, State regulation of the arrangement would have been precluded by ERISA's preemption provisions. On the other hand, if the MEWA was not an ERISA-covered plan, which was generally the case, ERISA's preemption provisions did not apply and States were free to regulate the entity in accordance with applicable State law. As a result of the 1983 MEWA amendments to ERISA, discussed in detail later in this booklet, States are now free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan.

Under current law, a MEWA that constitutes an ERISA-covered plan is required to comply with the provisions of Title I of ERISA applicable to employee welfare benefit plans, in addition to any State insurance laws that may be applicable to the MEWA. If a MEWA is determined not to be an ERISA-covered plan, the persons who operate or manage the MEWA may nonetheless be subject to ERISA's fiduciary responsibility provisions if such persons are responsible for, or

exercise control over, the assets of ERISA-covered plans. In both situations, the Department of Labor would have concurrent jurisdiction with the State(s) over the MEWA.

The following discussion provides a general overview of the factors considered by the Department of Labor in determining whether an arrangement is an "employee welfare benefit plan" covered by ERISA, the requirements applicable to welfare plans under Title I of ERISA, and the regulation of persons who administer and operate MEWAs as fiduciaries to ERISA-covered welfare plans.

❒ What is an "employee welfare benefit plan"?

The term "employee welfare benefit plan" (or welfare plan) is defined in Section 3(1) of ERISA, 29 U.S.C. §1002(1), as follows:

> *any plan, fund, or program which was heretofore or is hereafter* ***established or maintained by*** *an* ***employer*** *or by an* ***employee organization****, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A)* ***medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death*** *or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).*
> ***(Emphasis supplied.)***

A determination as to whether a particular arrangement meets the statutory definition of "welfare plan," typically involves a two-step analysis. The first part of the analysis involves a determination as to whether the benefit being provided is a benefit described in Section 3(1). The second part of the analysis involves a determination as to whether the benefit arrangement is established or maintained by an "employer" or an "employee organization." Each of these steps is discussed below.

❒ Is there a plan, fund or program providing a benefit described in Section 3(1)?

A plan, fund or program will be considered an ERISA-covered welfare plan only to the extent it provides one or more of the benefits described in Section 3(1).

As reflected in the definition of "welfare plan," the benefits included as welfare plan benefits are broadly described and wide ranging in nature. By regulation, the Department of Labor has provided additional clarifications as to what are and are not benefits described in Section 3(1) (See: 29 CFR §2510.3-1). In most instances, however, it will be fairly clear from the facts whether a benefit described in Section 3(1) is being provided to participants.

For example, the provision of virtually any type of health, medical, sickness, or disability benefit will be the provision of a benefit described in Section 3(1). Where there is an employer or employee organization providing one or more of the described benefits, the Department has generally held that there is a "plan," regardless of whether the program of benefits is written or informal, funded (i.e., with benefits provided through a trust or insurance) or unfunded (i.e., with benefits provided from the general assets of the employer or employee organization), offered on a routine or ad hoc basis, or is limited to a single employee-participant.

If it is determined that a Section 3(1) benefit is being provided, a determination then must be made as to whether the benefit is being provided by a plan "established or maintained by an employer or by an employee organization, or by both." Under Section 3(1), a plan, even though it provides a benefit described in Section 3(1), will not be deemed to be an ERISA-covered employee welfare benefit plan unless it is established or maintained by an employer (as defined in ERISA Section 3(5)), or by an employee organization (as defined in ERISA Section 3(4)), or by both an employer and employee organization.

For example, MEWAs provide benefits described in Section 3(1) (e.g., medical and hospital benefits), but MEWAs generally are not established or maintained by either an employer or employee organization and, for that reason, do not constitute ERISA-covered plans.

❒ What is an "employer"?

The term "employer" is defined in Section 3(5) of ERISA, 29 U.S.C. §1002(5), to mean:

> *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.*

Under the definition of "employer," an employee welfare benefit plan might be established by a single employer or by a group or association of employers acting on behalf of its employer-members with respect to the plan. "Employer" status is rarely an issue where only a single employer is involved in the provision of welfare benefits to employees. However, questions frequently are raised as to whether a particular group or association constitutes an "employer" for purposes of Section 3(5).

In order for a group or association to constitute an "employer" within the meaning of Section 3(5), there must be a bona fide group or association of employers acting in the interest of its employer-members to provide benefits for their employees. In this regard, the Department has expressed the view that where several unrelated employers merely execute identically worded trust agreements or similar documents as a means to fund or provide benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association exists for purposes of Section 3(5). Similarly, where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of their status as employers (i.e., the group or association members include persons who are not employers) or where control of the group or association is not vested solely in employer members, the group or association is not a bona fide group or association of employers for purposes of Section 3(5).

The following factors are considered in determining whether a bona fide group or association of employers exists for purposes of ERISA: 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 of employer-members; and who actually controls and directs the activities and operations of the benefit program. In addition, employer-members of the group or association that participate in the benefit program must, either directly or indirectly, exercise control over that program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the benefit program. It should be noted that whether employer-members of a particular group or association exercise control in substance over a benefit program is an inherently factual issue on which the Department generally will not rule.

Where no bona fide group or association of employers exists, the benefit program sponsored by the group or association would not itself constitute an ERISA-covered welfare plan; however, the Department would view each of the employer-members that utilizes the group or association benefit program to provide welfare benefits to its employees as having established separate, single-employer welfare benefit plans subject to ERISA. In effect, the arrangement sponsored by the group or association would, under such circumstances, be viewed merely as a vehicle for funding the provision of benefits (like an insurance company) to a number of individual ERISA-covered plans.

If a benefit program is not maintained by an employer, the program may nonetheless be an ERISA-covered plan if it is maintained by an "employee organization."

❒ What is an "employee organization"?

The term "employee organization" is defined in Section 3(4) of ERISA, 29 U.S.C. §1002(4). There are two types of organizations included within the definition of "employee organization." The first part of the definition includes:

> *any labor union or any organization of any kind, or any agency or employee representation committee, association, group or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; . . .*

This part of the definition is generally limited to labor unions. In order for an organization to satisfy this part of the definition of "employee organization," employees must participate in the organization (i.e., as voting members) and the organization must exist, at least in part, for the purpose of dealing with employers concerning matters relating to employment.

The second part of the definition of "employee organization" includes:

> *. . . any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.*

While the term "employees' beneficiary association" is not defined in Title I of ERISA, the Department of Labor applies the same criteria it utilized in construing that term under the Welfare and Pension Plans Disclosure Act, which preceded ERISA's enactment. Applying those criteria, an organization or association would, for purposes of ERISA Section 3(4), be an "employees' beneficiary association" only if: **(1)** membership in the association is conditioned on employment status (i.e., members must have a commonality of interest with respect to their employment relationships); **(2)** the association has a formal organization, with officers, by-laws, or other indications of formality; **(3)** the association generally does not deal with an employer (as distinguished from organizations described in the first part of the definition of "employee organization"); and **(4)** the association is organized for the purpose, in whole or in part, of establishing an employee benefit plan.

It should be noted that the term "employees' beneficiary association" used in Section 3(4) of ERISA is not synonymous with the term "voluntary employees' beneficiary association" used in Section 501(c)(9) of the Internal Revenue Code (the Code). Code Section 501(c)(9) provides a tax exemption for a "voluntary employees' beneficiary association" providing life, sickness, accident, or other benefits to its members or their dependents or beneficiaries. While many trusts established under ERISA-covered welfare plans obtain an exemption from Federal taxation by satisfying the requirements applicable to voluntary employees' beneficiary associations, satisfying such requirements under the Internal Revenue Code is not in and of itself indicative of whether the entity is an "employees' beneficiary association" for purposes of ERISA Section 3(4).

❒ What types of plans are excluded from coverage under Title I of ERISA?

There are certain arrangements that appear to meet the definition of an "employee welfare benefit plan" but which nonetheless are not subject to the provisions of Title I of ERISA.

Section 4(b) of ERISA, 29 U.S.C. §1003(b), specifically excludes from Title I coverage the following plans: **(1)** governmental plans (as defined in Section 3(32)); **(2)** church plans (as defined in Section 3(33)); **(3)** plans maintained solely to comply with workers' compensation, unemployment compensation, or disability insurance laws; and **(4)** certain plans maintained outside the United States.

In addition, the Department of Labor has issued regulations, 29 CFR §2510.3-1, which clarify the definition of "employee welfare benefit plan." Among other things, these regulations serve to distinguish certain "payroll practices" from what might otherwise appear to be ERISA-covered welfare plans (e.g., payments of normal compensation to employees out of the employer's general assets during periods of sickness or vacation).

❒ What requirements apply to an employee welfare benefit plan under Title I of ERISA?

In general, an employee welfare benefit plan covered by ERISA is subject to the reporting and disclosure requirements of Part 1 of Title I; the fiduciary responsibility provisions of Part 4 of Title I; the administration and enforcement provisions of Part 5 of Title I; the continuation coverage provisions of Part 6 of Title I of ERISA and the health care provisions of Part 7 of ERISA. It is important to note that, unlike ERISA-covered pension plans, welfare plans are not subject to the participation, vesting, or funding standards of Parts 2 and 3 of Title I of ERISA. It also is important to note that merely undertaking to comply with the provisions of ERISA, such as with the reporting and disclosure requirements, does not make an arrangement an ERISA-covered plan.

The following is a general overview of the various requirements applicable to welfare plans subject to ERISA.

Under Part 1 of Title I, 29 U.S.C. §§1021 - 1031, the administrator of an employee benefit plan is required to furnish participants and beneficiaries with a summary plan description (SPD), which describes, in understandable terms, their rights, benefits, and responsibilities under the plan. If there are material changes to the plan or changes in the information required to be contained in the summary plan description, summaries of these changes are also required to be furnished to participants.

The plan administrator also is required, under Part 1, to file with the Department an annual report (the Form 5500 Series) each year which contains financial and other information concerning the operation of the plan. The Form 5500 Series is a joint Department of Labor - Internal Revenue Service - Pension Benefit Guaranty Corporation annual report form series. The forms are filed with the Department of Labor, which processes the forms and furnishes the data to the Internal Revenue Service. Pursuant to regulations issued by the Department, welfare plans with fewer than 100 participants that are fully insured or unfunded (i.e., benefits are paid from the general assets of the employer) are not required to file annual reports with the Department of Labor. If a plan administrator is required to file an annual report, the administrator also generally is required to furnish participants and beneficiaries with a summary of the information contained in that annual report, i.e., a summary annual report.

The Department of Labor's regulations governing the application, content, and timing of the various reporting and disclosure requirements are set forth at 29 CFR §2520.101-1, et seq.

Part 4 of Title I, 29 U.S.C. §1101 - 1114, sets forth standards and rules governing the conduct of plan fiduciaries. In general, any person who exercises discretionary authority or control respecting the management of a plan or respecting management or disposition of the assets of a plan is a "fiduciary" for purposes of Title I of ERISA. Under ERISA, fiduciaries are required, among other things, to discharge their duties "solely in the interest of plan participants and beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan." In discharging their duties, fiduciaries must act prudently and in accordance with documents governing the plan, insofar as such documents are consistent with ERISA. (See: ERISA Section 404.) Part 4 also describes certain transactions involving a plan and certain parties, such as

the plan fiduciaries, which, as a result of the inherent conflicts of interest present, are specifically prohibited (See: ERISA Section 406). In certain instances there may be a statutory exemption or an administrative exemption, granted by the Department, which permits the parties to engage in what would otherwise be a prohibited transaction, if the conditions specified in the exemption are satisfied (See: ERISA Section 408).

Part 5 of Title I, 29 U.S.C. §§1131 - 1145, contains the administration and enforcement provisions of ERISA. Among other things, these provisions describe the remedies available to participants and beneficiaries, as well as the Department, for violations of the provisions of ERISA (See: ERISA Sections 501 and 502). With regard to benefit claims, Part 5, at Section 503, requires that each employee benefit plan maintain procedures for the filing of benefit claims and for the appeal of claims that are denied in whole or in part (See also: 29 CFR §2560.503-1).

Part 5 also sets forth, at Section 514, ERISA's preemption provisions. In general, Section 514(a) provides that provisions of ERISA shall supersede any and all State laws insofar as they "relate to" any employee benefit plan. Section 514(b), however, saves certain State laws, as well as Federal laws, from ERISA preemption, including an exception for the State regulation of MEWAs. These provisions are discussed in detail later in this booklet.

Part 6 of Title I, 29 U.S.C. §§1161 - 1168, contains the "continuation coverage" provisions, also referred to as the "COBRA" provisions because they were enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. In general, the continuation coverage provisions require that participants and their covered dependents be afforded the option of maintaining coverage under their health benefit plan, at their own expense, upon the occurrence of certain events (referred to as "qualifying events") that would otherwise result in a loss of coverage under the plan. "Qualifying events" include, among other things:

-- *death of the covered employee, termination (other than by reason of an employee's gross misconduct), or reduction of hours of covered employment;*

-- *divorce or legal separation of the covered employee from the employee's spouse;*

-- *a dependent child ceasing to be a dependent under the generally applicable requirements of the plan.*

Continuation coverage may be maintained for periods up to 18 months, 36 months, or even longer depending on the qualifying event and other circumstances.

It is important to note that while Title I of ERISA contains continuation coverage requirements and participants and beneficiaries may enforce their rights to continuation coverage in accordance with the remedies afforded them under Section 502 of Title I of ERISA, the Department of Labor has limited regulatory and interpretative jurisdiction with respect to the continuation coverage provisions. Specifically, the Department of Labor has responsibility for the COBRA notification and disclosure provisions, while the Internal Revenue Service has regulatory and interpretative responsibility for all the other provisions of COBRA under the Internal Revenue Code.

Part 7 of Title I of ERISA, 29 U.S.C.§1181 et seq., contains provisions setting forth specific benefit requirements applicable to group health plans and health insurance issuers under the Health Insurance Portability and Accountability Act (HIPAA), the Newborns' and Mothers' Health Protection Act (Newborn's Act), the Mental Health Parity Act (MHPA), and the Women's Health and Cancer Rights Act (WHCRA).

The HIPAA portability rules, at Section 701 of ERISA, place limitations on a group health plan's ability to impose pre-existing condition exclusions and provides special enrollment rights for certain individuals that lose other health coverage or who experience a life change. Section 702 contains HIPAA's nondiscrimination rules that prohibit plans or issuers from establishing rules for eligibility to enroll in the plan or charging individuals higher premium amounts based on a health factor. In addition, Section 703 of Part 7 sets forth provisions for guaranteed renewably in MEWAs and multiemployer plans.

The Newborns' Act (in Section 711 of ERISA) generally requires group health plans that offer maternity hospital benefits for mothers and newborns to pay for at least a 48-hour hospital stay for the mother and newborn following normal childbirth or a 96-hour hospital stay following a cesarean. MHPA, at Section 712, provides for parity in the application of annual and dollar limits on mental health benefits with annual lifetime dollar limits on medical/surgical benefits. WHCRA, at Section 713, provides protections for patients who elect breast reconstruction or certain other follow-up care in connection with a mastectomy.

❒ To what extent does ERISA govern the activities of MEWAs that are not "employee welfare benefit plans"?

Under ERISA, persons who exercise discretionary authority or control over the management of ERISA-covered plans or the assets of such plans are considered fiduciaries and, therefore, are subject to ERISA's fiduciary responsibility provisions. When the sponsor of an ERISA-covered plan purchases health care coverage for its employees from a MEWA, the assets of the MEWA generally are considered to include the assets of the plan (i.e., "plan assets"), unless the MEWA is a State-licensed insurance company. (See: 29 C.F.R. §§2510.3-101 and 2510.3-102 relating to the definition of "plan assets.") In exercising discretionary authority or control over plan assets, such as in the payment of administrative expenses and in the making of benefit claim determinations, the persons operating the MEWA would be performing fiduciary acts that are governed by ERISA's fiduciary provisions. Where a fiduciary breaches statutorily mandated duties under ERISA, or where a person knowingly participates in such breach, the U.S. Department of Labor may pursue civil sanctions.

Inasmuch as MEWAs typically are not ERISA-covered welfare plans and the Department of Labor does not have direct regulatory authority over the business of insurance, the Department's investigations of MEWAs necessarily focus on whether the persons operating MEWAs have breached their fiduciary duties under ERISA to employee plans that have purchased health coverage from the MEWA. Because of the factual and transactional nature of fiduciary breach determinations, investigations of possible fiduciary breaches tend to be more complex and time-consuming than investigations involving alleged violations of specific

statutory requirements, such as the reporting, disclosure, and claims procedure requirements. For example, MEWA investigations typically require detailed reviews of the financial records and documents relating to the operation of the MEWA, the contracts between the MEWA and the service providers to the MEWA, participation or other agreements between the MEWA and ERISA-covered welfare plans, as well as the actual transactions engaged in by the MEWA, in order to determine whether there has been a violation of ERISA's fiduciary standards.

Accordingly, while the Department may pursue enforcement actions with respect to MEWAs, such action is considerably different from, and often more limited than, the remedies generally available to the States under their insurance laws. In this regard, it is important to note that, in many instances, States may be able to take immediate action with respect to a MEWA upon determining that the MEWA has failed to comply with licensing, contribution, or reserve requirements under State insurance laws, whereas investigating and substantiating a fiduciary breach under ERISA may take considerably longer.

Regulation of Multiple Employer Welfare Arrangements under State Insurance Laws

As noted in the introduction, States, prior to 1983, were effectively precluded by ERISA's broad preemption provisions from regulating any employee benefit plan covered by Title I of ERISA. As a result, a State's ability to regulate MEWAs was often dependent on whether the particular MEWA was an ERISA-covered plan. In an effort to address this problem, the U.S. Congress amended ERISA in 1983 to establish a special exception to ERISA's preemption provisions for MEWAs. This exception, which is discussed in detail below, was intended to eliminate claims of ERISA-plan status and Federal preemption as an impediment to State regulation of MEWAs by permitting States to regulate MEWAs that are ERISA-covered employee welfare benefit plans.

The following discussion relating to ERISA's preemption provisions and the 1983 MEWA amendments is intended to clarify what is and what is not a "multiple employer welfare arrangement" within the meaning of ERISA Section 3(40), and the extent to which States may regulate MEWAs, as provided by ERISA Section 514(b)(6).

❒ What is the general scope of ERISA preemption?

Under the general preemption clause of ERISA Section 514(a), 29 U.S.C. §1144(a), ERISA preempts any and all State laws which "relate to" any employee benefit plan subject to Title I of ERISA. However, there are a number of exceptions to the broad preemptive effect of Section 514(a) set forth in ERISA Section 514(b), 29 U.S.C. §1144(b), referred to as the "savings clause."

Section 514(a) of ERISA provides, in relevant part, that:

> *Except as provided in subsection (b) of this section [Section 514], the provisions of this title [title I] . . . supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .*

In determining whether a State law may "relate to" an employee benefit plan, the U.S. Supreme Court has determined that the words "relate to" should be construed expansively. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983), the Court

held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." (See also: *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985).

As noted above, however, while a State law may be found to "relate to" an employee benefit plan, within the meaning of Section 514(a) of ERISA, the law may nonetheless be saved from ERISA preemption to the extent that an exception described in Section 514(b) applies.

With regard to the application of State insurance laws to ERISA-covered plans, Section 514(b)(2) contains two relevant exceptions. This section provides, in relevant part, that:

> **(A)** Except as provided in subparagraph (B), nothing in this title [title I] shall be construed to exempt or relieve any person from any law of any State which regulates insurance....
>
> **(B)** Neither an employee benefit plan..., nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer... for purposes of any law of any State purporting to regulate insurance companies, insurance contracts,....

Section 514(b)(2)(A) referred to as the "savings clause" essentially preserves to the States the right to regulate the business of insurance and persons engaged in that business (See: *Metropolitan Life Insurance Co.* v. *Massachusetts*, cited above, for a discussion of the criteria applied by the U.S. Supreme Court in determining whether a State law is one that "regulates insurance.") However, while Section 514(b)(2)(A) saves from ERISA preemption State laws that regulate insurance, Section 514(b)(2)(B), referred to as the "deemer clause," makes clear that a State law that "purports to regulate insurance" cannot deem an employee benefit plan to be an insurance company.

While plans purchasing insurance are, as a practical matter, indirectly affected by State insurance laws (inasmuch as the insurance contracts purchased by the plans are subject to State insurance law requirements), the "deemer clause," prior to 1983, effectively prevented the direct application of State insurance laws to ERISA-covered employee benefit plans. In 1983, however, ERISA was amended, as part of Public

Law 97-473 (January 14, 1983), to add Section 514(b)(6) to ERISA's preemption provisions.

In general, Section 514(b)(6) provides a special exception for the application of State insurance laws to ERISA-covered welfare plans that are "multiple employer welfare arrangements" (MEWAs). Because the application of Section 514(b)(6) is limited to benefit programs that are MEWAs, the following discussion first reviews what is and what is not a MEWA for purposes of the Section 514(b)(6) exception, followed by a detailed review of the exception and its effect on State regulation of MEWAs.

❒ What is a "multiple employer welfare arrangement"?

The term "multiple employer welfare arrangement" is defined in ERISA Section 3(40), 29 U.S.C. §1002(40). Section 3(40)(A) provides as follows:

> **(A)** The term "multiple employer welfare arrangement" 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 paragraph **(1)** [welfare plan benefits] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or arrangement that is established or maintained -
>
> **(i)** *under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements;*
>
> **(ii)** *by a rural electric cooperative; or*
>
> **(iii)** *by a rural telephone cooperative association*[*]
> ***(Emphasis supplied.)***

[*] The Rural Telephone Cooperative Associations ERISA Amendments Act of 1991 (Public Law No. 102-89) amended the definition of "multiple employer welfare arrangement" to exclude ERISA-covered welfare plans established or maintained by "rural telephone cooperative associations," as defined in ERISA section 3(40)(B)(v), effective August 14, 1991, the date of enactment.

As reflected above, the definition of MEWA includes both ERISA-covered employee welfare benefit plans and other arrangements which offer or provide medical, surgical, hospital care or benefits, or benefits in the event of sickness, accident, disability, or any other benefit described in ERISA Section 3(1) (See: definition of "employee welfare benefit plan" on page 6 for a complete list of benefits). Therefore, whether a particular arrangement is or is not an employee welfare benefit plan subject to ERISA is irrelevant for purposes of determining whether the arrangement is a MEWA. In order to constitute a MEWA, however, a determination must be made that:

-- *the arrangement offers or provides welfare benefits to the employees of two or more employers or to the beneficiaries of such employees (i.e., the arrangement is not a single employer plan); and*

-- *the arrangement is not excepted from the definition of MEWA as established or maintained under or pursuant to one or more collective bargaining agreements, or by a rural electric cooperative, or by a rural telephone cooperative association.*

Set forth below are a number of issues which should be considered in making a MEWA determination.

❒ Does the arrangement offer or provide benefits to the employees of two or more employers?

1. Plans maintained by one employer or a group of employers under common control

If a plan is maintained by a single-employer for the exclusive purpose of providing benefits to that employer's employees, former employees (e.g., retirees), or beneficiaries (e.g., spouses, former spouses, dependents) of such employees, the plan will be considered a single employer plan and not a MEWA within the meaning of ERISA Section 3(40). For purposes of Section 3(40), certain groups of employers which have common ownership interests are treated as a single employer. In this regard, Section 3(40)(B)(i) provides that:

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

In determining whether trades or businesses are within the "same control group," Section 3(40)(B)(ii) provides that the term "control group" means a group of trades or businesses under "common control." Pursuant to Section 3(40)(B)(iii), whether a trade or business is under "common control" is to be determined under regulations issued by the Secretary applying principles similar to those applied in determining whether there is "common control" under section 4001(b) of Title IV of ERISA, except that common control shall not be based on an interest of less than 25 percent. Accordingly, trades or businesses with less than a 25 percent ownership interest will not be considered under "common control" and, therefore, will not be viewed as a single employer for purposes of determining whether their plan provides benefits to the employees of two or more employers under Section 3(40).

With regard to situations where there is a 25 percent or more ownership interest, it should be noted that the Department has not adopted regulations under Section 3(40)(B)(iii). Section 4001(b) of Title IV of ERISA and 29 CFR §4001.3(a) provide, however, the PBGC will determine that trades or businesses (whether or not incorporated) are under common control if they are "two or more trades or businesses under common control" as defined in regulations prescribed under Section 414(c) of the Internal Revenue Code. The regulations issued under Section 414(c) of the Code, see 26 CFR §1.414(c)-2, provide that "common control" generally means, (i) in the case of a parent-subsidiary group, the entities are connected through at least an 80 percent ownership interest, or (ii) in the case of a brother-sister group: (a) five or fewer persons own at least an 80 percent interest in each entity, and (b) the same five or fewer persons together own a greater than 50 percent interest in each entity, taking into account the ownership of each person only to the extent such ownership is identical with respect to each organization.

2. Plans maintained by groups or associations of unrelated employers

Questions have been raised as to whether a plan sponsored by a group or association acting on behalf of its employer-members, which are not part of a control group, constitutes a "single employer" for purposes of the MEWA definition. The question is premised on the fact that the term "employer" is defined in Section 3(5),

29 U.S.C. §1002(5), to mean "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." As discussed earlier, the Department has taken the position that a bona fide group or association of employers would constitute an "employer" within the meaning of ERISA Section 3(5) for purposes of having established or maintained an employee benefit plan (See: page 8).

However, unlike the specified treatment of a control group of employers as a single employer, there is no indication in Section 3(40), or the legislative history accompanying the MEWA provisions, that Congress intended that such groups or associations be treated as "single employers" for purposes of determining the status of such arrangements as a MEWA. Moreover, while a bona fide group or association of employers may constitute an "employer" within the meaning of ERISA Section 3(5), the individuals typically covered by the group or association-sponsored plan are not "employed" by the group or association and, therefore, are not "employees" of the group or association. Rather, the covered individuals are "employees" of the employer-members of the group or association. Accordingly, to the extent that a plan sponsored by a group or association of employers provides benefits to the employees of two or more employer-members (and such employer-members are not part of a control group of employers), the plan would constitute a MEWA within the meaning of Section 3(40).

3. Plans maintained by employee leasing organizations

When a health benefit plan is maintained by an employee leasing organization, there is often a factual question as to whether the individuals covered by the leasing organization's plan are employees of the leasing organization or employees of the client (often referred to as the "recipient") employers. If all the employees participating in the leasing organization's plan are determined to be employees of the leasing organization, the plan would constitute a "single employer" plan and not a MEWA. On the other hand, if the employees participating in the plan include employees of two or more recipient employers or employees of the leasing organization and at least one recipient employer, the plan would constitute a MEWA because it would be providing benefits to the employees of two or more employers.

Like a bona fide group or association of employers, an employee leasing organization may be an "employer" within the meaning of ERISA Section 3(5) to

the extent it is acting directly or indirectly in the interest of an employer. However, as with bona fide groups or associations of employers, "employer" status under Section 3(5) does not in and of itself mean the individuals covered by the leasing organization plan are "employees" of the leasing organization. As discussed below, in order for an individual to be considered an "employee" of an "employer" for purposes of the MEWA provisions, an employer-employee relationship must exist between the employer and the individual covered by the plan. In this regard, the payment of wages, the payment of Federal, State and local employment taxes, and the providing of health and/or pension benefits are not solely determinative of an employer-employee relationship. Moreover, a contract purporting to create an employer-employee relationship will not be determinative where the facts and circumstances establish that the relationship does not exist.

4. Determinations as to who is an "employee" of an employer

As discussed above, the term "employer" is defined to encompass not only persons with respect to which there exists an employer-employee relationship between the employer and individuals covered by the plan (i.e., persons acting directly as an employer), but also certain persons, groups and associations, which, while acting indirectly in the interest of or for an employer in relation to an employee benefit plan, have no direct employer-employee relationship with the individuals covered under an employee benefit plan. Therefore, merely establishing that a plan is maintained by a person, group or association constituting an "employer" within the meaning of ERISA Section 3(5) is not in and of itself determinative that the plan is a single-employer plan, rather than a plan that provides benefits to the employees of two or more employers (i.e., a MEWA). A determination must be made as to the party or parties with whom the individuals covered by the plan maintain an employer-employee relationship.

The term "employee" is defined in Section 3(6) of ERISA, 29 U.S.C. §1002(6), to mean "any individual **employed** by an employer." (Emphasis supplied.) The Department has taken the position that an individual is "employed" by an employer, for purposes of Section 3(6), when an employer-employee relationship exists. While in most instances the existence, or absence, of an employer-employee relationship will be clear, there may be situations when the relationship is not entirely free from doubt.

In general, whether an employer-employee relationship exists is a question that must be determined on the basis of the facts and circumstances involved. It is the position of the Department that, for purposes of Section 3(6), such determinations must be made by applying common law of agency principles.* In applying common law principles, consideration must be given to, among other things, whether the person for whom services are being performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which the result is to be accomplished; whether the person for whom services are being performed has the right to discharge the individual performing the services; whether the individual performing the services is as a matter of economic reality dependent upon the business to which he or she renders service, etc. In this regard, it should be noted that a contract purporting to create an employer-employee relationship will not control where common law factors (as applied to the facts and circumstances) establish that the relationship does not exist. (See: Advisory Opinion No. 92-05, Appendix A.)

Finally, pursuant to regulations issued by the Department of Labor, certain individuals are deemed not be "employees" for purposes of Title I of ERISA. Under the regulations, an individual and his or her spouse are deemed not be "employees" with respect to a trade or business which is wholly owned by the individual or the individual and his or her spouse. Also under the regulations, a partner in a partnership and his or her spouse are deemed not to be "employees" with respect to the partnership. (See: 29 CFR §2510.3-3(b) and (c).)

❒ Is MEWA status conditioned upon the plan being established or maintained by an employer(s)?

While the definition of MEWA refers to arrangements that offer or provide benefits to the employees of two or more employers, the definition of MEWA is not limited to arrangements established or maintained by an em-

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* While common law of agency factors typically have been applied in determining whether a person is an employee or independent contractor, common law principles are equally applicable to determining by whom an individual is employed. See: *Professional & Executive Leasing, Inc. v. Commissioner, 89 TC No. 19(1987).* Also see: *Nationwide Mutual Insurance Co. et al. v. Darden, 503 U.S., 318, 112 S. Ct. 1344(1992).*

ployer. In fact, Section 3(40) does not condition MEWA status on the arrangement being established or maintained by any particular party. Accordingly, the MEWA status of an arrangement is not affected by the absence of any connection or nexus between the arrangement and the employers whose employees are covered by the arrangement. For example, in Advisory Opinion No. 88-05, the Department of Labor concluded that an arrangement established by an association to provide health benefits to its members, who were full-time ministers and other full-time employees of certain schools and churches, constituted a MEWA even though there was no employer involvement with the association's plan.

❒ Is the arrangement excluded from the definition of MEWA?

Once it has been determined that an ERISA-covered welfare plan provides benefits to the employees of two or more employers, a determination must be made as to whether any of the exclusions from MEWA status apply to the arrangement. Pursuant to ERISA Section 3(40)(A), three types of arrangements are specifically excluded from the definition of "multiple employer welfare arrangement," even though such arrangements may provide benefits to the employees of two or more employers. Each of these types of arrangements is discussed in general terms below.

1. Plans maintained pursuant to collective bargaining agreements

Section 3(40)(A)(i) of ERISA specifically excludes from the MEWA definition any plan or other arrangement that is established or maintained "under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements." The Department has concluded that the exception under Section 3(40)(A)(i) should be limited to plans providing coverage primarily to those individuals covered under collective bargaining agreements. Criteria for what constitutes a plan established or maintained under or pursuant to collective bargaining is set forth in the Department's regulation at 29 CFR §2510.3-40(b). (See Appendix C). The criteria are intended to ensure that the statutory exception is only available to plans whose participant base is predominantly comprised of the bargaining unit employees on whose behalf such benefits were negotiated and other individuals with a close nexus to the bargaining unit or the employer(s) of the bargaining unit employees.

The regulation provides that an entity will be treated as established or maintained under or pursuant to collective bargaining for purposes of the exception in

Section 3(40)(A)(i) if it meets three affirmative requirements and does not fall within three exclusions. The affirmative requirements are:

- -- the arrangement itself is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA;

- -- at least 85 percent of the participants in the plan who are employed under one or more collective bargaining agreements meeting the requirements of the regulation or who otherwise fall within one of the other categories of persons identified in the regulation as having a "nexus" to the bargaining unit or employers of the bargaining unit employees; and

- -- the plan is incorporated or referenced in a written agreement between one or more employers and one or more employee organizations, which agreement, itself or together with other agreements among the same parties, is the product of a *bona fide* collective bargaining relationship between the employer(s) and the employee organization(s) and contains certain terms that ordinarily are in collective bargaining agreements.

The regulation sets forth eight factors indicative of *bona fide* collective bargaining. The regulation provides that if four of the eight factors are met, there is a rebuttable presumption that the bargaining was *bona fide*. In addition, the regulation lists a variety of factors that may be examined to rebut the presumption regarding a plan that meets four of the eight factors, or to prove a plan is in fact collectively bargained despite its failure to meet four of eight factors.

The regulation provides, however, that a plan will be deemed to be a MEWA even if it ostensibly meets the affirmative criteria described above, if: (1) the plan is self-funded or partially self-funded and is marketed to employers or sole proprietors; (2) the principal intent of the purported collective bargaining agreement is to evade compliance with state law and regulations applicable to insurance; or (3) there is fraud, forgery, or willful misrepresentation that the plan satisfies the affirmative criteria in the regulation.

The Department also has promulgated regulations at 29 CFR part 2570, subpart H, providing for administrative hearings to obtain a determination by the Secretary of

Labor as to whether a particular entity is an employee welfare benefit plan established or maintained under or pursuant to one or more collective bargaining agreements for purposes of Section 3(40) of ERISA. The hearing procedure is available only in situations where the jurisdiction or law of a state has been asserted against a plan or other arrangement that contends it meets the exception in section 3(40)(A)(i) for collectively bargained plans. A petition for a hearing may be initiated only by the plan or other arrangement. The regulations specifically provide that filing a petition for a hearing is not intended to provide a basis for delaying or staying a state proceeding against the plan or arrangement.

2. Rural Electric Cooperatives

Section 3(40)(A)(ii) specifically excludes from the definition of MEWA any plan or other arrangement that is established or maintained by a "rural electric cooperative."

Section 3(40)(B)(iv) defines the term "rural electric cooperative" to mean:

(I) any organization which is exempt from tax under Section 501(a) of the Internal Revenue Code of 1986 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of Section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under Section 501(a) of such Code and at least 80 percent of the members of which are organizations described in subclause (I).

3. Rural Telephone Cooperative Associations

Section 3(40)(A)(iii) specifically excludes from the definition of MEWA any plan or other arrangement that is established or maintained by a "rural telephone cooperative association." This exception to MEWA status for rural telephone cooperative associations became effective on August 14, 1991, the enactment date of the Rural Telephone Cooperative Associations ERISA Amendments Act of 1991 (Public Law No. 102-89).

Section 3(40)(B)(v), also added to ERISA by Public Law No. 102-89, defines the term "rural telephone cooperative association" to mean an organization described in paragraph (4) or (6) of Section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under Section 501(a) and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

To restate the definition of MEWA somewhat differently, a MEWA, within the meaning of Section 3(40), includes any ERISA-covered employee welfare benefit plan which is not:

(1) a single employer plan (which includes employers within the same control group);

(2) a plan established or maintained under or pursuant to a collective bargaining agreement;

(3) a plan established or maintained by a rural electric cooperative; or

(4) a plan established or maintained by a rural telephone cooperative association.

If an ERISA-covered employee welfare benefit plan is a MEWA, States may, as discussed below, apply and enforce State insurance laws with respect to the plan in accordance with the exception to ERISA preemption under Section 514(b)(6).

❒ To what extent may States regulate ERISA-covered welfare plans that are MEWAs?

If an ERISA-covered welfare plan is a MEWA, States may apply and enforce their State insurance laws with respect to the plan to the extent provided by ERISA Section 514(b)(6)(A), 29 U.S.C. §1144(b)(6)(A). In general, Section 514(b)(6)(A) provides an exception to ERISA's broad preemption provisions for the application and enforcement of State insurance laws with respect to any employee welfare benefit plan that is a MEWA within the meaning of ERISA Section 3(40).

In effect, Section 514(b)(6)(A) serves to provide an exception to the "deemer clause" of Section 514(b)(2)(B), which otherwise precludes States from deeming an ERISA-covered plan to be an insurance company for purposes of State insurance laws, by permitting States to treat certain ERISA-covered plans (i.e., MEWAs) as insurance companies, subject to a few limitations. While the range of State insurance law permitted under Section 514(b)(6)(A) is subject to certain limitations, the Department of Labor believes that these limitations should have little, if any, practical affect on the ability of States to regulate MEWAs under their insurance laws.

There is nothing in Section 514(b)(6)(A) that limits the applicability of State insurance laws to only those insurance laws which specifically or otherwise reference "multiple employer welfare arrangements" or "MEWAs." Similarly, while the specific application of a particular insurance law to a particular MEWA is a matter within the jurisdiction of the State, there is nothing in Section 514(b)(6) that would preclude the application of the same insurance laws that apply to any insurer to ERISA-covered plans which constitute MEWAs, subject only to the limitations set forth in Section 514(b)(6)(A).

Under Section 514(b)(6)(A), the extent to which State insurance laws may be applied to a MEWA that is an ERISA-covered plan is dependent on whether or not the plan is fully insured.

❒ What State insurance laws may be applied to a fully insured plan?

Section 514(b)(6)(A)(i) provides:

> *in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement* ***and is fully insured*** *(or which is a multiple employer welfare arrangement subject to an exemption under sub-paragraph (B)),* ***any law of any State which regulates insurance may apply to such arrangement to the extent such law provides --***
>
> **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... **(Emphasis supplied.)**

Under Section 514(b)(6)(A)(i), it is clear that, in the case of fully insured MEWAs, States may apply and enforce any State insurance law requiring the maintenance of specific reserves or contributions designed to ensure that the MEWA will be able to satisfy its benefit obligations in a timely fashion. Moreover, it is the view of the Department of Labor that 514(b)(6)(A)(i) clearly enables States to subject MEWAs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of State-insurance law necessary to ensure compliance with the State insurance reserves, contributions and funding requirements.

❒ What is a "fully insured" MEWA?

Section 514(b)(6)(D) provides that, for purposes of Section 514(b)(6)(A), "a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State." In this regard, a determination by the Department of Labor as to whether a particular MEWA is "fully insured" is not required in order for a State to treat a MEWA as "fully insured" for purposes of applying State insurance law in accordance with Section 514(b)(6).

❒ What State insurance laws may be applied to a plan that is not fully insured?

Section 514(b)(6)(A)(ii) provides:

in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title [title I], ***any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title*** *[Title I].* ***(Emphasis supplied)***

Accordingly, if a MEWA is not "fully insured," the only limitation on the applicability of State insurance laws to the MEWA is that the law not be inconsistent with Title I of ERISA.

❒ Under what circumstances might a State insurance law be "inconsistent" with Title I of ERISA?

In general, a State law would be inconsistent with the provisions of Title I to the extent that compliance with such law would abolish or abridge an affirmative protection or safeguard otherwise available to plan participants and beneficiaries under Title I or would conflict with any provision of Title I, making compliance with ERISA impossible. For example, any State insurance law which would adversely affect a participant's or beneficiary's right to request or receive documents described in Title I of ERISA, or to pursue claims procedures established in accordance with Section 503 of ERISA, or to obtain and maintain continuation health coverage in accordance with Part 6 of ERISA would be viewed as inconsistent with the provisions of Title I. Similarly, a State insurance law that would require an ERISA-covered plan to make imprudent investments would be inconsistent with the provisions of Title I.

On the other hand, a State insurance law generally will not be deemed "inconsistent" with the provisions of Title I if it requires ERISA-covered plans constituting MEWAs to meet more stringent standards of conduct, or to provide more or greater protection to plan participants and beneficiaries than required by ERISA. The Department has expressed the view that any State insurance law which sets standards requiring the maintenance of specified levels of reserves and specified levels of contributions in order for a MEWA to be considered, under such law, able to pay benefits will generally not be "inconsistent" with the provisions of Title I for purposes of Section 514(b)(6)(A)(ii). The Department also has expressed the view that a State law regulating insurance which requires a license or certificate of authority as a condition precedent or otherwise to transacting insurance business or which subjects persons who fail to comply with such requirements to taxation, fines and other civil penalties, including injunctive relief, would not in and of itself be "inconsistent" with the provisions of title I for purposes of Section 514(b)(6)(A)(ii). (See: Advisory Opinion 90-18, Appendix A).

❒ Has the Department of Labor granted any exemptions from State regulation for MEWAs which are not fully insured?

Pursuant to Section 514(b)(6)(B), the Secretary of Labor may, under regulations, exempt from Section 514(b)(6)(A)(ii) MEWAs which are not fully insured. Such exemptions may be granted on an individual or class basis. While the Department has the authority to grant exemptions from the requirements of Section 514(b)(6)(A)(ii), such authority does not extend to the requirements of Section 514(b)(6)(A)(i) relating to the maintenance of specified levels of reserves and specified levels of contributions under State insurance laws.

The Department has neither prescribed regulations for such exemptions nor granted any such exemptions since the enactment of the MEWA provisions in 1983.

Form M-1 Filing Requirement for MEWAs

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a filing requirement for MEWAs. The purpose of the Form M-1 filing requirement is to provide EBSA with information concerning compliance by MEWAs with the requirements of Part 7 of ERISA (including the provisions of HIPAA, the Mental Health Parity Act, the Newborns and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act).

Under the new reporting requirement, the one-page Form M-1 is generally required to be filed once a year, due on March 1; however, plan administrators can request a 60-day extension.

To help filers, EBSA has published a guide for completing the Form M-1, which is available by calling the EBSA toll-free line at **1-866-444-EBSA (3272)** and on the Internet at **www.dol.gov/ebsa**. Plan administrators may also contact us with any questions or for assistance in completing the Form M-1 by calling the EBSA Help Desk at 202-693-3860.

ERISA ADVISORY OPINIONS

Advisory opinions relating to Title I of ERISA are issued by the Employee Benefits Security Administration and represent the official views of the U.S. Department of Labor on the interpretation and application of the provisions of ERISA. Advisory opinions are issued pursuant to ERISA Procedure 76-1, which, among other things, describes the circumstances under which the Department will and will not rule on particular matters and the effect of advisory opinions generally. A copy of ERISA Procedure 76-1 is reprinted as Appendix B. Pursuant to Section 12 of ERISA Procedure 76-1, advisory opinions, as well as advisory opinion requests, accompanying documentation, and related correspondence are available to the general public.

It should be noted that the advisory opinion process is not a fact-finding process. Advisory opinions are generally based solely on the facts and representations submitted to the Department by the party or parties requesting the opinion. Therefore, advisory opinions should not be viewed as determinations by the Department as to the accuracy of any of the facts and representations provided by the requesting party and cited in such opinions.

❒ Is an advisory opinion on the MEWA status of an arrangement necessary in order for a State to exercise jurisdiction over the arrangement?

No. First, there is nothing in ERISA Section 3(40) which conditions MEWA status on the obtaining of an opinion from the Department. Second, in most instances, the question of whether a particular arrangement is a MEWA will require factual, rather than interpretative, determinations. That is, if the arrangement meets the definition of a MEWA - because it is providing health or similar benefits to the employees of more than one employer (i.e., the arrangement is not a single-employer plan) and the arrangement is not established or maintained under or pursuant to a collective bargaining agreement or by a rural electric cooperative, or by a rural telephone cooperative association - the arrangement is, by definition, a MEWA, whether or not the Department rules on the matter.

❒ Is it necessary to determine by advisory opinion whether a MEWA is an ERISA-covered employee benefit plan?

In most cases, ***no***. While the MEWA exception to ERISA's preemption provisions does impose a few limitations on the ability of States to regulate MEWAs that are ERISA-covered plans, these limitations, as discussed earlier and in Advisory Opinion No. 90-18 (See: Appendix A), should not, as a practical matter, have any significant effect on a State's application and enforcement of its insurance laws with respect to a MEWA which is an ERISA-covered plan. Accordingly, a determination as to whether or not a MEWA is an ERISA- covered plan is not necessary in most instances.

❒ If it is determined that an advisory opinion is necessary, what information is required in order for the Department to issue a ruling?

If a MEWA determination is needed, the advisory opinion request should include sufficient facts and representations to conclude whether the arrangement is providing benefits described in Section 3(1) of ERISA (See: pages 5-6) whether benefits are being provided to the employees of two or more employers, whether the employers of covered employees are members of the same control group of employers, and whether the arrangement is established or maintained pursuant to or under a collective bargaining agreement or by a rural electric cooperative or rural telephone cooperative association.

If an ERISA-coverage determination is needed, the advisory opinion request should also include sufficient information to determine whether the arrangement is established or maintained by an employer, employee organization, or by both (See: pages 6-10). An advisory opinion request for such a determination should include copies of plan and trust documents, constitutions and by-laws, if any, administrative agreements, employer-participation agreements, collective bargaining agreements, if applicable, and any other documents or correspondence that might have a bearing on the status of the arrangement for ERISA purposes.

❒ Where should advisory opinion requests be sent?

Requests for advisory opinions involving MEWAs should be sent to the following address:

Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
Room N-5669
200 Constitution Avenue, NW
Washington, DC 20210

ERISA ENFORCEMENT

Enforcement of the provisions of Title I of ERISA is carried out by the Employee Benefits Security Administration's Office of Enforcement. The Office of Enforcement consists of a national office and 15 field offices located throughout the United States. The national office provides policy direction and technical and management support for the field offices, in addition to conducting investigations in selected sensitive areas. Most, if not all, MEWA-related investigations are conducted by the field offices under the supervision of an area or district director, with oversight and coordination provided by the national office.

In an effort to facilitate State and Federal enforcement efforts in the MEWA area, EBSA's field offices have established, or are in the process of pursuing, cooperative arrangements with the States in their jurisdiction pursuant to which the offices will share and discuss cases opened and closed by EBSA involving MEWAs. In addition, field offices will, in accordance with such agreements, make available documents obtained through voluntary production or pursuant to a civil subpoena. In order to ensure proper coordination of MEWA-related initiatives, State officials should direct information and/or inquiries (other than advisory opinion requests) to the director of the EBSA area office responsible for their particular State.

For more information for the field office near you, contact EBSA's Participant and Compliance Assistance toll-free number - **1-866-444-EBSA (3272)** - or view it on the agency's Web site.

View this and other free EBSA publications at **www.dol.gov/ebsa**.

Appendix A
Advisory Opinions
and
Information Letters

July 2, 1990

U.S. Department of Labor
Pension and Welfare Benefits Administration
Washington. DC 20210

90-18A
ERISA SEC
514(b)(6)(A)(ii)

Mr. J. Scott Kyle
Texas State Board of Insurance
1110 San Jacinto
Austin, Texas 78701-1998

Dear Mr. Kyle:

This responds to your letter of May 8, 1990, regarding MDPhysicians and Associates, Inc. Employee Benefit Plan (MDPEBP). You request the views of the Department of Labor concerning issues that arise, as described below, under section 514(b)(6)(A) of the Employee Retirement Income Security Act of 1974 (ERISA).

In Opinion 90-10A, the Department of Labor (the Department) concluded that MDPEBP is a multiple employer welfare arrangement (MEWA) within the meaning of section 3(40) of ERISA and, therefore, is subject to state regulation at least to the extent provided in section 514(b)(6)(A) of ERISA, regardless of whether MDPEBP is an employee benefit plan covered by title I of ERISA. You state in your letter that MDPhysicians and Associates, Inc., which administers MDPEBP, has filed suit against the Texas State Board of Insurance and Texas Attorney General for a declaratory judgment relating to the ability of the State of Texas to regulate or prohibit MDPEBP. MDPhysicians and Associates, Inc. contends in its complaint that, among other things, any attempt by the State of Texas to regulate MDPEBP by requiring licensure of MDPEBP as an insurer would be inconsistent with title I of ERISA, and that the State of Texas lacks statutory authority to regulate MDPEBP in any respect in the absence of enabling legislation respecting the regulation of self-insured MEWAs.

You state that Texas does not have legislation specifically aimed at regulation of self-funded MEWAs which are employee welfare benefit plans covered by title I of ERISA. It is the position of the State Board of Insurance that such plans are doing an insurance business and are subject to the same requirements as any other insurer operating in Texas. You further state that the Texas Insurance Code provides that no person or insurer may do the business of insurance in Texas without specific authorization of statute, unless exempt under the provisions of Texas or federal law. The Code establishes procedures for issuance of certificates of authority to insurers who meet statutory requirements. Persons who transact insurance business in Texas without a certificate of authority or valid claim to exemption are subject to taxation, fines, and other civil penalties, including injunctive relief to effect cessation of operation.

Assuming, arguendo, that MDPEBP is an employee welfare benefit plan covered by title I of ERISA, you request the Departmentís views as to whether or not a requirement by the State of Texas that MDPEBP (or any similar plan which might be found to be both an employee welfare benefit plan and a MEWA as defined by ERISA) obtain a certificate of authority to transact insurance business in Texas, and be subject to statutory penalties and injunction should it operate without a certificate of authority, would be inconsistent with title I of ERISA.

Section 514(b)(6)(A) of ERISA provides an exception to preemption under ERISA section 514(a) for any ERISA-covered employee welfare benefit plan that is a MEWA. In general, the exception permits application of state insurance law to a MEWA as follows: If the MEWA is îfully insuredî within the meaning of section 514(b)(6)(D) of ERISA, state insurance law may apply to the extent it provides standards requiring the maintenance of specified levels of reserves and contributions, and provisions to enforce such standards (See section 514(b)(6)(A)(i)). If the MEWA is not fully insured, any law of any state which regulates insurance may apply to the extent not inconsistent with title I of ERISA (See 514(b)(6)(A)(ii)). It appears from your letter that the parties do not dispute that MDPEBP is not fully insured within the meaning of ERISA section 514(b)(6)(D).

We hope the following is responsive to your request.

First, it is the view of the Department of Labor that section 514(b)(6)(A) saves from ERISA preemption any law of

any state which regulates insurance, without regard to whether such laws specifically or otherwise reference MEWAs or employee benefit plans which are MEWAs, subject only to the limitations set forth in subparagraphs (A)(i) and (A)(ii) of that section. Similarly, while we are unable to rule on the specific application of the Texas Insurance Code to MDPEBP, a matter within the jurisdiction of the Texas State Board of Insurance, it is the view of the Department that, with the exception of the aforementioned limitations, there is nothing in ERISA which would preclude the application of the same state insurance laws which apply to any insurer which is not an ERISA-covered plan to ERISA-covered plans which constitute MEWAs within the meaning of ERISA section 3(40).

Second, it is the view of the Department that Congress, in enacting the MEWA provisions, recognized that the application and enforcement of state insurance laws to ERISA-covered MEWAs 1/ provide both appropriate and necessary protection for the participants and beneficiaries covered by such plans, in addition to those protections afforded by ERISA. For this reason, the Department is of the opinion that in the context of section 514(b)(6)(A)(ii), which, in the case of a MEWA which is not fully insured, saves from ERISA preemption any law of any state which regulates insurance to the extent such law is not inconsistent with the provisions of title I of ERISA, a state law which regulates insurance would be inconsistent with the provisions of title I to the extent that compliance with such law would abolish or abridge an affirmative protection or safeguard otherwise available to plan participants and beneficiaries under title I of ERISA,2/ or conflict with any provision of title I of ERISA. 3/ For example, state insurance law which would require an ERISA-covered MEWA to make imprudent investments would be deemed to be ìinconsistentî with the provisions of title I of ERISA because compliance with such a law would ìconflictî with the fiduciary responsibility provisions of ERISA section 404, and, as such, would be preempted pursuant to the provisions of ERISA section 514(b)(6)(A)(ii).4/

However, a state insurance law will, generally, not be deemed ìinconsistentî with the provisions of title I of ERISA if it requires ERISA-covered MEWAs to meet more stringent standards of conduct, or to provide more or greater protections to plan participants and beneficiaries, than required by ERISA. For example, state insurance laws which would require more informational disclosure to plan participants of an ERISA-covered MEWA will not be deemd by the Department to be ìinconsistentî with the provisions of ERISA. Similarly, a state insurance law prohibiting a fiduciary of an ERISA-covered MEWA from availing himself of an ERISA statutory or administratively-granted exemption permitting certain behavior will not be deerned by the Department to be ìinconsistentî with the provisions of ERISA.

1/ The principles discussed in this letter apply to those MEWAs which are also title I plans, and, thus, such MEWAs will be referred to as ìERISA-covered MEWAsî .

2/ For example, any state insurance law which would adversely affect a participantís or beneficiaryís rights under title I of ERISA to review or receive documents to which the participant or beneficiary is otherwise entitled would be viewed as inconsistent with the provisions of title I. Similarly, any state insurance law which would adversely affect a participantís or beneficiaryís right to continuation of health coverage in accordance with Part 6 of title I or to pursue claims procedures established in accordance with section 503 of title I would be viewed as inconsistent with the provisions of title I of ERISA.

3/ In this regard, the Department believes an actual conflict with the provisions of ERISA will occur when state insurance law makes compliance a ìphysical impossibilityî. See Florida Lime & Avocado Growers. Inc., v. Paul, 373 U.S. 132, 142-43, 83 S.Ct. 1210, 1217, 10 L.Ed.2d 248 (1963).

4/ While certain permissive state insurance laws may not be ìinconsistentî with the provisions of title I of ERISA as here defined, the behavior permitted under such laws may yet be denied to ERISA-covered MEWAs and their fiduciaries pursuant to ERISA section 514(b)(6)(A)(ii), which applies the provisions of title I as well as state insurance laws which are not inconsistent with the provisions of title I of ERISA to such MEWAs. For example, neither ERISA-covered MEWAs nor their fiduciary managers may take advantage of laws which would permit an ERISA-covered MEWA to engage in transactions which are prohibited under the provisions of ERISA section 406; to effectuate exculpatory provisions relieving a fiduciary from responsibility or liability for any responsibility, obligation, or duty under ERISA; or, to fail to meet the reporting and disclosure requirements contained in part 1 of title I of ERISA.

Finally, the Department also notes that, in its opinion, any state insurance law which sets standards requiring the maintenance of specified levels of reserves and specified levels of contributions to be met in order for a MEWA to be considered, under such law, able to pay benefits in full when due will generally not be considered to be ìinconsistentî with the provisions of title I of ERISA pursuant to ERISA section 514(b) (6)(A) (ii) .

Thus, it is the opinion of the Department that a state law regulating insurance which requires the obtaining of a license or certificate of authority as a condition precedent or otherwise to transacting insurance business or which subjects persons who fail to comply with such requirements to taxation, fines, and other civil penalties, including injunctive relief, would not in and of itself adversely affect the protections and safeguards Congress intended to be available to participants and beneficiaries or conflict with any provision of title I of ERISA, and, therefore, would not, for purposes of section 514(b)(6)(A)(ii), be inconsistent with the provisions of title I. Moreover, given the clear intent of Congress to permit states to apply and enforce their insurance laws with respect to ERISA-covered MEWAs, as evidenced by the enactment of the MEWA provisions, it is the view of the Department that it would be contrary to Congressional intent to conclude that states, while having the authority to apply insurance laws to such plans, do not have the authority to require and enforce registration, licensing, reporting and similar requirements necessary to establish and monitor compliance with those laws.

Finally, we would note that while section 514(b)(6)(B) of ERISA provides that the Secretary of Labor may prescribe regulations under which .the Department may exempt MEWAs from state regulation under section 514(b)(6)(A)(ii), the Department has neither prescribed regulations in this area, nor granted any such exemptions.

This letter constitutes an advisory opinion under ERISA Procedures 76-1.

Sincerely,

Robert J. Doyle
Director of Regulations
and Interpretaions

January 27, 1992

Mr. Chuck Huff
Georgia Insurance Department
Seventh Floor, West Tower
Floyd Building
2 Martin Luther King, Jr., Drive
Atlanta, Georgia 30334

92-05A
ERISA SECTION
3(40), 514(b)(6)

Dear Mr. Huff:

This is in response to your request regarding the status of a self-funded health benefit program sponsored by Action Staffing, Inc. (Action) under title I of the Employee Retirement Income Security Act (ERISA). Specifically, you have requested an opinion as to whether the Action health benefit program is an employee welfare benefit plan within the meaning of section 3(1) of title I of ERISA, and whether the Action health benefit program is a multiple employer welfare arrangement (MEWA), within the meaning of ERISA section 3(40) and, therefore, subject to applicable state insurance laws at least to the extent permitted under section 514(b)(6)(A) of title I of ERISA.

According to your letter, Action identifies its operations as those of a ìstaff leasingî company. Action markets its services and issues proposals to potential client employers in a variety of trades and businesses. If a client employer agrees to the terms of the proposal, an Agreement for Services is executed with Action. Under the terms of the Agreement for Services, a specimen copy of which accompanied your request, Action agrees to lease personnel to the client employer, subject to the payment of certain fees being paid by the client employer. Pursuant to the ìServicesî section of the Agreement for Services, it is provided that:

> Action shall . . . provide the following services with regard to the leased employees: The recruitment, hiring, directing and controlling of employees in their day-to-day assignments; the disciplining, replacing, termination and the designation of the date of separation from employment; the promotion, reward, evaluation and from time to time the redetermination of the wages, hours and other terms and conditions of employment of the employees. . .

Action maintains a self-funded health program for leased employees.

With regard to its health benefit program, Action represents that the program is an ERISA-covered employee welfare benefit plan maintained by a single employer, i.e., Action.

Information submitted with your request, however, indicates that, in at least one instance, an Action client, with employees participating in the Action health benefit program, hired Action to enable employees to participate in the Action health benefit program. According to the information provided, the client, rather than Action, retains the right to control, evaluate, direct, hire and fire all employees.

ERISA section 3(40)(A) defines the term ìmultiple employer welfare arrangementî to mean:

> . . . 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 paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such arrangement does not include any plan or arrangement which is established or maintained --
>
> (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,
> (ii) by a rural electric cooperative, or
> (iii) by a rural telephone cooperative association.

Inasmuch as there is no indication that the Action health benefit program is established or maintained under or pursuant to one or more collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association, the only issue relating to the health programís status as a MEWA appears to be whether the program provides benefits, as described in ERISA section 3(1), ìto the employees of two or more employers.î The resolution of this issue is dependent on whether, for purposes of ERISA section 3(40), the employees covered by the Action health benefit program are employees of a single employer (i.e., Action) or more than one employer (i.e., Actionís clients).

ERISA section 3(5) defines the term ìemployerî to mean:

> . . . 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.

As reflected above, the term ìemployerî, for purposes of title I of ERISA, encompasses not only persons with respect to whom there exists an employer-employee relationship between the employer and individuals covered by the plan (i.e., persons acting directly as an employer), but also certain persons, groups and associations, which, while acting indirectly in the interest of or for an employer in relation to an employee benefit plan, have no direct employer-employee relationship with the individuals covered under an employee benefit plan. Therefore, merely because a person, group or association may be determined to be an ìemployerî within the meaning of ERISA section 3(5) does not mean that the individuals covered by the plan with respect to which the person, group or association is an ìemployerî are ìemployeesî of that employer.

The term ìemployeeî is defined in ERISA section 3(6) to mean ìany individual employed by an employer.î (Emphasis added). An individual is ìemployedî by an employer, for purposes of section 3(6), when an employer-employee relationship exists. For purposes of section 3(6), whether an employer-employee relationship exists will be determined by applying common law principles and taking into account the remedial purposes of ERISA. In making such determinations, therefore, consideration must be given to whether the person for whom services are being performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work, but also as to the details and means by which the result is to be accomplished; whether the person for whom services are being performed has the right to discharge the individual performing the services; and whether the individual performing the services is as a matter of economic reality dependent upon the business to which he or she renders services, among other considerations.

While the Action Agreement for Services submitted with your request purports, with respect to the leased employees, to establish in Action the authority and control associated with a common law employer-employee relationship, your submission indicates that in at least one instance the client employer, rather than Action, actually retained and exercised such authority and control.* In this regard, it should be noted that a contract purporting to create an employer-employee relationship will not control where common law factors (as applied to the facts and circumstances) establish that the relationship does not exist.

It should also be noted that it is the view of the Department that where the employees participating in the plan of an employee leasing organization include ìemployeesî of two or more client (or ìrecipientî) employers, or employees of the leasing organization and at least one client employer, the plan of the leasing organization would, by definition, constitute a MEWA because the plan would be providing benefits to the employees of two or more employers.

On the basis of the information provided, the Action health benefit program covered at least one clientís employees with respect to whom Action did not have an employer-employee relationship and, accordingly, were not

* Although we conclude in this situation that some of the individuals participating as ìemployeesî in the health benefit program are ìemployeesî of the client employers, the Department notes that Action may also considered an ìemployerî within the meaning of ERISA section 3(5).

ìemployeesî of Action within the meaning of ERISA section 3(6). Therefore, in the absence of any indication that Action and its client employers constitute a ìcontrol groupî within the meaning of ERISA section 3(40)(B)(i), it is the view of the Department that the Action health benefit program provides benefits to the employees of two or more employers and is, therefore, a multiple employer welfare arrangement within the meaning section 3(40)(A). Accordingly, the preemption provisions of ERISA would not preclude state regulation of the Action health benefit program to the extent provided in ERISA section 514(b)(6)(A). In this regard, we are enclosing, for your information, a copy of Opinion 90-18A (dated July 2, 1990) which discusses the scope of the statesí authority to regulate MEWAs pursuant to section 514(b)(6)(A) of ERISA.

Because your request for an opinion was concerned primarily with the issue of whether or not the Action health benefit program is subject to the applicable regulatory authority of the State of Georgiaís insurance laws or is saved from such authority under the general preemption provision of section 514(a) of title I of ERISA, and because of the opinion above, we have determined it is not necessary at this time to render an opinion as to whether the Action health benefit program is an employee welfare benefit plan within the meaning of section 3(1) of that title.

This letter constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of that procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

Robert J. Doyle
Director of Regulations
and Interpretations
Enclosure

March 1, 2002

Commissioner Mike Pickens
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Dear Commissioner Pickens :

This is in reply to a letter, dated February 11, 2002, from Sara Farris, Associate Counsel with the Arkansas Insurance Department, requesting information regarding the applicability of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). Specifically, she asked for the view of the Department of Labor (Department) on whether section 514 of Title I of ERISA precludes the Arkansas Department of Insurance (ADOI) from regulating the United Employers Voluntary Employees Beneficiary Association (UEVEBA), National Association for Working Americans (NAWA), and American Benefit Plans (ABP).

We understand that the ADOI has initiated a cease and desist proceeding alleging illegal insurance activities by UEVEBA, NAWA, ABP, and John Rhondo aka John Ramirez and David Neal. An issue has arisen in that proceeding as to whether ADOI has jurisdiction to regulate UEVEBA as an unauthorized insurer or as an unlicensed multiple employer welfare arrangement (MEWA). UEVEBA is contending that it is not subject to state insurance regulation by reason of Title I of ERISA. Ms. Farris provided us a with copy of a transcript from the February 1, 2002, hearing in the cease and desist order proceeding and copies of the respondentsí exhibits and selected ADOI exhibits. The following summary is based solely on information in the transcript and exhibits ; it is not, and should not be treated as, factual findings of the Department.

UEVEBA states that it is organized under section 501(c)(9) of the Internal Revenue Code as a tax-exempt, non-profit voluntary employeesí beneficiary association (VEBA) and as a VEBA trust.[1] The trustee of the VEBA trust is ìThe 4 Corners Company, LLC,î which acts through its managing member John Rhondo aka John Ramirez.

The UEVEBA Defined Contribution Health and Welfare Limited Benefit Medical Plan is a prototype plan document developed by ABP. The prototype documents also include a summary plan description, trust agreement, and adoption agreement. The UEVEBA prototype plan document provides for medical, dental, vision, hearing and pharmaceutical benefits, and life insurance. NAWA, either directly or through ABP, markets the UEVEBA arrangement and assists employers in the process of adopting the UEVEBA prototype plan and becoming participating employers in the VEBA trust. Employers, by executing the UEVEBA adoption agreement used in Arkansas, establish their own individual employee welfare benefit plans under the terms and conditions set forth in the UEVEBA prototype plan document. The employers also execute a standard trust joinder agreement where the employer, among other things, agrees to join UEVEBA, designates UEVEBA as the planís trust, authorizes the VEBA trustee to act on behalf of the employer in administering the VEBA trust, and agrees to make contributions to the VEBA trust for the payment of benefits for the employerís eligible employees, spouses, dependents or beneficiaries.[2] The prototype summary plan description is used to disclose information about benefits, rights and obligations under the plan and is distributed to eligible employees. It appears that more than two, and possibly as many as 400 or more, separate and unrelated private sector employers have adopted the

[1] UEVEBAís name appears to have been changed in 1998 from the ìCalifornia Association of Medical Professionals Voluntary Employees Beneficiary Association Trust.î

[2] A trust joinder agreement attached to a January 10, 2002 letter from John Ramirez to the Colorado Commissioner of Insurance identified UEVEBA as the ìUnited Employers Voluntary Employees Beneficiary Association I (Herein ëVEBAí)î while copies of other trust joinder agreements identified UEVEBA as ìUnited Vendors of America Chapter I Voluntary Employeesí Beneficiary Association (the ëUEVEBAí) . . . .î We have assumed for purposes of this letter that these differences reflect different trade names under which UEVEBA conducts its operations.

UEVEBA prototype plan document and use the UEVEBA arrangement to provide benefits to their eligible employees, spouses, dependents, and other beneficiaries.

Under the UEVEBA prototype adoption agreement used in Arkansas, contributions from participating employers are made to a pooled trust account held by the VEBA trustee for the benefit of eligible employees, and their spouses, dependents and other beneficiaries. It appears that third party administrators (TPAs) have been designated by the VEBA trustee to act as representatives in operating a ìRegistered Officeî and transacting business on behalf of the VEBA trustee. In some cases, employer contributions may be deposited in a TPAís UEVEBA Deposit Bank Account and transmitted to the VEBA pooled trust account. UEVEBA provides benefits to covered employees, and their spouses, dependents and beneficiaries from the VEBA pooled trust account.[3] In the event the VEBA pooled trust account is insufficient to pay benefits due, UEVEBA agreed that it would file a claim under a reinsurance contract it entered into with Equity Reinsurance International (ERI), a division of Cosmopolitan Life Insurance Company. Under the reinsurance contract, ERI agreed, subject to certain terms, conditions, and limitations in the contract, to indemnify UEVEBA for benefit liabilities it assumed in connection with employers who adopted the UEVEBA arrangement. UEVEBAís pooled trust account arrangement is structured so that the single employer plans share actuarial risks with each other as part of participating in the UEVEBA arrangement.

Section 514(a) of Title I of ERISA generally preempts state laws purporting to regulate an employee benefit plan covered under that title. There are, however, exceptions to this general preemption provision. The relevant exception for purposes of your inquiry is in subsection 514(b)(6)(A), which allows state insurance regulation of MEWAs and MEWA trusts without regard to whether they are employee benefit plans covered by Title I of ERISA. Section 3(40)(A) of ERISA defines the term MEWA, in relevant part, to mean : ì[A]n 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 [section 3(1) of ERISA] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained ó (i) under or pursuant to one or more agreements which the Secretary [of Labor] finds to be collective bargaining agreements, (ii) by a rural electric cooperative, or (iii) by a rural telephone cooperative association.î

If a MEWA is not itself an ERISA covered plan, which is generally the case, ERISAís preemption provisions do not apply and States are free to regulate the MEWA in accordance with applicable state law. In such cases, the Department would view each of the employer members that use the MEWA to provide welfare benefits to its employees as having established separate welfare benefit plans subject to ERISA.[4] In effect, the MEWA would be merely a vehicle for funding and administering the provision of benefits (like an insurance company) to a number of separate ERISAcovered plans. The Department has concurrent jurisdiction with the States to regulate persons who operate such MEWAs to the extent those persons have responsibility for, or control over, the assets of ERISA plans that participate in the MEWA.[5]

If the MEWA is itself an ERISA-covered plan, it would be subject to the provisions of ERISA governing employee welfare benefit plans, and would also be subject to a broad range of state insurance laws.

Section 514(b)(6)(A)(i) of ERISA provides that, in the case of a MEWA that is itself a plan and is fully insured, states may apply to and enforce against the MEWA any state insurance law requiring the maintenance of

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[3] Although adoption agreements refer to benefits provided under insurance contracts purchased by the plan administrator and held by the VEBA trust, such insurance contracts were not in the materials we received.

[4] UEVEBA appears to allow plans to participate that are not be subject to Title I of ERISA (e.g ., governmental plans, church plans, and certain plans covering only self-employed individuals and their spouses). Participation by non-ERISA plans does not change the Title I conclusion regarding the Statesí ability to regulate the MEWA.

[5] When the sponsor of an ERISA-covered plan uses a MEWA to provide health care coverage for its employees, the assets of the MEWA generally are considered to include the assets of the plan, unless the MEWA is a state licensed insurance company. In exercising discretionary authority or control over plan assets, such as paying administrative expenses and making benefit claim determinations, the person or persons operating the MEWA would be performing fiduciary acts governed by ERISAís fiduciary provisions.

specific reserves or contributions designed to ensure that the MEWA will be able to satisfy its benefit obligations in a timely fashion. In the Departmentís view, section 514(b)(6)(A)(i) enables states to subject such MEWAs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of state insurance law necessary to ensure compliance with state insurance reserve, contribution and funding requirements. Section 514(b)(6)(D) provides that a MEWA is ìfully insuredî for this purpose ìonly if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service or insurance organization, qualified to conduct business in a State.î

In the case of a MEWA that is itself a plan but is not fully insured, section 514(b)(6)(A)(ii) allows any state insurance laws to be applied to the MEWA subject only to the limitation that the law is ìnot inconsistentî with Title I of ERISA. The Department has expressed the view that a state insurance law would not be inconsistent with Title I if it requires a MEWA to meet more stringent standards of conduct, or to provide greater protection to plan participants and beneficiaries than required by ERISA. The Department has also expressed the view that a state law regulating insurance would not, in and of itself, be inconsistent with the provisions of Title I if it requires a license or certificate of authority as a condition to transacting business, requires maintenance of specific reserves or contributions designed to ensure that the MEWA will be able to satisfy its benefit obligations in a timely fashion, requires financial reporting, examination or audit, or subjects persons who fail to comply to taxation, fines, civil penalties, and injunctive relief.

We understand that UEVEBA and the other respondents argue that section 514(b)(6)(C) of ERISA forbids Arkansas from regulating the UEVEBA arrangement because the VEBA trust acts a pooled trust holding the assets of single employer plans that participate in the UEVEBA arrangement. This argument misconstrues section 514(b)(6)(C). That section provides that nothing in provisions of section 514(b)(6)(A) that specifically allow states to regulate MEWAs ìshall affect the manner or the extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a MEWA and which is a plan, fund, or program participating in, subscribing to, or otherwise using a MEWA to fund or administer benefits to such planís participants and beneficiaries.î In analyzing this provision, it is important to distinguish between (1) individual employee benefit plans that obtain benefits through a MEWA, and (2) the MEWA itself. Section 514(b)(6)(C) prevents individual employee benefit plans covered by ERISA from themselves being deemed insurance companies or otherwise regulated as insurance under state insurance law merely because they utilize a MEWA in obtaining benefits; the section does not provide immunity to the MEWA itself from state insurance regulation, or to a pooled trust forming part of a MEWA. See Atlantic Health Care Benefits Trust v. Foster, 809 F.Supp. 365, 370 (M.D.Pa., 1992).

The information supplied indicates that the UEVEBA arrangement is being operated for the purpose of providing health and welfare benefits to employees of two or more employers. Nothing in the material we received suggested that the UEVEBA arrangement is established or maintained under or pursuant to one or more agreements that the Secretary of Labor has found to be collective bargaining agreements, or by a rural electric cooperative or rural telephone cooperative association as defined in section 3(40) of ERISA. Accordingly, in the Departmentís view, it is a MEWA. It does not appear that any of the respondents are claiming that the UEVEBA arrangement is itself an ERISA-covered plan, and nothing in the information you provided suggests that the UEVEBA arrangement is itself such a plan. Therefore, ERISAís preemption provisions do not apply with respect to the UEVEBA arrangement (as distinguished from any individual ERISA-covered plans that obtain benefits through UEVEBA), and Arkansas is free to regulate the UEVEBA arrangement in accordance with applicable state law. Further, even if it the UEVEBA arrangement were itself found to be an ERISA-covered plan, Title I of ERISA does not preclude the application of Arkansas insurance law or regulations to the UEVEBA arrangement in accordance with section 514(b)(6)(A) of ERISA as described above.

We hope this information is of assistance to you. Should you have any questions concerning this letter, please contact me at (202) 693-8531. I have also enclosed a brochure prepared by the Department entitled ìMultiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act : A Guide to Federal and State Regulation.î

Sincerely,

John J. Canary
Chief, Division of Coverage, Reporting and Disclosure
Office of Regulations and Interpretations

Enclosure
cc: John Rhondo aka John Ramirez

Appendix B
Advisory Opinion Procedure

ERISA Proc. 76-1—Procedure for ERISA Advisory Opinions.

It is the practice of the Department of Labor (the Department) to answer inquiries of individuals or organizations affected, directly or indirectly, by the Employee Retirement Income Security Act of 1974 (Pub. L. 93-406, hereinafter "the Act") as to their status under the Act and as to the effect of certain acts and transactions. The answers to such inquiries are categorized as "information letters" and "advisory opinions." This "ERISA Procedure" (ERISA Proc. 76-1) describes the general procedures of the Department in issuing information letters and advisory opinions under the Act, and is designed to promote efficient handling of inquiries and to facilitate prompt responses.

Section 7 of this procedure (instructions to individuals and organizations requesting advisory opinions relating to prohibited transactions and common definitions) is reserved. This section will set forth the procedures to be followed to obtain an advisory opinion relating to prohibited transactions and common definitions, such as whether a person is a party in interest and a disqualified person. In general, this section will incorporate a revenue procedure to be published by the Internal Revenue Service.

This advisory opinion procedure consists of rules of agency procedure and practice, and is therefore excepted under 5 U.S.C. 552(b)(3)(A) of the Administrative Procedure Act from the ordinary notice and comment provisions for agency rulemaking. Accordingly, the procedure is effective August 27, 1976.

SEC. 1. Purpose. The purpose of this ERISA Procedure is to describe the general procedures of the Department of Labor (the Department) in issuing information letters and advisory opinions to individuals and organizations under the Employee Retirement Income Security Act of 1974 (Pub. L. 93-406), hereinafter referred to as "the Act." This ERISA Procedure also informs individuals and organizations, and their authorized representatives, where they may direct requests for information letters and advisory opinions, and outlines procedures to be followed in order to promote efficient handling of their inquiries.

SEC. 2. General practice. It is the practice of the Department to answer inquiries of individuals and organizations, whenever appropriate, and in the interest of sound administration of the Act, as to their status under the Act and as to the effects of their acts or transactions. One of the functions of the Department is to issue information letters and advisory opinions in such matters.

SEC. 3. Definitions. .01 An "information letter" is a written statement issued either by the Pension and Welfare Benefit Programs (Office of Employee Benefits Security), U.S. Department of Labor, Washington, D.C. or a Regional Office or an Area Office of the Labor-Management Services Administration, U.S. Department of Labor, that does no more than call attention to a well-established interpretation or principle of the Act, without applying it to a specific factual situation. An information letter may be issued to any individual or organization when the nature of the request from the individual or the organization suggests that it is seeking general information, or where the request does not meet all the requirements of section 6 or 7 of this procedure, and it is believed that such general information will assist the individual or organization.

.02 An "advisory opinion" is a written statement issued to an individual or organization, or to the authorized representative of such individual or organization, by the Administrator of Pension and Welfare Benefit Programs or his delegate, that interprets and applies the Act to a specific factual situation. Advisory opinions are issued only by the Administrator of Pension and Welfare Benefit Programs or his delegate.

.03 Individuals and organizations are those persons described in section 4 of this procedure.

SEC. 4. Individuals and organizations who may request advisory opinions or information letters. .01 Any individual or organization affected directly or indirectly, by the Act may request an information letter or an advisory opinion from the Department.

.02 A request by or for an individual or organization must be signed by the individual or organization, or by the authorized representative of such individual or organization. See section 7.03 of this procedure.

SEC. 5. Discretionary Authority to Render Advisory Opinions. .01 The Department will issue advisory opinions involving the interpretation of the application of one or more sections of the Act, regulations promulgated under the Act, interpretive bulletins, or exemptions issued by the Department to a specific factual situation. Generally, advisory opinions will be issued by the Department only with respect to prospective transactions (i.e., a transaction which will be entered into). Moreover, there are certain areas where, because of the inherently factual nature of the problem involved, or because the subject of the request for opinion is under investigation for a violation of the Act, the Department ordinarily will not issue advisory opinions. Generally, an advisory opinion will not be issued on alternative courses of proposed transactions, or on hypothetical situations, or where all parties involved are not sufficiently identified and described, or where material facts or details of the transaction are omitted.

.02 The Department ordinarily will not issue advisory opinions relating to the following sections of the Act:

.02(a) Section 3(18), relating to whether certain consideration constitutes adequate consideration;

.02(b) Section 3(26), relating to whether the valuation of any asset is at current value;

.02(c) Section 3(27), relating to whether the valuation of any asset is at present value;

.02(d) Section 102(a)(1), relating to whether a summary plan description is written in a manner calculated to be understood by the average participant.

.02(e) Section 103(a)(3)(A), relating to whether the financial statements and schedules required to be included in the Annual Report are presented fairly in conformity with generally accepted accounting principles applied on a consistent basis;

.02(f) Section 103(b)(1), relating to whether a matter must be included in a financial statement in order to fully and fairly present the financial statement of the plan;

.02(g) Section 202 (other than section 202(a)(3) and

(b)(1)) relating to minimum participation standards;

.02(h) Section 203 (other than sections 202(a)(3)(B), (b)(1) (flush language), (b)(2), (b)(3)(A);

.02(i) Section 204 of the Act (other than sections 204(b)(1)(B), (b)(1)(A), (C), (D), (E)), relating to benefit accrual requirements;

.02(j) Section 205(e), relating to the period during which a participant may elect in writing not to receive a joint and survivor annuity;

.02(k) Section 208, relating to mergers and consolidation of plans or transfer of plan assets;

.02(1) Section 209(a)(1), relating to whether the report required by section 209(a)(1) is sufficient to inform the employee of his accrued benefits under the plan, etc.

.02(m) Sections 302 through 305, relating to minimum funding standards;

.02(n) Section 403(c)(1), relating to the purposes for which plan assets must be held;

.02(o) Section 404(a), relating to fiduciary duties as applied to particular conduct; and,

.02(p) Section 407(a)(2) and (3) and (c)(1), relating to fair market value, as applied to whether the value of any particular security or real property constitutes fair market value.

This list is not all inclusive and the Department may decline to issue advisory opinions relating to other sections of the Act whenever warranted by the facts and circumstances of a particular case. The Department may, when it is deemed appropriate and in the best interest of sound administration of the Act, issue information letters calling attention to established principles under the Act, even though the request that was submitted was for an advisory opinion.

.03 Pending the adoption of regulations (either temporary or final) involving the interpretation of the application of a provision of the Act, consideration will be given to the issuance of advisory opinions relating to such provisions of the Act only under the following conditions:

.03(a) If an inquiry presents an issue on which the answer seems to be clear from the application of the provisions of the Act to the facts described, the advisory opinion will be issued in accordance with the procedures contained herein.

.03(b) If an inquiry presents an issue on which the answer seems reasonably certain but not entirely free from doubt, an advisory opinion will be issued only if it is established to the satisfaction of the Department, that a business emergency requires an advisory opinion or that unusual hardship to the plan or its participants and beneficiaries will result from failure to obtain an advisory opinion. In any case in which the individual or organization believes that a business emergency exists or that an unusual hardship to the plan or its participants and beneficiaries will result from the failure to obtain an advisory opinion, the individual or organization should submit with the request a separate letter setting forth the facts necessary for the Department to make a determination in this regard. In this connection, the Department will not deem a "business emergency" to result from circumstances within the control of the individual or organization such as, for example, scheduling within an inordinately short time the closing date of a transaction or a meeting of the Board of Directors or the shareholders of a corporation.

.03(c) If an inquiry presents an issue that cannot be reasonably resolved prior to the issuance of a regulation, an advisory opinion will not be issued.

.04 The Department ordinarily will not issue advisory opinions on the form or effect in operation of a plan, fund, or program (or a particular provision or provisions thereof) subject to Title I of the Act. For example, the Department will not issue an advisory opinion on whether a plan satisfies the requirements of Parts 2 and 3 of Title I of the Act.

SEC. 6. Instructions to individuals and organizations requesting advisory opinions from the Department. .01 If an advisory opinion is desired, a request should be submitted to: Office of Regulations and Interpretations, Room N5669, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

.02 A request for an advisory opinion must contain the following information:

.02(a) The name and type of plan or plans (e.g., pension, profit-sharing, or welfare plan); the Employer Identification Number (EIN); the Plan Number (PN) used by the plan in reporting to the Department of Labor on Form EBS-1 or a copy of the first two pages of the most recent Form EBS-1 filed with the Department.

.02(b) A detailed description of the act or acts or transaction or transactions with respect to which an advisory opinion is requested. Where the request pertains to only one step of a larger integrated act or transaction, the facts, circumstances, etc., must be submitted with respect to the entire transaction. In addition, a copy of all documents submitted must be included in the individual's or organization's statement and not merely incorporated by reference, and must be accompanied by an analysis of their bearing on the issue or issues, specifying the pertinent provisions.

.02(c) A discussion of the issue or issues presented by the act or acts or transaction or transactions which should be addressed in the advisory opinion.

.02(d) If the individual or organization is requesting a particular advisory opinion, the requesting party must furnish an explanation of the grounds for the request, together with a statement of relevant supporting authority. Even though the individual or organization is urging no particular determination with regard to a proposed or prospective act or acts or transaction or transactions, the party requesting the ruling must state such party's views as to the results of the proposed act or acts or transaction or transactions and furnish a statement of relevant authority to support such views.

.03 A request for an advisory opinion by or for an individual or organization must be signed by the individual or organization or by the individual's or organization's authorized representative. If the request is signed by a representative of an individual or organization, or the representative may appear before the Department in connec-

tion with the request, the request must include a statement that the representative is authorized to represent the individual or organization.

.04 A request for an advisory opinion that does not comply with all the provisions of this procedure will be acknowledged, and the requirements that have not been met will be noted. Alternatively, at the discretion of the Department, the Department will issue an information letter to the individual or organization.

.05 If the individual or organization or the authorized representative, desires a conference in the event the Department contemplates issuing an adverse advisory opinion, such desire should be stated in writing when filing the request or soon thereafter in order that the Department may evaluate whether in the sole discretion of the Department, a conference should be arranged and at what stage of the consideration a conference would be most helpful.

.06 It is the practice of the Department to process requests for information letters and advisory opinions in regular order and as expeditiously as possible. Compliance with a request for consideration of a particular matter ahead of its regular order, or by a specified time, tends to delay the disposition of other matters. Requests for processing ahead of the regular order, made in writing (submitted with the request or subsequent thereto) and showing clear need for such treatment, will be given consideration as the particular circumstances warrant. However, no assurance can be given that any letter will be processed by the time requested. The Department will not consider a need for expedited handling to arise if the request shows such need has resulted from circumstances within the control of the person making the request.

.07 An individual or organization, or the authorized representative desiring to obtain information relating to the status of his or her request for an advisory opinion may do so by contacting the Office of Regulatory Standards and Exceptions, Pension and Welfare Benefit Programs, U.S. Department of Labor, Washington, D.C.

SEC. 7. Instructions to individuals and organizations requesting advisory opinions relating to prohibited transactions and common definitions. .01 [Reserved]

.02 [Reserved]

.03 [Reserved]

SEC. 8. Conferences at the Department of Labor. If a conference has been requested and the Department determines that a conference is necessary or appropriate, the individual or organization or the authorized representative will be notified of the time and place of the conference. A conference will normally be scheduled only when the Department in its sole discretion deems it will be necessary or appropriate in deciding the case. If conferences are being arranged with respect to more than one request for an opinion letter involving the same individual or organization, they will be so scheduled as to cause the least inconvenience to the individual or organization.

SEC. 9. Withdrawal of requests. The individual or organization's request for an advisory opinion may be withdrawn at any time prior to receipt of notice that the Department intends to issue an adverse opinion, or the issuance of an opinion. Even though a request is withdrawn, all correspondence and exhibits will be retained by the Department and will not be returned to the individual or organization.

SEC. 10. Effect of Advisory Opinion. An advisory opinion is an opinion of the Department as to the application of one or more sections of the Act, regulations promulgated under the Act, interpretive bulletins, or exemptions. The opinion assumes that all material facts and representations set forth in the request are accurate, and applies only to the situation described therein. Only the parties described in the request for opinion may rely on the opinion, and they may rely on the opinion only to the extent that the request fully and accurately contains all the material facts and representations necessary to issuance of the opinion and the situation conforms to the situation described in the request for opinion.

SEC. 11. Effect of Information Letters. An information letter issued by the Department is informational only and is not binding on the Department with respect to any particular factual situation.

SEC. 12. Public inspection. .01 Advisory opinions shall be open to public inspection at the Public Disclosure Room, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20216.

.02 Background files (including the request for an advisory opinion, correspondence between the Department and the individual or organization requesting the advisory opinion) shall be available upon written request. Background files may be destroyed after three years from the date of issuance.

.03 Advisory opinions will be modified to delete references to proprietary information prior to disclosure. Any information considered to be proprietary should be so specified in a separate letter at the time of request. Other than proprietary information, all materials contained in the public files shall be available for inspection pursuant to section 12.02.

.04 The cost of search, copying and deletion of any references to proprietary information will be borne by the person requesting the advisory opinion or the background file.

SEC. 13. Effective date. This procedure is effective August 27, 1976, the date of its publication in the Federal Register.

Signed at Washington, D.C., this 24th day of August 1976.

James D. Hutchinson
Administrator of Pension and
Welfare Benefit Programs
U.S. Department of Labor

Appendix C
Regulations

Department of Labor
Employee Benefits Security Administration

29 CFR Part 2510 and 2570

RIN 1210-AA48

Employee Retirement Income Security Act of 1974; Procedures for Administrative Hearings Regarding Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA

AGENCY: Employee Benefits Security Administration, Labor.

ACTION: Final rule.

SUMMARY: This document contains a regulation under the Employee Retirement Income Security Act of 1974, as amended, (ERISA or the Act) setting forth specific criteria that, if met and if certain other factors set forth in the regulation are not present, constitute a finding by the Secretary of Labor (the Secretary) that a plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40) of ERISA. Employee welfare benefit plans, such as health care plans, that meet the requirements of the regulation are excluded from the definition of "multiple employer welfare arrangements" under section 3(40) of ERISA and consequently are not subject to state regulation of multiple employer welfare arrangements as provided for by the Act. Regulations published elsewhere in this issue of the Federal Register set forth a procedure for obtaining a determination by the Secretary as to whether a particular employee welfare benefit plan is established or maintained under or pursuant to one or more agreements that are collective bargaining agreements for purposes of section 3(40) of ERISA. The procedure is available only in situations where the jurisdiction or law of a state has been asserted against an entity that contends it meets the exception for plans established or maintained under or pursuant to one or more collective bargaining agreements. This regulation is intended to assist labor organizations, plan sponsors and state insurance departments in determining whether a plan is a "multiple employer welfare arrangement" within the meaning of section 3(40) of ERISA.

EFFECTIVE DATE: June 9, 2003.

FOR FURTHER INFORMATION CONTACT: Elizabeth A. Goodman, Office of Regulations and Interpretations, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., Room N-5669, Washington, DC 20210, (202) 693-8510. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

A. Background

The Statute

Section 3(40) of ERISA defines the term multiple employer welfare arrangement (MEWA), in pertinent part, as 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 paragraph (1) of section 3 of the Act to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements.

This definition was added to ERISA by the Multiple Employer Welfare Arrangement Act of 1983, Sec. 302(b), Pub. L. 97-473, 96 Stat. 2611, 2612 (29 U.S.C. 1002(40)) (the MEWA amendments), which also amended section 514(b) of ERISA to narrow the scope of federal preemption of state laws applicable to MEWAs. The purpose of the MEWA amendments generally was to permit states to regulate employee welfare benefit plans that are MEWAs; the extent of the states' jurisdiction over such entities under the MEWA amendments depends on whether or not the MEWA is fully insured. Sec. 302(b), Pub.L. 97-473, 96 Stat. 2611, 2613 (29 U.S.C. 1144(b)(6)).

The Multiple Employer Welfare Arrangement Act of 1983, which was introduced to counter what the Congressional drafters termed abuse by the "operators of bogus 'insurance' trusts," see 128 Cong. Rec. E2407 (1982) (Statement of Congressman Erlenborn), significantly enhanced the states' ability to regulate MEWAs. Nevertheless, problems in this area persist. Among other things, the exception for collectively bargained plans contained in section 3(40) has been exploited by some MEWA operators who, through the use of sham unions and collective bargaining agreements, market fraudulent insurance schemes under the guise of collectively bargained welfare plans exempt from state insurance regulation. Another problem in this area involves the use of collectively bargained plans as vehicles for marketing health care coverage to individuals and employers with no relationship to the bargaining process or the underlying bargaining agreement. The definition of a MEWA in section 3(40) was drafted to exclude certain types of plans. As pertains to this rulemaking, section 3(40)(A)(i) of ERISA provides that employee welfare benefit plans that are found by the Secretary of Labor (the Secretary) to be established or maintained under or pursuant to one or more collective bargaining agreements are not MEWAs for purposes of ERISA. Such collectively bargained plans, as a result, were not made subject to the regulatory jurisdiction of the states pursuant to the MEWA amendments.

The Department of Labor (the Department) notes that also appearing in today's Federal Register are final regulations relating to filing the Form M-1 and Civil Monetary Penalties for failure or refusal to file the Form M-1. For information on the Form M-1 and related civil monetary penalties, contact Deborah S. Hobbs or Amy J. Turner, Employee Benefits Security Administration, U.S. Department of Labor, Room C-5331, 200 Constitution Ave., NW., Washington, DC 20210 (telephone (202) 693-8335) (this is not a toll-free number).

The Proposed Regulations

On October 27, 2000, the Department published a notice in the Federal Register (65 FR 64482) containing a proposed regulation (the criteria regulation) setting forth specific criteria that, if met in the case of a specific plan, and provided that certain other factors set forth in the proposed regulation are not present, would constitute a finding by the Secretary pursuant to section 3(40)(A)(i) of ERISA that a plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40) of ERISA. The Department also simultaneously published in the Federal Register (65 FR 64498) proposed regulations (the procedural regulations) that set forth an administrative procedure for obtaining, under certain limited circumstances, an individualized determination by the Secretary as to whether a particular employee welfare benefit plan is established or maintained under or pursuant to one or more agreements that are collective bargaining agreements for purposes of section 3(40) of ERISA.

The proposed regulations followed the recommendations of the ERISA section 3(40) Negotiated Rulemaking Advisory Committee (the Committee). The Committee was convened under the Negotiated Rulemaking Act (the NRA) and the Federal Advisory Committee Act (the FACA), 5 U.S.C. App. 2, to assist the Department in developing proposed regulations to implement section 3(40)(A)(i) of ERISA, 29 U.S.C. 1002(40)(A)(i).

The criteria regulation set forth standards that, if satisfied, would constitute a finding by the Secretary that a plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40).

The proposed regulation established four general criteria for a finding that a plan was established or maintained under or pursuant to collective bargaining for purposes of section 3(40)(A)(i). First, the entity in question had to be an employee welfare benefit plan within the meaning of ERISA section 3(1). Second, the preponderance of those participants covered by the plan (at least 80%) had to have a nexus to the bargaining relationships under or pursuant to which the plan was established or maintained (referred to as the "nexus" group or test). Third, the agreements under or pursuant to which the plan is established or maintained had to have certain characteristics that indicate that they were, for purposes of section 3(40) of ERISA only, collective bargaining agreements, including that the agreements were the product of a "bona fide collective bargaining relationship." Fourth, the proposed regulation listed eight specific "factors" deemed to indicate the existence, for purposes of section 3(40) only, of a bona fide collective bargaining relationship. If at least four of those specified factors were present, the regulation indicated that a bona fide collective bargaining relationship underlying the agreements under or pursuant to which the plan is established or maintained could be presumed to exist.

The proposed criteria regulation included a ninth non-specific "factor" in the list. The ninth factor indicated that the Secretary would consider, in making a finding, whether "other objective or subjective indicia of actual collective bargaining and representation" were present. The inclusion of this "catch-all" factor recognized that, in any particular case, other facts might need to be taken into account to determine whether a bona fide collective bargaining relationship existed, especially where the entity did not meet at least four of the eight specific factors, or where, despite meeting four of the eight factors, there were other facts indicating that a bona fide collective bargaining relationship did not exist.

The proposed criteria regulation also specified circumstances that, if present, would lead to a conclusion that an employee welfare benefit plan is not established or maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements. The regulation stated that, for any plan year in which the specified circumstances were present, a plan that otherwise met the criteria of the regulation should not be deemed to be excluded from the MEWA definition by virtue of section 3(40)(A)(i).

The proposed regulation provided that, under certain limited circumstances, an entity would be permitted to petition the Secretary for an individual finding. The ability to petition, however, would arise under the proposed regulation only if a state's law or jurisdiction had been asserted against the entity in an administrative or judicial proceeding. The procedural regulations set forth specific processes for petitioning for an individual finding.

Public Comments

Subsequent to publication of the proposed regulations, the Department received seven public comments. The Department reconvened the Committee and held a public meeting on March 1, 2002, to obtain the Committee's views on the public comments. Minutes of this meeting, as well as other meetings, of the Committee are available for inspection by the public in the Department's Public Disclosure Room, 200 Constitution Avenue, NW., N1513, Washington, DC 20210.

The following discussion summarizes the issues raised by the public comments, the Committee's

discussion of those issues at the public meeting, and the Department's decisions, which are reflected in the final regulations.

1. Whether the Factors Set Forth in the Proposed Criteria Regulation as Presumptive of Bona Fide Collective Bargaining Should Be Expanded or Modified

Two commenters suggested that the Department should expand the list of factors indicative of a bona fide collective bargaining relationship. One commenter argued that such an expansion is necessary to make sure that small employers and employers in manufacturing, warehousing, service and other non-construction related industries could easily meet this criterion. The commenter further suggested that government certification of a union, as a collective bargaining agent should be a stand-alone safe harbor factor. The other commenter noted that newly established unions, particularly those organizing in the health care field, might have difficulty meeting four of the eight factors. That commenter suggested that an additional factor—that the welfare plan was being administered along sound actuarial principles—be added to the list of factors. The commenter also suggested that the examples set out as part of the non-specific ninth factor be listed individually as separate factors that could be counted towards meeting the "safe harbor."

In discussing these comments, the Committee noted that these issues were not new and had been considered by the Committee in its initial deliberations. It was noted that the language of the proposed regulation went as far as possible to be inclusive of various types of collective bargaining relationships. The purpose of the ninth "catch-all" factor is to take into account that the eight specific factors may not encompass all bona fide collective bargaining relationships. Concerns were also expressed about lowering the threshold for what constitutes a bona fide collective bargaining relationship. Bona fide collectively bargained arrangements are not likely to be challenged under the regulation by the states. The consensus of the Committee was that the eight factors should not be expanded or modified.

After consideration of the comments and the Committee's discussion, the Department has decided not to expand or modify the factors presumptive of a bona fide collective bargaining relationship. The final regulation therefore retains, in section 2510.3-40(b)(4)(i)-(viii), the factors as originally proposed. In the view of the Department, the regulation carefully distinguishes between the specific factors that generally evidence a bona fide collective bargaining relationship and the types of activities and fact patterns that are common to sham MEWA operators. Expanding or modifying the factors to include less well-established or less common situations, or making any single factor a stand-alone safe-harbor, may make it easier for sham MEWA operators to mimic the regulation's factors presumptive of a bona fide collective bargaining relationship.

The Department also declines to add to the factors, as suggested by one commenter, the fact that the plan is maintained on sound actuarial principles. Although maintaining a plan on sound actuarial principles is important in other regards, that a plan is actuarially sound does not necessarily evidence the existence of a bona fide collective bargaining relationship. The Department notes, however, that the final regulations are structured to take into account the possibility that a bona fide collective bargaining relationship might, in some case, fail to meet the "safe harbor" factors. In addition to including the ninth catch-all factor, the regulations permit entities that assert they are in fact established or maintained under or pursuant to bona fide collective bargaining, and against which state law or jurisdiction is asserted, to petition for an individualized finding from the Department as to their status.

2. Whether the Definition of Collective Bargaining Agreement Should Be Modified

The Department received one comment suggesting that the definition of collective bargaining agreement in section 2510.3-(40)(b)(3) needed to be modified to correct a technical defect. As proposed, the regulation required that a plan be "incorporated or referenced in a written agreement between two or more employers and one or more employee organizations." The commenter argued that the requirement of a minimum of two employers, rather than one, was unnecessarily narrow, since there may be situations where a plan that originally was established or maintained under or pursuant to a collective bargaining agreement signed by two or more employers, is now maintained only by one due to a dwindling number of participating employers, although the plan still covers the employees of more than one employer.

The Committee, in discussing this issue, considered whether, in addition to the reasons articulated by the commenter, the language of paragraph 2510.3-40(b)(3) should be changed to make clear that the regulation applies to plans established or maintained under or pursuant to collective bargaining by a single employer but covering the employees of other employers who do not bind themselves to the collective bargaining agreement. It was noted that such entities are MEWAs. The Committee's discussion focused on the fact that it is important for the regulation to make clear that such entities are subject to evaluation under the regulation to see whether in fact they meet the exception under section 3(40) for plans established or maintained under or pursuant to collective bargaining.

On the basis of the public comment and the Committee's discussion, the Department has determined to amend 2510.3-40 to provide that the conditions of (b)(3) will be met if the written agreement referencing the plan is between one or more employers, rather than

two or more employers, and one or more employee organizations.

3. Whether the Nexus Group Categories Should Be Expanded or Modified

As part of the process for determining whether a preponderance of the participants covered by the plan have a nexus to the bargaining relationships under or pursuant to which the plan is established or maintained, the proposed criteria regulation defined a "nexus group" of categories of participants who could be counted towards the 80% coverage level set in the proposed regulation as demonstrating such a preponderance. One commenter requested that the nexus group categories be expanded to include employees of an employer trade association that has negotiated any of the multiemployer agreements under or pursuant to which a plan is established or maintained. The commenter noted that the proposed regulation included, as part of the nexus group, employees of employee organizations that sponsor or jointly sponsor a plan, or are represented on the committee, joint board of trustees, or other similar group of representatives of the parties who sponsor the plan. The commenter noted that employees of employer associations might have a similar connection to the collective bargaining process. The commenter asserted that employer trade associations often are involved in negotiating collective bargaining agreements on behalf of many employers, and that such employers routinely become signatories to, or otherwise adopt, agreements that have been negotiated by their employer associations. The multiemployer plans that result from such bargaining often cover the employees of the employer association as well as the employees of the employers represented by the association.

The Committee concluded that, as a matter of parity, employees of an authorized representative of employers in collective bargaining should be included in the nexus group, just as are employees of the employee organization.

Based on its consideration of the comment and the Committee's discussion, the Department has determined to amend 2530.3-40(b)(2)(vi) to include, as a separate category, the employees of an authorized employer representative that actually engaged in the collective bargaining that led to the agreement that references the plan as described in 2510.3-40(b)(3)(i).

4. Whether the Regulation Should Be Expanded To Include Entities That Are Not Collectively Bargained, i.e., Long-Established MEWAs, Union-Only Sponsored Public Sector Benefit Plans

The Department received two comments suggesting that the regulation should be expanded to include certain types of entities that technically are not established or maintained under or pursuant to collective bargaining. The commenters were concerned that issuance of regulations providing clear guidance addressing what the Secretary finds to be collective bargaining for the purposes of the collective bargaining exception in 3(40) of ERISA might result in more state regulation of entities that are not established pursuant to collective bargaining than there had been in the absence of regulations.

The first commenter was a long-established MEWA that contended that it should be excluded from the scope of the MEWA definition pursuant to a "grandfather" provision in the regulation, allowing it to operate free of state regulation even though it is not a plan established or maintained under or pursuant to collective bargaining, because it had been operating on a financially sound basis for many years. A similar comment had been previously submitted to the Committee for consideration prior to the issuance of its Report to the Secretary. Another commenter requested that the preamble to the regulation discuss the nature of legal defense funds for peace officers, which are established by employee organizations for the employees of more than one employer, but are not actually the subject of collective bargaining.

The Committee reiterated its belief, as noted in the preamble to the proposed criteria regulation, that the regulation should serve only to define what constitutes a plan that is established or maintained under or pursuant to collective bargaining. The Department believes that the issues raised by these commenters go beyond the scope of the regulation and, therefore, has determined not to modify the final regulation in response to these comments.

5. Whether and How the Procedural Regulation Should Be Modified in Order To Obviate the Possibility That It May Hinder or Impede Timely State Enforcement Actions

One commenter expressed concern that the availability of administrative proceedings for an individualized section 3(40) finding in cases where the jurisdiction or law of a state has been asserted may result in delays in state enforcement that could substantially hinder a state's ability to take timely enforcement actions against sham MEWA operators. The commenter stated that time is often of the essence in such circumstances and that a delay of even a few days in a state's taking effective action against a MEWA may seriously increase the harm to the participants in the MEWA by permitting the amount of unpaid medical benefit claims to increase, allowing the plan to collect additional illegal premiums, and impinging or eliminating the states' ability to preserve assets by giving the plan operators and opportunity to transfer and hide funds. The commenter specifically identified the need to be able to obtain preliminary and permanent injunctive relief and cease and desist orders where sham union plans are continuing to collect premiums or failing to pay claims. The commenter asserted that, unless the Department made clear that the availability of administrative proceedings was not meant to provide a

basis for a stay or delay of state enforcement actions, the regulations should not be implemented.

Recognizing the need to ensure that the regulations assist, rather than hinder, state enforcement efforts against sham MEWA operators and that there are situations where time is of the essence for effective enforcement by the states, the Committee recommended that the regulatory language be clarified to emphasize that the section 3(40) ALJ proceedings are not a basis in themselves for a stay-of-state administrative or judicial proceedings against a putative MEWA.

As proposed, paragraph 2510.3-40(g)(2) of the criteria regulation provided that "nothing in this section or in part 2570, subpart H of this chapter is intended to have any effect on applicable law relating to stay or delay of a state administrative or court proceeding or enforcement subpoena." In response to the commenter and the concerns of the Committee, the Department has amended that paragraph to state that "nothing in this section or in part 2570, subpart H of this chapter is intended to provide the basis for a stay or delay of a state administrative or court proceeding or enforcement of a subpoena."

Miscellaneous Changes

In its consideration of a final regulation, the Committee questioned whether consideration should be given to the effect of plan mergers on counting years of service for purposes of the determining the "nexus" group. In this regard, the Committee noted that the nexus group in section 2510.3-40(b)(2) includes retirees who either participated in the welfare benefit plan for at least five of the last 10 years preceding their retirement or are receiving benefits as participants under a multiemployer pension benefit plan that is maintained under the same agreement referred to in paragraph (b)(2)(i), and have at least five years of service or the equivalent under that pension plan. The Committee suggested that participation in the pre-merger multiemployer plans should also be considered in determining whether employees meet the requirements of these categories of the nexus group. The Committee also raised the issue of whether employment in the bargaining unit under the pre-merger plan should be considered for determining whether an individual is a bargaining unit alumnus under 2510.3-40(b)(2)(vii) where the merger was based on a merger of unions. The Committee noted that Example 2 of the proposed regulation addresses how a merger affects the evaluation of the factors in (b)(4)(iii) and (iv) and suggested that another example could be added to the final regulation to address the effect of merging unions and multiemployer plans on the nexus group analysis. After considering the issues raised by the Committee, the Department has determined that it is appropriate to clarify the examples at 2510.3-40(e) to make clear that, in the case of a merger of multiemployer plans, participation in a predecessor plan or employment with a predecessor union may be considered for purposes of determining the nexus group individuals in section 2510.3-40(b)(2)(ii) and (vii). In this regard, a new paragraph (3) was added to Example 2 to clarify that the merger of two unions and the related pension and health and welfare plans will not affect the determinations of who is a "retiree" or a "bargaining unit alumni" for purposes of determining the nexus group under the regulation.

In reviewing the 75% test in paragraph (b)(4)(vi) of 2510.3-40, the Department decided that the regulation should be modified to make clear that in determining the amount of premiums or contributions to which the 75% test applies does not include any amount that a participant or beneficiary might be required to pay as a co-pay or deductible under the provided coverage. Accordingly, the Department has modified paragraph 2510.3-40(b)(4)(iv) to make clear that, in addition to dental or vision care and coverage for excepted benefits under 29 CFR 2590.732(b), amounts payable by participants and beneficiaries as co-payments or deductibles are disregarded for purposes of the 75% test. In so clarifying this provision, however, the Department notes that if an entity were to establish a co-payment or deductible schedule designed solely to satisfy the criteria of paragraph 2510.3-40(b)(4)(vi), without actually requiring substantial employer contributions, evidence of such a design may be considered in evaluating whether for purposes of 2510.3-40(c)(3) there is fraud, forgery, or willful misrepresentation as to the factors relied on to demonstrate that the plan satisfies the criteria set forth in paragraph (b) of this section. The Department further notes that the collective bargaining history appropriately may be examined in a 3(40) proceeding, including a review of those factors in section 2510.3-40(b)(4).

Independent of the Committee's review of the regulations, the Department considered whether the proposed 80% minimum coverage requirement for the "nexus" test is too low. In the August 1, 1995, proposed regulation, the Department proposed that no less than 85% of the individuals covered by a plan must be within the "nexus" group. A number of commenters on that regulation expressed concern that the percentage was too high. In developing a new proposal, the Committee recommended, and the Department proposed, an 80% test. In this regard, the preamble to the proposal indicated that "[t]he Committee recommended a 20% margin for coverage of non-nexus people, even though it understood that the percentage of participants in collectively bargained plans who are not within one of the nexus categories is rarely likely to be that high." 65 FR 64485 (Oct. 27, 2000). While comments were specifically invited on the 80% test, no comments were received on that provision. Moreover, the Department received no comments suggesting that changing the 80% test to an 85% test would present a problem for affected plans. The Department further notes that H.R. 2563 of the 107th Congress, the "Bipartisan Patients Protection Act," as passed by the U.S. House of Representatives, among other things, amends ERISA section 3(40)(A)(i) to clarify the standards applicable to determining whether a plan is established or maintained pursuant to

collective bargaining agreements. See section 423 of H.R. 2563. Although similar in many respects to the regulatory standards proposed by the Department, H.R. 2563 limits the percentage of non-nexus group individuals to 15 percent.

On the basis of the comments, as well as the discussions of the Committee, the Department does not believe that, in the absence of any data to the contrary, requiring 85% of the covered individuals to be within the "nexus" group, rather than 80%, will have any significant effect on the status of otherwise bona fide collectively bargained plans. Increasing the "nexus" group percentage to 85% should enhance the regulation's deterrent effect on sham MEWA operators who attempt to masquerade as collectively bargained plans in order to avoid state insurance regulation and oversight. In an environment where problems with sham MEWA operators are growing, the Department believes that any action it can take to reduce the likelihood of health insurance fraud against workers and their families is action that should be taken. Accordingly, the Department determined it appropriate to modify paragraph (b)(2) of 2510.3-40 to require that at least 85% of the participants in the plan be within the "nexus" group (described in subparagraphs (i) through (x) of 2510.3-40(b)(2)).

B. Economic Analysis Under Executive Order 12866

Under Executive Order 12866, the Department must determine whether a regulatory action is "significant" and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a "significant regulatory action" as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities (also referred to as "economically significant"); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, it has been determined that this action is "significant" within the meaning of 3(f)(4), and therefore subject to review by the Office of Management and Budget (OMB). Consistent with the Executive Order, the Department has undertaken an assessment of the costs and benefits of this regulatory action. This analysis is detailed below.

Summary

Although neither the benefits nor costs have been fully quantified, the Department believes that the benefits of this final regulation more than justify its costs. The final regulation yields positive benefits by reducing uncertainty over which welfare benefit plans are excepted from the definition of a multiple employer welfare arrangement under section 3(40) and are therefore not subject to state regulation. The Department sought comments from the public concerning its analysis of benefits and costs of the proposed regulation. Having received no comments, the Department has relied on its initial analysis in concluding that the benefits of the final regulation justify its costs.

The regulation's elements for distinguishing collectively bargained plans from MEWAs are verifiable through documentation that plans or their agents generally maintain as part of usual business practices. The regulation also incorporates elements of flexibility, allowing entities to demonstrate the existence of a bona fide collective bargaining agreement, one of the regulatory factors, by satisfying any four of eight specified factors. Finally, the regulation is both sufficiently broad to include all plans established or maintained under or pursuant to one or more collective bargaining agreements, yet is discriminating enough to ensure that state law will apply to entities not meeting the criteria. Only a very small number of entities are likely to be treated differently as a result of promulgation of this criteria regulation. In the case of the few entities that will be determined to be not collectively bargained plans, the additional cost attributable to state regulation is outweighed by the benefit that such state regulation will provide by way of additional protections for participants and beneficiaries.

Background

It is the view of the Department that the uncertainty created by the lack of clear criteria for distinguishing collectively bargained plans from MEWAs has encouraged unscrupulous operators of sham MEWAs in attempts to escape or delay state regulatory efforts by asserting that states lack jurisdiction to regulate such entities because they are excluded from the definition of MEWA by reason of the exception for collectively bargained plans. In order to establish their authority to regulate, states have had to take additional steps, such as initiating administrative or legal proceedings contesting the defendant's status as a collectively bargained plan, and have been the subject of actions initiated by sham MEWA operators, such as suits for federal declaratory judgment or removal actions.

Confusion about whether a plan was established or maintained under or pursuant to an agreement which the Secretary finds to be a collective bargaining agreement has made it difficult for the states to enforce appropriate laws. The criteria regulation will reduce or eliminate this uncertainty. It will provide

greater clarity for entities and states and reduce the time and expense attributable to court actions or requests to the Department for guidance.

Benefits of the Regulation—Reducing Uncertainty

Plans and arrangements will benefit from greater assurance concerning their actual legal status. States, through an enhanced ability to regulate based on the greater certainty offered by the regulation, will be better able to protect employers, participants, and beneficiaries from unscrupulous MEWA operators. Further, the majority of plans established or maintained under or pursuant to collective bargaining agreements currently operate in a manner that is consistent with the regulation. Most entities will therefore not perceive any need to undertake a systematic reassessment of their status under the regulation. It is possible, however, that some will choose to undertake such an assessment by "comparison testing" the plan's operations against the "safe harbor" criteria established in the final regulation. The Department has estimated below the number of entities likely to undertake a status assessment and the costs likely to be associated with those activities.

Costs of the Regulation

Entities Potentially Affected. To estimate the number of entities potentially affected by the final rule, the Department examined available data on multiemployer welfare plans established or maintained under or pursuant to collective bargaining agreements, and the number of entities self-reporting as MEWAs. Under ERISA, multiemployer collectively bargained plans are required to file an annual financial report, the Form 5500. MEWAs are required to file the Form M-1 annually. The 1998 Form 5500 filings by multiemployer collectively bargained plans numbered about 2,000 (with about 6 million participants). The MEWAs that filed Form M-1 for the year 2000, pursuant to section 101 of ERISA and related interim final rules (65 FR 7152, February 11, 2000) numbered about 600 (with about 2 million participants).[1] The total number of MEWAs and collectively bargained plans, which represents the total universe of arrangements that might have questions about their legal status and "comparison test" under this regulation, is estimated at about 2,600 (8 million participants).

The Department was unable to identify any direct measure of the number of entities whose status is uncertain or whose status would remain uncertain under the regulation. Therefore, in order to assess the economic impact of reduced uncertainty under the regulation, the Department examined proxies for the number of entities that might be subject to such uncertainty. After estimating the total number of MEWAs and collectively bargained plans at 2,600, the Department then tallied the number of inquiries to the Department concerning MEWAs and the number of MEWA-related lawsuits to which the Department has been party, taking this to represent a reasonable indicator of the number of entities that have been subject to uncertainty in the past.

Department data indicate that in recent years, the Department has received an average of about nine MEWA-related requests for information each year from state and federal agencies and the private sector. The Department also considered the number of MEWA-related lawsuits that were filed by the Department in recent years. An average of about 45 actions have been brought each year. For purposes of this analysis, it has been assumed that each case involved a different MEWA. Accordingly, the Department has estimated for purposes of this economic analysis that approximately 54 entities (45 + 9) annually may have reason to be uncertain about their legal status with respect to section 3(40) of ERISA, or about two percent of the estimated total number of 2,600 MEWAs and collectively bargained plans.

The Department views this approximate number of 54 entities per year as a conservatively high estimate of the number of entities whose status could be made more certain by issuance of this regulation. On one hand, because some number of entities may confront uncertainty without becoming either the subject of an inquiry addressed to the Department or a lawsuit to which the Department is party, this estimate may represent only a subset of the entities that face uncertainty over their status. On the other hand, this estimate may overstate the number of entities that face uncertainty because it is known that not all requests to the Department or court actions actually raised issues related directly to the collective bargaining exception under section 3(40).

Assessment of Status. The Department estimates the cost to the 54 entities of conducting an assessment of their status under the regulation to be small. Such cost would be largely generated by reviewing records kept by third parties or by the entity in the ordinary course of business. The Department assumes that such a review requires 16 hours of an attorney's or comparable professional's time, plus 5 hours of clerical staff time. At $72 per hour and $21 per hour respectively, the total cost would be $1,173 per entity, or about $63,342 on aggregate per year for 54 entities. This cost would be incurred only once for a given entity unless its circumstances changed substantially relative to the standard. The Department believes that the cost is more than justified by savings to entities that, by conducting this assessment, avoid the need to engage in litigation or seek guidance from the Department in order to determine their status. These net savings represent a net benefit of this regulation.

Following a self-assessment of status, some fraction of these 54 entities might nonetheless find themselves in a situation leading them to seek an

[1] This represents a smaller number of plans and fewer participants than the numbers projected at the time of the proposal. Because the Form M-1 requirement had not been fully implemented at the time of the proposal, actual information on its use was not available, and the Department relied on survey data regarded as the most comparable at the time.

administrative determination from the Secretary under the procedural regulations, incurring attendant costs, perhaps because a state's jurisdiction or laws are asserted against the entity. The administrative process under the procedural regulations is, in the Department's view, an efficient and less costly process for resolving such disputes than would be available in the absence of the procedural regulations. The Department has elected to attribute the net benefit from these savings not to this regulation, but to the accompanying procedural regulations.

Reclassifying Incorrectly Classified Entities. Some number of entities, generally a subset of the 54 estimated annually to face uncertainty over status, will be reclassified as a result of comparison testing against the regulation's criteria. Entities that formerly considered themselves to be excluded from the MEWAs definition as collectively bargained plans may be required under the criteria regulation to classify themselves as MEWAs. These MEWAs will likely incur costs to comply with newly applicable state requirements. Such requirements vary from state to state, making it difficult to estimate the cost of compliance, but it is likely that costs might include those attributable to audits, funding and reserves, reporting, premium taxes and assessments, provision of state-mandated benefits, underwriting and rating rules, market conduct standards, and managed care patient protection rules, among other costs. These costs may be higher for those MEWAs that conduct business in more than one state.

Relevant literature suggests these costs can amount to ten percent of premium.[2] The cost may be substantially more if a state regulates premium rates and the entity otherwise would have benefited from insuring a population whose health costs are far lower than average. However, these added costs are transfers and not true economic costs because they serve as cross-subsidies that reduce costs for populations that are costlier than average.

As noted above, the universe of 2,600 entities that includes those potentially subject to uncertainty covers 8 million participants, or about 3,100 participants per entity on average. Industry surveys put the cost of health coverage at about $4,500 per employee and retiree per year. Applying these figures to 54 entities that might face uncertainty over status—an upper bound on the number likely to be reclassified—produces an upper-bound estimated cost of about $75 million.[3]

The Department has concluded that actual costs will be far lower than this and will be outweighed by the benefit of the associated protections that will flow from clarifying the state's authority to regulate. As noted above, it is likely that the true number of entities that are reclassified as MEWAs will be a fraction of the estimated 54 that annually might face uncertainty over status. Among those that are reclassified, certain entities likely would already have elected voluntarily to comply with some of the state regulatory requirements and therefore would not incur any cost from the application of state law. For those that would not have complied with relevant state law, operation of the regulation may impose additional costs, such as meeting solvency requirements or providing mandated benefits. The additional costs are offset and justified by increased security for plans and improved coverage for participants. Thus, the added cost from state regulation would be offset by the benefits derived from the protections that state regulations provide. GAO, in 1992, identified $124 million in unpaid claims owed by sham MEWAs. Department enforcement actions involving MEWAs in recent years have identified monetary violations of approximately $121.6 million. With state licensing and solvency requirements in place, at least some incidences of the $124 million in unpaid claims cited in the GAO study or the $121.6 million in violations would most likely not have occurred.

It is also possible that some entities considered to be MEWAs because they are not collectively bargained will be reclassified under the criteria regulation as collectively bargained plans. However, this number seems likely to be very small because entities that can legitimately be treated as collectively bargained have an economic incentive to do so. Any entities that are so classified benefit from the savings of having no obligation to comply with state regulatory requirements. There is no meaningful loss of benefits from the absence of state protections in such cases because the combination of a legitimate collective bargaining agreement and the application of ERISA provides adequate protections.

[2] Data from the Health Insurance Association of America (Source Book of Health Insurance Data, 1999-2000) suggests that insurance companies' loss ratios for group health insurance policies historically ranged from about 85 percent to 90 percent. The inverse of the loss ratio, or about 10 percent to 15 percent, generally would include all of these costs except those associated with benefit mandates and some managed care protections, as well as insurance company profits, income taxes, and normal administrative overhead. Loss ratios tend to be higher (and these costs lower) for larger group policies, and MEWAs are likely to be large. The cost of benefit mandates and managed care protection will very across states depending on their extent and across MEWAs depending largely on the degree to which they otherwise are included voluntarily in the insurance products they provide. One study estimated that mandates raise premiums by between 4 percent and 13 percent (Gail A. Jensen and Michael A. Morrisey, Mandated Benefit Laws and Employer-Sponsored Health Insurance (Washington, DC: HIAA 1999)).

[3] Recent data from actual Form M-1 filings results in a higher estimated number of participants per entity than was indicated in the proposal; therefore, the estimated cost for the final regulation exceeds the $58 million cost estimate for the proposal.

C. Paperwork Reduction Act

This Notice of Final Rulemaking is not subject to the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.) because it does not contain a "collection of information" as defined in 44 U.S.C. 3502(3).

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a rule will not have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires that the agency present a regulatory flexibility analysis at the time of the publication of the notice of final rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of analysis under the RFA, the Employee Benefits Security Administration (EBSA) continues to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for exemptions or simplified annual reporting and disclosure for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department has previously issued at 29 CFR 2520.104-20, 2520.104-21, 2520.104-41, 2520.104-46, and 2520.104b-10, certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare benefit plans covering fewer than 100 participants and that satisfy certain other requirements.

Further, while some large employers may have small plans, generally, most small plans are maintained by small employers. Thus, EBSA believes that assessing the impact of this rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). At the time of the proposed rule, EBSA requested comments on the appropriateness of the size standard used in evaluating the impact of this rule on small entities; no comments were received that would cause the Department to reevaluate its size standard.

On this basis, however, EBSA has determined that this rule will not have a significant economic impact on a substantial number of small entities. In support of this determination, and in an effort to provide a sound basis for this conclusion, EBSA has prepared the following final regulatory flexibility analysis.

(1) *Reasons for Action*. EBSA is proposing this regulation because it believes that regulatory guidance concerning the definition of a "plan or arrangement which is established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements" (ERISA 3(40)(A)(1)) is necessary to ensure that state insurance regulators have ascertainable guidelines to help regulate MEWAs operating in their jurisdictions. The guidance will also allow sponsors of employee welfare benefit plans to determine independently whether their entities are excepted under section 3(40) of ERISA. A more detailed discussion of the agency's reasoning for issuing the regulation is found above.

(2) *Objective*. The objective of the regulation is to provide criteria for the application of an exception to the definition "multiple employer welfare arrangement" (MEWA) found in section 3(40) of ERISA for a "plan or other arrangement which is established or maintained—(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements." An extensive list of authority may be found in the Statutory Authority section, below.

(3) *Estimate of Small Entities Affected*. Form 5500 filings and Form M-1 filings indicate that there are about 2,600 entities that could be classified as collectively bargained plans or MEWAs and that could be affected by the new criteria for defining collectively bargained plans. It is expected, however, that a very small number of these entities will have fewer than 100 participants. By their nature, the affected entities must involve at least two employers, which decreases the likelihood of their covering fewer than 100 participants. Also, the underlying goals behind the formation of these entities, such as gaining purchasing and negotiating power through economies of scale, improving administrative efficiencies, and gaining access to additional benefit design features, are not readily accomplished if the group of covered lives remains small.

Available data indicate that about 200 or eight percent of the 2,600 entities have fewer than 100 participants. Based on the health coverage reported in the Employee Benefits Supplement to the 1993 Current Population Survey and a 1993 Small Business Administration survey of retirement and other benefit coverages in small firms, the Department estimates that there are more than 2.5 million private group health plans with fewer than 100 participants. Thus, the number of small plans and MEWAs potentially affected is very small in light of this large number of small plans. Even if every one of the 2,600 entities at issue had fewer than 100 participants, the number of entities affected would represent approximately one-tenth of one percent of all small group health plans. Accordingly, the Department has determined that this regulation will not

have a significant economic impact on a substantial number of small entities.

Although relatively few small plans and other entities are expected to be affected by this proposal, it is known that the employers typically involved in these entities are often small (that is, they have fewer than 500 employees, which is generally consistent with the definition of small entity found in regulations issued by the Small Business Administration (13 CFR 121.201)). At the time of the proposed regulation, the Department sought comments and data with respect to the number of small employers potentially impacted by the establishment of a standard for determining whether a welfare benefit plan is established or maintained under or pursuant to one or more collective bargaining agreements. No comments or data were received in response to this request; the Department therefore continues to believe that, because these plans and arrangements involve at least two employers, and assuming that each is small, it can be estimated that at least 5,200 small employers may be affected.

It is possible that a small employer participating in what it thinks is a legitimate MEWA may find that it has unknowingly participated in a sham MEWA and will need to change its method of providing welfare benefits to its employees. By enabling states to regulate fraudulent and financially unsound MEWAs, therefore, the regulation may limit the sources of welfare benefits available to some small businesses, requiring them to seek alternative coverage for their employees. The greater benefit for employers, however, is an increased certainty that the MEWAs that remain in business will meet state regulatory standards and will be more certain to provide promised health, life, disability or other welfare benefits to employees. Consequently, employers will receive a net benefit from the reduced incidence of fraud and insolvency among the pool of MEWAs in the marketplace.

(4) *Reporting and Recordkeeping.* In most cases, the records used to determine if a welfare benefit plan is established or maintained under or pursuant to a collective bargaining agreement are routinely prepared and held by a collectively bargained multiemployer plan in the ordinary course of business. For any entities that are newly determined to be MEWAs under the regulation, there will be an economic impact related to the start-up costs of compliance with state regulations. These costs arise from state requirements, however, and not the requirements of this regulation. Start-up costs under state regulations may include expenses of registration, licensing, financial reporting, auditing, and any other requirement of state insurance law. Reporting and filing this information with the state would require the professional skills of an attorney, accountant, or other health benefit plan professional; however, post start-up, the majority of the recordkeeping and reporting could be handled by clerical staff.

(5) *Duplication.* No federal rules have been identified that duplicate, overlap, or conflict with the final rule.

(6) *Alternatives.* The regulation adopts generally the views of the consensus report of the Committee that was established to provide an alternative to the Department's earlier Notice of Proposed Rulemaking on Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements, published in the **Federal Register** (60 FR 39209, Aug. 1, 1995). At that time, recognizing that guidance was needed to clarify the collective bargaining exception to the MEWA regulation, the Department had proposed certain criteria describing the collective bargaining agreement. Commenters on the first proposed regulation expressed concerns related to plan compliance and the issue of state regulation.

Based on the comments received, the Department subsequently turned to negotiated rulemaking, establishing the Committee to assist the Department in developing acceptable criteria. The Committee included representatives from labor unions, multiemployer plans, state governments, employer/management associations, Railway Labor Act plans, third-party administrators, independent agents and brokers of health care products, insurance carriers and the federal government. Because this rule takes into account the Committee's consensus views, and because the Committee represented a full cross-section of the parties affected by the rule, including state, federal, association, and private sector health care organizations, the Department believes that, as an alternative to the 1995 NPRM, this regulation accomplishes the stated objectives of the Secretary and will have a beneficial effect on small employer participation in MEWAs.

The Department has concluded that the implementation of the regulation will be less costly than alternative methods of determining compliance with section 3(40), such as through case-by-case analysis by EBSA of each employee welfare benefit plan or litigation. In addition, if the Department elected not to define specific guidelines for the application of section 3(40), thereby enabling sham MEWAs to continue to evade state regulation, costs for small businesses would rise in terms of loss of coverage and unpaid claims. No other significant alternatives that would minimize economic impact on small entities were identified.

Further, the Department has concluded that it would be inappropriate to create a specific exemption under the regulation for small MEWAs because small MEWAs are just as likely as large MEWAs to be underfunded or otherwise have inadequate reserves to meet the benefit claims submitted for payment.

E. Small Business Regulatory Enforcement Fairness Act

The rule being issued here is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to Congress and the Comptroller General for review. The rule is not a "major rule" as that term is defined in 5 U.S.C. 804, because it is not likely to result in (1) An

annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or federal, state, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

F. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 et seq.), as well as Executive Order 12875, this rule does not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of $100 million.

G. Executive Order 13132

When an agency promulgates a regulation that has federalism implications, Executive Order 13132 (64 FR 43255, August 10, 1999), requires the Agency to provide a federalism summary impact statement. Pursuant to section 6(c) of the Order, such a statement must include a description of the extent of the agency's consultation with State and local officials, a summary of the nature of their concerns and the agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of the State have been met.

This regulation has federalism implications because it sets forth standards and procedures for determining whether certain entities may be regulated under certain state laws or whether such state laws are preempted with respect to such entities. The state laws at issue are those that regulate the business of insurance.

From the inception of the Committee through final deliberations on comments received on the proposed regulation, a representative from the National Association of Insurance Commissioners (NAIC), representing the interests of state governments in the regulation of insurance, participated in the rulemaking. NAIC raised the following concerns at Committee meetings: (1) That the rule should allow MEWAs to be easily distinguishable from collectively bargained plans so that MEWAs properly may be subjected to state jurisdiction and regulation; (2) that the rule should prevent the unlicensed sale of health insurance; and (3) that losses to individuals in the form of unreimbursed and denied medical claims should be eliminated.

The Department's position is that there is a substantial need for this regulation. Unscrupulous individuals have been able to exploit the lack of clear guidance regarding the criteria for determining whether an entity is established or maintained pursuant to collective bargaining agreements to create entities that falsely promise benefits they are unable to provide. These operators, free of state solvency and reserve requirements, have marketed unlicensed health insurance to small employers, often offering health insurance at significantly lower rates than state-licensed insurance companies. Ultimately, these operations have often gone bankrupt, leaving individuals with significant unpaid health claims and without health insurance. The lack of clear guidance has hampered states in their efforts to regulate these entities, and appropriate state regulation would reduce or eliminate the risk of losses to employers, employees and their families.

This regulation provides objective criteria for distinguishing collectively bargained plans from arrangements subject to state insurance law. The regulation will facilitate state enforcement efforts against arrangements attempting to misuse the collectively bargained exception in section 3(40) of ERISA. In that regard, the regulation will reduce the incidence of sale of unlicensed insurance under the guise of collectively bargained plans and will limit the losses to individuals in the form of unreimbursed medical and other welfare benefit insurance claims.

The Department notes further, as discussed more fully above, that one commenter expressed concern that the availability of administrative proceedings for an individualized section 3(40) finding in cases where the jurisdiction or law of a state has been asserted may result in delays in state enforcement that could substantially hinder a state's ability to take timely enforcement actions against sham MEWA operators. Recognizing the need to ensure that the regulations assist, rather than hinder, state enforcement efforts against sham MEWA operators, and taking into account the input of the Committee, including the NAIC representative, the Department has amended the regulation to make clear that it is not intended to provide the basis for a stay or delay of any state actions, including administrative or court proceedings and enforcement subpoenas, where immediate state enforcement action is warranted.

List of Subjects in 29 CFR Part 2510

Collective bargaining, Employee benefit plans, Pensions.

nFor the reasons set forth in the preamble, 29 CFR part 2510 is amended as follows:

PART 2510—[AMENDED] DEFINITION OF TERMS USED IN SUBCHAPTERS C, D, E, F, AND G OF THIS CHAPTER

n1. The authority citation for part 2510 is revised to read as follows:

Authority: 29 U.S.C. 1002(2), 1002(21), 1002(37), 1002(40), 1031, and 1135; Secretary of Labor's Order 1-2003, 68 FR 5374; Sec. 2510.3-101 also issued under sec. 102 of Reorganization Plan No. 4 of 1978, 43 FR 47713, 3 CFR, 1978 Comp., p. 332 and E.O. 12108, 44 FR 1065, 3 CFR, 1978 Comp., p. 275, and 29 U.S.C. 1135 note. Sec. 2510.3-102 also issued under sec. 102

of Reorganization Plan No. 4 of 1978, 43 FR 47713, 3 CFR, 1978 Comp., p. 332 and E.O. 12108, 44 FR 1065, 3 CFR, 1978 Comp., p. 275.

n2. Add new section 2510.3-40 to read as follows:

Sec. 2510.3-40 Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA.

(a) *Scope and purpose.* Section 3(40)(A) of the Employee Retirement Income Security Act of 1974 (ERISA) provides that the term "multiple employer welfare arrangement" (MEWA) does not include an employee welfare benefit plan that is established or maintained under or pursuant to one or more agreements that the Secretary of Labor (the Secretary) finds to be collective bargaining agreements. This section sets forth criteria that represent a finding by the Secretary whether an arrangement is an employee welfare benefit plan established or maintained under or pursuant to one or more collective bargaining agreements. A plan is established or maintained under or pursuant to collective bargaining if it meets the criteria in this section. However, even if an entity meets the criteria in this section, it will not be an employee welfare benefit plan established or maintained under or pursuant to a collective bargaining agreement if it comes within the exclusions in the section. Nothing in or pursuant to this section shall constitute a finding for any purpose other than the exception for plans established or maintained under or pursuant to one or more collective bargaining agreements under section 3(40) of ERISA. In a particular case where there is an attempt to assert state jurisdiction or the application of state law with respect to a plan or other arrangement that allegedly is covered under Title I of ERISA, the Secretary has set forth a procedure for obtaining individualized findings at 29 CFR part 2570, subpart H.

(b) *General criteria.* The Secretary finds, for purposes of section 3(40) of ERISA, that an employee welfare benefit plan is "established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements" for any plan year in which the plan meets the criteria set forth in paragraphs (b)(1), (2), (3), and (4) of this section, and is not excluded under paragraph (c) of this section.

(1) The entity is an employee welfare benefit plan within the meaning of section 3(1) of ERISA.

(2) At least 85% of the participants in the plan are:

(i) Individuals employed under one or more agreements meeting the criteria of paragraph (b)(3) of this section, under which contributions are made to the plan, or pursuant to which coverage under the plan is provided;

(ii) Retirees who either participated in the plan at least five of the last 10 years preceding their retirement, or

(A) Are receiving benefits as participants under a multiemployer pension benefit plan that is maintained under the same agreements referred to in paragraph (b)(3) of this section, and

(B) Have at least five years of service or the equivalent under that multiemployer pension benefit plan;

(iii) Participants on extended coverage under the plan pursuant to the requirements of a statute or court or administrative agency decision, including but not limited to the continuation coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, sections 601-609, 29 U.S.C. 1169, the Family and Medical Leave Act, 29 U.S.C. 2601 et seq., the Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. 4301 et seq., or the National Labor Relations Act, 29 U.S.C. 158(a)(5);

(iv) Participants who were active participants and whose coverage is otherwise extended under the terms of the plan, including but not limited to extension by reason of self-payment, hour bank, long or short-term disability, furlough, or temporary unemployment, provided that the charge to the individual for such extended coverage is no more than the applicable premium under section 604 of the Act;

(v) Participants whose coverage under the plan is maintained pursuant to a reciprocal agreement with one or more other employee welfare benefit plans that are established or maintained under or pursuant to one or more collective bargaining agreements and that are multiemployer plans;

(vi) Individuals employed by:

(A) An employee organization that sponsors, jointly sponsors, or is represented on the association, committee, joint board of trustees, or other similar group of representatives of the parties who sponsor the plan;

(B) The plan or associated trust fund;

(C) Other employee benefit plans or trust funds to which contributions are made pursuant to the same agreement described in paragraph (b)(3) of this section; or

(D) An employer association that is the authorized employer representative that actually engaged in the collective bargaining that led to the agreement that references the plan as described in paragraph (b)(3) of this section;

(vii) Individuals who were employed under an agreement described in paragraph (b)(3) of this section, provided that they are employed by one or more employers that are parties to an agreement described in paragraph (b)(3) and are covered under the plan on terms that are generally no more favorable than those that apply to similarly situated individuals described in paragraph (b)(2)(i) of this section;

(viii) Individuals (other than individuals described in paragraph (b)(2)(i) of this section) who are employed by employers that are bound by the terms of an agreement described in paragraph (b)(3) of this section and that employ personnel covered by such agreement, and who are covered under the plan on terms that are generally no more favorable than those that apply to such covered personnel. For this purpose, such

individuals in excess of 10% of the total population of participants in the plan are disregarded;

(ix) Individuals who are, or were for a period of at least three years, employed under one or more agreements between or among one or more "carriers" (including "carriers by air") and one or more "representatives" of employees for collective bargaining purposes and as defined by the Railway Labor Act, 45 U.S.C. 151 et seq., providing for such individuals' current or subsequent participation in the plan, or providing for contributions to be made to the plan by such carriers; or

(x) Individuals who are licensed marine pilots operating in United States ports as a state-regulated enterprise and are covered under an employee welfare benefit plan that meets the definition of a qualified merchant marine plan, as defined in section 415(b)(2)(F) of the Internal Revenue Code (26 U.S.C.).

(3) The plan is incorporated or referenced in a written agreement between one or more employers and one or more employee organizations, which agreement, itself or together with other agreements among the same parties:

(i) Is the product of a *bona fide* collective bargaining relationship between the employers and the employee organization(s);

(ii) Identifies employers and employee organization(s) that are parties to and bound by the agreement;

(iii) Identifies the personnel, job classifications, and/or work jurisdiction covered by the agreement;

(iv) Provides for terms and conditions of employment in addition to coverage under, or contributions to, the plan; and

(v) Is not unilaterally terminable or automatically terminated solely for non-payment of benefits under, or contributions to, the plan.

(4) For purposes of paragraph (b)(3)(i) of this section, the following factors, among others, are to be considered in determining the existence of a bona fide collective bargaining relationship. In any proceeding initiated under 29 CFR part 2570 subpart H, the existence of a bona fide collective bargaining relationship under paragraph (b)(3)(i) shall be presumed where at least four of the factors set out in paragraphs (b)(4)(i) through (viii) of this section are established. In such a proceeding, the Secretary may also consider whether other objective or subjective indicia of actual collective bargaining and representation are present as set out in paragraph (b)(4)(ix) of this section.

(i) The agreement referred to in paragraph (b)(3) of this section provides for contributions to a labor-management trust fund structured according to section 302(c)(5), (6), (7), (8), or (9) of the Taft-Hartley Act, 29 U.S.C. 186(c)(5), (6), (7), (8) or (9), or to a plan lawfully negotiated under the Railway Labor Act;

(ii) The agreement referred to in paragraph (b)(3) of this section requires contributions by substantially all of the participating employers to a multiemployer pension plan that is structured in accordance with section 401 of the Internal Revenue Code (26 U.S.C.) and is either structured in accordance with section 302(c)(5) of the Taft-Hartley Act, 29 U.S.C. 186(c)(5), or is lawfully negotiated under the Railway Labor Act, and substantially all of the active participants covered by the employee welfare benefit plan are also eligible to become participants in that pension plan;

(iii) The predominant employee organization that is a party to the agreement referred to in paragraph (b)(3) of this section has maintained a series of agreements incorporating or referencing the plan since before January 1, 1983;

(iv) The predominant employee organization that is a party to the agreement referred to in paragraph (b)(3) of this section has been a national or international union, or a federation of national and international unions, or has been affiliated with such a union or federation, since before January 1, 1983;

(v) A court, government agency, or other third-party adjudicatory tribunal has determined, in a contested or adversary proceeding, or in a government-supervised election, that the predominant employee organization that is a party to the agreement described in paragraph (b)(3) of this section is the lawfully recognized or designated collective bargaining representative with respect to one or more bargaining units of personnel covered by such agreement;

(vi) Employers who are parties to the agreement described in paragraph (b)(3) of this section pay at least 75% of the premiums or contributions required for the coverage of active participants under the plan or, in the case of a retiree-only plan, the employers pay at least 75% of the premiums or contributions required for the coverage of the retirees. For this purpose, coverage under the plan for dental or vision care, coverage for excepted benefits under 29 CFR 2590.732(b), and amounts paid by participants and beneficiaries as co-payments or deductibles in accordance with the terms of the plan are disregarded;

(vii) The predominant employee organization that is a party to the agreement described in paragraph (b)(3) of this section provides, sponsors, or jointly sponsors a hiring hall(s) and/or a state-certified apprenticeship program(s) that provides services that are available to substantially all active participants covered by the plan;

(viii) The agreement described in paragraph (b)(3) of this section has been determined to be a bona fide collective bargaining agreement for purposes of establishing the prevailing practices with respect to wages and supplements in a locality, pursuant to a prevailing wage statute of any state or the District of Columbia.

(ix) There are other objective or subjective indicia of actual collective bargaining and representation, such as that arm's-length negotiations occurred between the parties to the agreement described in paragraph (b)(3) of this section; that the predominant employee organization that is party to such agreement actively represents employees covered by such

agreement with respect to grievances, disputes, or other matters involving employment terms and conditions other than coverage under, or contributions to, the employee welfare benefit plan; that there is a geographic, occupational, trade, organizing, or other rationale for the employers and bargaining units covered by such agreement; that there is a connection between such agreement and the participation, if any, of self-employed individuals in the employee welfare benefit plan established or maintained under or pursuant to such agreement.

(c) *Exclusions.* An employee welfare benefit plan shall not be deemed to be "established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements" for any plan year in which:

(1) The plan is self-funded or partially self-funded and is marketed to employers or sole proprietors

(i) By one or more insurance producers as defined in paragraph (d) of this section;

(ii) By an individual who is disqualified from, or ineligible for, or has failed to obtain, a license to serve as an insurance producer to the extent that the individual engages in an activity for which such license is required; or

(iii) By individuals (other than individuals described in paragraphs (c)(1)(i) and (ii) of this section) who are paid on a commission-type basis to market the plan.

(iv) For the purposes of this paragraph (c)(1):

(A) "Marketing" does not include administering the plan, consulting with plan sponsors, counseling on benefit design or coverage, or explaining the terms of coverage available under the plan to employees or union members;

(B) "Marketing" does include the marketing of union membership that carries with it plan participation by virtue of such membership, except for membership in unions representing insurance producers themselves;

(2) The agreement under which the plan is established or maintained is a scheme, plan, stratagem, or artifice of evasion, a principal intent of which is to evade compliance with state law and regulations applicable to insurance; or

(3) There is fraud, forgery, or willful misrepresentation as to the factors relied on to demonstrate that the plan satisfies the criteria set forth in paragraph (b) of this section.

(d) Definitions. (1) Active participant means a participant who is not retired and who is not on extended coverage under paragraphs (b)(2)(iii) or (b)(2)(iv) of this section.

(2) Agreement means the contract embodying the terms and conditions mutually agreed upon between or among the parties to such agreement. Where the singular is used in this section, the plural is automatically included.

(3) Individual employed means any natural person who furnishes services to another person or entity in the capacity of an employee under common law, without regard to any specialized definitions or interpretations of the terms "employee," "employer," or "employed" under federal or state statutes other than ERISA.

(4) Insurance producer means an agent, broker, consultant, or producer who is an individual, entity, or sole proprietor that is licensed under the laws of the state to sell, solicit, or negotiate insurance.

(5) Predominant employee organization means, where more than one employee organization is a party to an agreement, either the organization representing the plurality of individuals employed under such agreement, or organizations that in combination represent the majority of such individuals.

(e) *Examples.* The operation of the provisions of this section may be illustrated by the following examples.

Example 1. Plan A has 500 participants, in the following 4 categories of participants under paragraph (b)(2) of this section:

In determining whether at least 85% of Plan A's participant population is made up of individuals with the required nexus to the collective bargaining agreement as required by paragraph (b)(2) of this section, the Plan may count as part of the nexus group only[[Page 17483]]50 (10% of the total plan population) of the 100 individuals described in paragraph (b)(2)(viii) of this section. That is because the number of individuals meeting the category of individuals in paragraph (b)(2)(viii) exceeds 10% of the total participant population by 50 individuals. The paragraph specifies that of those individuals who would otherwise be deemed to be nexus individuals because

Categories of participants	Total number	Nexus group	Non-nexus
1. Individuals working under CBAs	335 (67%)	335 (67%)	0
2. Retirees	50 (10%)	50 (10%)	0
3. "Special Class"—Non-CBA, non-CBA-alumni	100 (20%)	50 (10%)	50 (10%)
4. Non-nexus participants	15 (3%)	0	15 (3%)
Total	500 (100%)	435 (87%)	65(13%)

they are the type of individuals described in paragraph (b)(2)(viii), the number in excess of 10% of the total plan population may not be counted in the nexus group. Here, 50 of the 100 individuals employed by signatory employers, but not covered by the collective bargaining agreement, are counted as nexus individuals and 50 are not counted as nexus individuals. Nonetheless, the Plan satisfies the 85% criterion under paragraph (b)(2) because a total of 435 (335 individuals covered by the collective bargaining agreement, plus 50 retirees, plus 50 individuals employed by signatory employers), or 87%, of the 500 participants in Plan A are individuals who may be counted as nexus participants under paragraph (b)(2). Beneficiaries (e.g., spouses, dependent children, etc.) are not counted to determine whether the 85% test has been met.

Example 2. (i) International Union MG and its Local Unions have represented people working primarily in a particular industry for over 60 years. Since 1950, most of their collective bargaining agreements have called for those workers to be covered by the National MG Health and Welfare Plan. During that time, the number of union-represented workers in the industry, and the number of active participants in the National MG Health and Welfare Plan, first grew and then declined. New Locals were formed and later were shut down. Despite these fluctuations, the National MG Health and Welfare Plan meets the factors described in paragraphs (b)(4)(iii) and (iv) of this section, as the plan has been in existence pursuant to collective bargaining agreements to which the International Union and its affiliates have been parties since before January 1, 1983.

(ii) Assume the same facts, except that on January 1, 1999, International Union MG merged with International Union RE to form International Union MRGE. MRGE and its Locals now represent the active participants in the National MG Health and Welfare Plan and in the National RE Health and Welfare Plan, which, for 45 years, had been maintained under collective bargaining agreements negotiated by International Union RE and its Locals. Since International Union MRGE is the continuation of, and successor to, the MG and RE unions, the two plans continue to meet the factors in paragraphs (b)(4)(iii) and (iv) of this section. This also would be true if the two plans were merged.

(iii) Assume the same facts as in paragraphs (i) and (ii) of this Example. In addition to maintaining the health and welfare plans described in those paragraphs, International Union MG also maintained the National MG Pension Plan and International Union RE maintained the National RE Pension Plan. When the unions merged and the health and welfare plans were merged, National MG Pension Plan and National RE Pension Plan were merged to form National MRGE Pension Plan. When the unions merged, the employees and retirees covered under the pre-merger plans continued to be covered under the post-merger plans pursuant to the collective bargaining agreements and also were given credit in the post-merger plans for their years of service and coverage in the pre-merger plans. Retirees who originally were covered under the pre-merger plans and continue to be covered under the post-merger plans based on their past service and coverage would be considered to be "retirees" for purposes of 2550.3-40(b)(2)(ii). Likewise, bargaining unit alumni who were covered under the pre-merger plans and continued to be covered under the post-merger plans based on their past service and coverage and their continued employment with employers that are parties to an agreement described in paragraph (b)(3) of this section would be considered to be bargaining unit alumni for purposes of 2550.3-40(b)(2)(vii).

Example 3. Assume the same facts as in paragraph (ii) of Example 2 with respect to International Union MG. However, in 1997, one of its Locals and the employers with which it negotiates agree to set up a new multiemployer health and welfare plan that only covers the individuals represented by that Local Union. That plan would not meet the factor in paragraph (b)(4)(iii) of this section, as it has not been incorporated or referenced in collective bargaining agreements since before January 1, 1983.

Example 4. (i) Pursuant to a collective bargaining agreement between various employers and Local 2000, the employers contribute $2 per hour to the Fund for every hour that a covered employee works under the agreement. The covered employees are automatically entitled to health and disability coverage from the Fund for every calendar quarter the employees have 300 hours of additional covered service in the preceding quarter. The employees do not need to make any additional contributions for their own coverage, but must pay $250 per month if they want health coverage for their dependent spouse and children. Because the employer payments cover 100% of the required contributions for the employees' own coverage, the Local 2000 Employers Health and Welfare Fund meets the "75% employer payment" factor under paragraph (b)(4)(vi) of this section.

(ii) Assume, however, that the negotiated employer contribution rate was $1 per hour, and the employees could only obtain health coverage for themselves if they also elected to contribute $1 per hour, paid on a pre-tax basis through salary reduction. The Fund would not meet the 75% employer payment factor, even though the employees' contributions are treated as employer contributions for tax purposes. Under ERISA, and therefore under this section, elective salary reduction contributions are treated as employee contributions. The outcome would be the same if a uniform employee contribution rate applied to all employees, whether they had individual or family coverage, so that the $1 per hour employee contribution qualified an employee for his or her own coverage and, if he or she had dependents, dependent coverage as well.

Example 5. Arthur is a licensed insurance broker, one of whose clients is Multiemployer Fund M, a partially self-funded plan. Arthur takes bids from insurance companies on behalf of Fund M for the insured portion of its coverage, helps the trustees to evaluate the bids, and places the Fund's health insurance coverage with the carrier that is selected.

Arthur also assists the trustees of Fund M in preparing material to explain the plan and its benefits to the participants, as well as in monitoring the insurance company's performance under the contract. At the Trustees' request, Arthur meets with a group of employers with which the union is negotiating for their employees' coverage under Fund M, and he explains the cost structure and benefits that Fund M provides. Arthur is not engaged in marketing within the meaning of paragraph (c)(1) of this section, so the fact that he provides these administrative services and sells insurance to the Fund itself does not affect the plan's status as a plan established or maintained under or pursuant to a collective bargaining agreement. This is the case whether or how he is compensated.

Example 6. Assume the same facts as Example 5, except that Arthur has a group of clients who are unrelated to the employers bound by the collective bargaining agreement, whose employees would not be "nexus group" members, and whose insurance carrier has withdrawn from the market in their locality. He persuades the client group to retain him to find them other coverage. The client group has no relationship with the labor union that represents the participants in Fund M. However, Arthur offers them coverage under Fund M and persuades the Fund's Trustees to allow the client group to join Fund M in order to broaden Fund M's contribution base. Arthur's activities in obtaining coverage for the unrelated group under Fund M constitutes marketing through an insurance producer; Fund M is a MEWA under paragraph (c)(1) of this section.

Example 7. Union A represents thousands of construction workers in a three-state geographic region. For many years, Union A has maintained a standard written collective bargaining agreement with several hundred large and small building contractors, covering wages, hours, and other terms and conditions of employment for all work performed in Union A's geographic territory. The terms of those agreements are negotiated every three years between Union A and a multiemployer Association, which signs on behalf of those employers who have delegated their bargaining authority to the Association. Hundreds of other employers—including both local and traveling contractors—have chosen to become bound to the terms of Union A's standard area agreement for various periods of time and in various ways, such as by signing short-form binders or "me too" agreements, executing a single job or project labor agreement, or entering into a subcontracting arrangement with a signatory employer. All of these employ individuals represented by Union A and contribute to Plan A, a self-insured multiemployer health and welfare plan established and maintained under Union A's standard area agreement. During the past year, the trustees of Plan A have brought lawsuits against several signatory employers seeking contributions allegedly owed, but not paid to the trust. In defending that litigation, a number of employers have sworn that they never intended to operate as union contractors, that their employees want nothing to do with Union A, that Union A procured their assent to the collective bargaining agreement solely by threats and fraudulent misrepresentations, and that Union A has failed to file certain reports required by the Labor Management Reporting and Disclosure Act. In at least one instance, a petition for a decertification election has been filed with the National Labor Relations Board. In this example, Plan A meets the criteria for a regulatory finding under this section that it is a multiemployer plan established and maintained under or pursuant to one or more collective bargaining agreements, assuming that its participant population satisfies the 85% test of paragraph (b)(2) of this section and that none of the disqualifying factors in paragraph (c) of this section is present. Plan A's status for the purpose of this section is not affected by the fact that some of the employers who deal with Union A have challenged Union A's conduct, or have disputed under labor statutes and legal doctrines other than ERISA section 3(40) the validity and enforceability of their putative contract with Union A, regardless of the outcome of those disputes.

Example 8. Assume the same facts as Example 7. Plan A's benefits consultant recently entered into an arrangement with the Medical Consortium, a newly formed organization of health care providers, which allows the Plan to offer a broader range of health services to Plan A's participants while achieving cost savings to the Plan and to participants. Union A, Plan A, and Plan A's consultant each have added a page to their Web sites publicizing the new arrangement with the Medical Consortium. Concurrently, Medical Consortium's Web site prominently publicizes its recent affiliation with Plan A and the innovative services it makes available to the Plan's participants. Union A has mailed out informational packets to its members describing the benefit enhancements and encouraging election of family coverage. Union A has also begun distributing similar material to workers on hundreds of non-union construction job sites within its geographic territory. In this example, Plan A remains a plan established and maintained under or pursuant to one or more collective bargaining agreements under section 3(40) of ERISA. Neither Plan A's relationship with a new organization of health care providers, nor the use of various media to publicize Plan A's attractive benefits throughout the area served by Union A, alters Plan A's status for purpose of this section.

Example 9. Assume the same facts as in Example 7. Union A undertakes an area-wide organizing campaign among the employees of all the health care providers who belong to the Medical Consortium. When soliciting individual employees to sign up as union members, Union A distributes Plan A's information materials and promises to bargain for the same coverage. At the same time, when appealing to the employers in the Medical Consortium for voluntary recognition, Union A promises to publicize the Consortium's status as a group of unionized health care service providers. Union A eventually succeeds in obtaining recognition based on its majority status among the employees working for Medical Consortium

employers. The Consortium, acting on behalf of its employer members, negotiates a collective bargaining agreement with Union A that provides terms and conditions of employment, including coverage under Plan A. In this example, Plan A still meets the criteria for a regulatory finding that it is collectively bargained under section 3(40) of ERISA. Union A's recruitment and representation of a new occupational category of workers unrelated to the construction trade, its promotion of attractive health benefits to achieve organizing success, and the Plan's resultant growth, do not take Plan A outside the regulatory finding.

Example 10. Assume the same facts as in Example 7. The Medical Consortium, a newly formed organization, approaches Plan A with a proposal to make money for Plan A and Union A by enrolling a large group of employers, their employees, and self-employed individuals affiliated with the Medical Consortium. The Medical Consortium obtains employers' signatures on a generic document bearing Union A's name, labeled "collective bargaining agreement," which provides for health coverage under Plan A and compliance with wage and hour statutes, as well as other employment laws. Employees of signatory employers sign enrollment documents for Plan A and are issued membership cards in Union A; their membership dues are regularly checked off along with their monthly payments for health coverage. Self-employed individuals similarly receive union membership cards and make monthly payments, which are divided between Plan A and the Union. Aside from health coverage matters, these new participants have little or no contact with Union A. The new participants enrolled through the Consortium amount to 18% of the population of Plan A during the current Plan Year. In this example, Plan A now fails to meet the criteria in paragraphs (b)(2) and (b)(3) of this section, because more than 15% of its participants are individuals who are not employed under agreements that are the product of a bona fide collective bargaining relationship and who do not fall within any of the other nexus categories set forth in paragraph (b)(2) of this section. Moreover, even if the number of additional participants enrolled through the Medical Consortium, together with any other participants who did not fall within any of the nexus categories, did not exceed 15% of the total participant population under the plan, the circumstances in this example would trigger the disqualification of paragraph (c)(2) of this section, because Plan A now is being maintained under a substantial number of agreements that are a "scheme, plan, stratagem or artifice of evasion" intended primarily to evade compliance with state laws and regulations pertaining to insurance. In either case, the consequence of adding the participants through the Medical Consortium is that Plan A is now a MEWA for purposes of section 3(40) of ERISA and is not exempt from state regulation by virtue of ERISA.

(f) Cross-reference. See 29 CFR part 2570, subpart H for procedural rules relating to proceedings seeking an Administrative Law Judge finding by the Secretary under section 3(40) of ERISA.

(g) Effect of proceeding seeking Administrative Law Judge Section 3(40) Finding.

(1) An Administrative Law Judge finding issued pursuant to the procedures in 29 CFR part 2570, subpart H will constitute a finding whether the entity in that proceeding is an employee welfare benefit plan established or maintained under or pursuant to an agreement that the Secretary finds to be a collective bargaining agreement for purposes of section 3(40) of ERISA.

(2) Nothing in this section or in 29 CFR part 2570, subpart H is intended to provide the basis for a stay or delay of a state administrative or court proceeding or enforcement of a subpoena.

Signed this 31st day of March 2003.

Ann L. Combs,
Assistant Secretary,
Employee Benefits Security Administration.

[FR Doc. 03-8113 Filed 4-7-03; 8:45 am]

DEPARTMENT OF LABOR
Employee Benefits Security Administration

29 CFR Part 2570

RIN 1210-AA48

Procedures for Administrative Hearings Regarding Plans Established or Maintained Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA

AGENCY: Employee Benefits Security Administration, Department of Labor.

ACTION: Final rule.

SUMMARY: This document contains regulations under the Employee Retirement Income Security Act of 1974, as amended, (ERISA or the Act) describing procedures for administrative hearings to obtain a determination by the Secretary of Labor (Secretary) as to whether a particular employee welfare benefit plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40) of ERISA. An administrative hearing is available only if the jurisdiction or law of a state has been asserted against a plan or other arrangement that contends it meets the exception for plans established or maintained under or pursuant to one or more collective bargaining agreements. A separate document published elsewhere in this issue of the Federal Register contains a rule setting forth the criteria for determining when an employee welfare benefit plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40) of ERISA. These regulations are intended to assist labor organizations, plan sponsors and state insurance departments in determining whether a plan is a "multiple employer welfare arrangement" within the meaning of section 3(40) of ERISA.

EFFECTIVE DATE: June 9, 2003.

FOR FURTHER INFORMATION CONTACT: Elizabeth A. Goodman, Office of Regulations and Interpretations, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., Room N-5669, Washington, DC 20210, (202) 693-8510. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

A. Background

These final rules set forth an administrative procedure for obtaining a determination by the Secretary of Labor (the Secretary) as to whether a particular employee benefit plan is established or maintained under or pursuant to one or more agreements that are collective bargaining agreements for purposes of section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA). These rules (the procedural regulations) are being published simultaneously with a final regulation (the criteria regulation) setting forth specific criteria that, if met and if certain other factors set forth in the final regulation are not present, constitute a finding by the Secretary that a plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40). Both of these final rulemakings take into account the views expressed by the ERISA section 3(40) Negotiated Rulemaking Advisory Committee (the Committee), which was convened by the Department under the Negotiated Rulemaking Act (NRA) and the Federal Advisory Committee Act (the FACA), 5 U.S.C. App. 2. Together, these final regulations will assist states, plan sponsors, and administrators of employee benefit plans, in determining the scope of state regulatory authority over plans or other arrangements as set forth in sections 3(40) and 514(b)(6) of ERISA.

The procedural rules provide for administrative hearings to obtain a determination by the Secretary as to whether a particular plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40) of ERISA. The rules are modeled on the procedures set forth in 29 CFR sections 2570.60 through 2570.71 regarding civil penalties under section 502(c)(2) of ERISA related to reports required to be filed under ERISA section 101(b)(1) and are designed to maintain the maximum degree of uniformity with those rules that is consonant with the need for an expedited procedure accommodating the specific characteristics necessary for proceedings under section 3(40). Accordingly, the rules adopt many, although not all, of the provisions of subpart A of 29 CFR part 18 for the 3(40) proceedings. In this regard, it should be noted that the rules apply only to adjudicatory proceedings before administrative law judges (ALJs) of the United States Department of Labor (the Department). An administrative hearing is available under these rules only to an entity that contends it meets the exception provided in section 3(40)(A)(i) for plans established or maintained under or pursuant to collective bargaining agreements and only if the jurisdiction or law of a state has been asserted against that entity.

These procedural rules were published in the Federal Register in proposed form on October 27, 2000, (65 FR 64498), simultaneously with the proposed criteria regulation. As discussed more fully in the preamble to the final criteria regulation, the Department received seven comments on the proposed criteria and procedural regulations, only one of which related to the procedural regulations. After considering the views of the Committee, which was reconvened by the Department for that purpose and met in public session on March 1, 2002, the Department has determined to issue the final procedural regulations in the same format and language as proposed.

The Department received only one comment relating to the proposed procedural rules. This comment

also concerned the criteria regulation and is discussed in the preamble to that final rule. As described in the preamble to the final criteria regulation, the Department has clarified the language of paragraph (g)(2) of the criteria regulation to emphasize that the ALJ proceedings do not provide a basis for a stay-of-state administrative or judicial proceedings. The language of the procedural regulations remains unchanged.

B. Economic Analysis Under Executive Order 12866

Under Executive Order 12866, the Department must determine whether a regulatory action is "significant" and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a "significant regulatory action" as an action that is likely to result in a rule (1) Having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, it has been determined that this action is "significant" within the meaning of 3(f)(4), and therefore subject to review by the Office of Management and Budget (OMB). Consistent with the Executive Order, the Department has undertaken an assessment of the costs and benefits of this regulatory action. The analysis is detailed below.

Summary

Pursuant to the requirements of Executive Order 12866, at the time of the Notice of Proposed Rulemaking, the Department sought comments and information from the public on its analysis of the benefits and costs of the proposed regulation. Having received none, the Department believes, based on its original discussion, that the benefits of this final regulation justify its costs. The regulation will benefit plans, states, insurers, and organized labor by reducing the cost of resolving some disputes over a state's right to regulate certain multiple employer welfare benefit arrangements, facilitating the conduct of hearings, reducing disputes over a plan or arrangement's status, and improving the efficiency and ensuring the consistency in determinations of such jurisdiction.

Background

When state law or jurisdiction is asserted over an entity that claims to be excepted from state regulation under the collective bargaining exception, the entity has the option of using these procedures to resolve the dispute. In the absence of the procedure provided under these regulations for determining whether a given plan or arrangement is established or maintained pursuant to a collective bargaining agreement, such disputes have generally been resolved in courts. The Department believes that resolving disputes through the procedures established by these regulations will generally be more efficient and less costly than resolving the disputes in a court of law. Also, determinations made in the single, specialized venue of administrative hearings are likely to be more consistent than determinations made in multiple, non-specialized court venues.

Benefits of the Regulation

The procedure established by these regulations will complement the criteria established by the criteria regulation. Together, the regulations will assist in accurately identifying MEWAs and collectively bargained plans and ensure that disputes over such classifications are resolved efficiently. For purposes of its assessment of the economic impact of the regulations, the Department has attributed the net benefits of ensuring accurate determinations to the criteria regulation.

It has attributed the net benefits of ensuring efficient resolution of disputes to these procedural regulations.

Determining Jurisdiction Accurately and Consistently

The criteria regulation will reduce existing confusion about whether an entity falls under the collective bargaining agreement exception. However, given the wide variety of agreements, plans and arrangements, as well as the potential for conflicting determinations where a MEWA is conducting business in more than one state, some uncertainties might remain. The Department has therefore established a procedure for obtaining an individualized hearing before a Department of Labor ALJ and for final appeals to the Secretary or the Secretary's delegate to determine an entity's legal status.

Employers and employees will benefit from an administrative decision that provides greater assurance that the entity will comply with applicable federal and state laws designed to protect welfare benefits. In addition, both the petitioner and the state whose authority is being asserted will benefit from the uniform application of criteria by the ALJ, avoiding any confusion that would result from inconsistent decisions. Finally, state insurance departments that receive a timely resolution about an entity's status as a MEWA will be able to swiftly deal with sham MEWAs and then

re-direct saved resources to other areas. Because an ALJ decision will be based on the criteria regulation, the Department has attributed the net benefit from the reclassification of currently inaccurately classified plans or arrangements (and the consequent application of appropriate state or federal protections) to that regulation.

Resolving Disputes Efficiently

An administrative hearing under the final regulations will economically benefit the small number of plans or arrangements that dispute state assertion of law or jurisdiction. The Department foresees improved efficiencies through use of administrative hearings that are at the option of entities over which state jurisdiction has been asserted. An administrative hearing allows the various parties to obtain a decision in a timely, efficient, and less costly manner than is usual in federal or state court proceedings, thus benefiting employers and employees.

The Department's analysis of costs involved in adjudication in a federal or state court versus an administrative hearing assumes that parties seeking to establish regulatory authority incur a baseline cost to resolve the question of status in federal or state court proceeding. This baseline cost includes, but is not limited to, expenditures for document production, attorney fees, filing fees, depositions, etc.

Because regulatory authority may be decided in motions or pleadings in cases where that issue is not primary, the direct cost of using only the courts as a decision-maker for such issues is too variable to specify; however, custom and practice indicate that the cost of an administrative hearing is similar to or represents a cost savings compared with the baseline cost of litigating in federal or state court. Because the procedures and evidentiary rules of an administrative hearing generally track the Federal Rules of Civil Procedure and of Evidence, document production is similar for both an administrative hearing and for a federal or state court proceeding. Documents such as by-laws, administrative agreements, collective bargaining agreements, and other documents and instruments governing the entity are generally kept in the normal course of business, and it is likely that the cost for an administrative hearing will be no more than that which would be incurred in preparation for litigation in a federal or state court. Certain administrative hearing practices and other new procedures initiated by this regulation may, however, represent a cost savings over litigation. For example, neither party need employ an attorney; the prehearing exchange is short and general; either party may move to shorten the time for the scheduling of a proceeding, including the time for conducting discovery; the general formality of the hearing may vary, particularly depending on whether the petitioner is appearing pro se; an expedited hearing is possible; and, the ALJ generally has 30 days after receipt of the transcript of an oral hearing or after the filing of all documentary evidence if no oral hearing is conducted to reach a decision.

The Department cannot predict that any or all of these conditions will exist, nor can it predict that any of these factors represent a cost-savings. However, it is likely that the specialized knowledge of ERISA that the ALJ will bring to the process will facilitate a prompt decision, reduce costs, and introduce a consistent standard to what has been a confusion of decisions on regulatory authority. ALJ case histories will educate MEWAs and states by articulating the characteristics of a collectively bargained plan, which clarity will in turn promote compliance with appropriate federal and state regulations. Participants and beneficiaries of arrangements that are newly identified as MEWAs will especially benefit from appropriate state oversight that provides for secure contributions and paid-up claims. In its Notice of Proposed Rulemaking, the Department solicited comments on the comparative cost of a trial in federal or state court versus an administrative hearing on the issue of whether an entity is a plan is established or maintained under or pursuant to an agreement or agreements that the Secretary finds to be collective bargaining agreements for purposes of section 3(40) of ERISA. No comments concerning the comparative costs of a trial versus an administrative hearing were received.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule will not have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires that the agency present a final regulatory flexibility analysis at the time of the publication of the notice of final rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

For purposes of analysis under the RFA, EBSA continues to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for exemptions or simplified annual reporting and disclosure for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department has previously issued at 29 CFR 2520.104-20, 2520.104-21, 2520.104-41, 2520.104-46 and 2520.104b-10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements

for small plans, including unfunded or insured welfare benefit plans covering fewer than 100 participants and which satisfy certain other requirements.

Further, while some large employers may have small plans, in general most small plans are maintained by small employers. Thus, EBSA believes that assessing the impact of this final rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). In its Notice of Proposed Rulemaking, EBSA requested comments on the appropriateness of the size standard used; no comments were received.

On this basis, EBSA has determined that this rule does not have a significant economic impact on a substantial number of small entities. In support of this determination, and in an effort to provide a sound basis for this conclusion, EBSA has prepared the following final regulatory flexibility analysis.

(1) Reason for the Action. The Department is establishing a procedure for an administrative hearing so that states and entities will be able to obtain a determination by the Secretary as to whether a particular employee welfare benefit plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of an exception to section 3(40) of ERISA.

(2) Objectives. The objective of these regulations is to make available to plans an individualized procedure for obtaining a hearing before a Department of Labor ALJ, and for appeals of an ALJ decision to the Secretary or the Secretary's delegate. The procedure is appropriate for the resolution of a dispute regarding an entity's legal status in situations where the jurisdiction or law of a state has been asserted against a plan that contends it meets the exception for plans established or maintained under or pursuant to one or more collective bargaining agreements.

(3) Estimate of Small Entities Affected. For purposes of this discussion, the Department has deemed a small entity to be an employee benefit plan with fewer than 100 participants. No small governmental jurisdictions are affected.

Based on Form 5500 filings and Form M-1 filings by MEWAs pursuant to interim final rules published in the Federal Register on February 11, 2000 (65 FR 7152), it is estimated that there about 2,600 entities that can be classified as either collectively bargained plans or as MEWAs; however, EBSA believes that a very small number of these arrangements will have fewer than 100 participants. By their nature, the affected arrangements must involve at least two employers, which decreases the likelihood of coverage of fewer than 100 participants. Also, underlying goals of the formation of these arrangements, such as gaining purchasing and negotiating power through economies of scale, improving administrative efficiencies, and gaining access to additional benefit design features, are not readily accomplished if the group of covered lives remains small.

The number of small plans found within the group of 2,600 collectively bargained plans or MEWAs is about 200, or eight percent. The Employee Benefits Supplement to the 1993 Current Population Survey and a 1993 Small Business Administration survey of retirement and other benefit coverages in small firms indicate that there are more than 2.5 million private group health plans with fewer than 100 participants. Thus, the 200 small entities potentially affected represent a very small portion of all small group health plans. Even if all 2,600 potentially affected entities were to have fewer than 100 participants, they would represent approximately one-tenth of one percent of all small group health plans.

The Department is not aware of any source of information indicating the number of instances in which state law or jurisdiction has been asserted over these entities, or the portion of those instances that involved the collective bargaining agreement exception. However, in order to develop an estimate of the number of plans or arrangements that might seek to clarify their legal status by using an administrative hearing as proposed by these regulations, the Department examined the number of lawsuits to which the Department had previously been a party. While this number is not viewed as a measure of the incidence of the assertion of state jurisdiction, it is considered the only reasonable available proxy for an estimate of a maximum number of instances in which the applicability of state requirements might be at issue.

In recent years, the Department has been a party to an average of 45 legal actions annually. The proportion of these lawsuits that involved a dispute over state jurisdiction based on a plan's or an arrangement's legal status is unknown. On the whole, 45 is therefore considered a reasonable estimate of an upper bound number of plans that could have been a party to a lawsuit involving a determination of the plan's legal status. Because this procedural regulation and the related criteria regulation are expected to reduce the number of disputes, the Department assumes that 45 represents a conservatively high estimate of the number of plans or arrangements that would petition for an administrative hearing. Of all small plans and arrangements, then, the greatest number of plans or arrangements likely to petition for an administrative hearing represents a tiny fraction of the total number of small plans.

In addition, the Department has assumed that an entity's exercise of the opportunity to petition for a finding will generally be less costly than available alternatives. Accordingly, the Department has concluded that these regulations will not have a significant economic impact on a substantial number of small entities.

(4) Reporting and Recordkeeping. In most cases, the records that will be used to support a petition for a

hearing pursuant to these procedures will be maintained by plans and MEWAs in the ordinary course of their business. Certain documents, such as affidavits, would likely be required to be prepared specifically for purposes of the petition. It is assumed that documents will most often be assembled and drafted by attorneys, although this is not required by the express terms of the procedure.

(5) Duplication. No federal rules have been identified that duplicate, overlap, or conflict with the final rule.

(6) Alternatives. The regulations are based on the consensus report of the Committee. Recognizing that guidance was needed in clarifying collective bargaining exceptions to the MEWA regulation, in 1995, the Department had published a Notice of Proposed Rulemaking on Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements in the Federal Register (60 FR 39209). Under the terms of the 1995 NPRM, it would have been within the authority of state insurance regulators to identify and regulate MEWAs operating in their jurisdictions. The 1995 proposal did not establish a method for obtaining individual findings by the Department.

The Department received numerous comments on the NPRM expressing concerns about plans' abilities to meet the standards set forth in the NPRM. Commenters also objected to granting authority to state regulators for determining whether a particular agreement was a collective bargaining agreement. Commenters strongly preferred that determination of whether a plan was established under or pursuant to a collective bargaining agreement lie with a federal agency and not with individual states.

Based on the comments received, the Department turned to negotiated rulemaking as an appropriate method of developing a revised Notice of Proposed Rulemaking. In September 1998, the Secretary established the Committee under the NRA. The Committee membership was chosen from the organizations that submitted comments on the Department's August 1995 NPRM and from the petitions and nominations for membership received in response to a Department Notice of Intent. These regulations are based on the Committee's consensus on the need for an individualized administrative proceeding in limited circumstances for determining the legal status of an entity. Based on the fact that the Committee represented a cross section of the state, federal, association, and private sector insurance organizations concerned with these issues, the Department believes that, as an alternative to the 1995 NPRM, these regulations accomplish the stated objectives of the Secretary and will have a beneficial effect on MEWAs, state insurance regulators, small employers who offer group health coverage, and plan participants. No other significant alternatives that would minimize the economic impact on small entities have been identified.

Participating in an administrative hearing to determine legal status is a voluntary undertaking on the part of a plan or arrangement. It would be inappropriate to create an exemption for small entities under the regulation because small entities are as much in need of clarification of their legal status as are larger entities.

D. Paperwork Reduction Act

In accordance with the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3501 et seq.), the Department submitted the information collection request (ICR) included in the Procedures for Administrative Hearings Regarding Plans Established or Maintained Pursuant to Collective Bargaining Agreements under section 3(40)(A) of ERISA to the Office of Management and Budget (OMB) for review and clearance at the time the NPRM was published in the Federal Register (65 FR 64498). A request for comments on the ICR was included in the NPRM. No comments were received about the ICR, and no changes have been made to the ICR in connection with this Notice of Final Rulemaking. OMB subsequently approved the ICR under control number 1210-0119. The approval will expire on January 31, 2004.

Agency: Employee Benefits Security Administration, Department of Labor.

Title: Petition for Finding under section 3(40) of ERISA.

OMB Number: 1210-0119.

Affected Public: Business or other for-profit; not-for-profit institutions.

Respondents: 45.

Responses: 45.

Average Time Per Response: 32 hours.

Estimated Total Burden Hours: 1.

Estimated Total Burden Cost (Operating and Maintenance): $104,100.

E. Small Business Regulatory Enforcement Fairness Act

The rule being issued here is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to Congress and the Comptroller General for review. The rule is not a "major rule" as that term is defined in 5 U.S.C. 804, because it is not likely to result in (1) An annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or federal, state, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

F. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 et seq.), as well as Executive Order 12875, this proposed rule does not include any federal mandate that may result in expenditures by state, local, or tribal governments, or the private sector, which may impose an annual burden of $100 million.

G. Executive Order 13132

When an agency promulgates a regulation that has federalism implications, Executive Order 13132 (64 FR 43255, Aug. 10, 1999) requires the Agency to provide a federalism summary impact statement. Pursuant to section 6(c) of the Order, such a statement must include a description of the extent of the agency's consultation with State and local officials, a summary of the nature of their concerns and the agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of the State have been met.

This regulation has Federalism implications because it sets forth standards and procedures for an ALJ hearing for determining whether certain entities may be regulated under certain state laws or whether such state laws are preempted with respect to such entities. The state laws at issue are those that regulate the business of insurance. A member of the National Association of Insurance Commissioners (NAIC), representing the interest of state governments in the regulation of insurance, participated in the negotiations throughout the negotiated rulemaking process that provided the basis for this regulation.

In response to comments from the public about the proposed rule, the NAIC raised a concern that the process by which the Department issues ALJ determinations regarding the collectively bargained status of entities should move forward as quickly as possible and not result in a stay of state enforcement proceedings against MEWAs. The final regulation specifically states that the proceedings shall be conducted as expeditiously as possible and that the parties shall make every effort to avoid delay at each stage of the proceeding. The companion regulation that establishes criteria for determining whether an employee benefit plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40) of ERISA provides that ALJ proceedings under this regulation are not intended to provide the basis for a stay or delay of a state administrative or court proceeding or enforcement of a subpoena.

List of Subjects in 29 CFR Part 2570

Administrative practice and procedure, Claims, Employee benefit plans, Government employees, Law enforcement, Penalties, Pensions, Reporting and recordkeeping requirements.

For the reasons set out in the preamble, Part 2570 of Chapter XXV of Title 29 of the Code of Federal Regulations is amended to read as follows:

PART 2570—[AMENDED]

1. The authority citation for part 2570 is revised to read as follows:

Authority: 5 U.S.C. 8477, 29 U.S.C. 1002(40), 1021, 1108, 1132, 1135; sec. 102, Reorganization Plan No. 4 of 1978, 43 FR 47713, 3 CFR, 1978 Comp. p. 332, and E.O. 12108, 44 FR 1065, 3 CFR, 1978 Comp., p. 275; Secretary of Labor's Order 1-2003, 68 FR 5374 (Feb. 3, 2003).

2. Add new Subpart H to read as follows:Subpart H—Procedures for Issuance of Findings Under ERISA Sec. 3(40)

Sec.

2570.150 Scope of rules.
2570.151 In general.
2570.152 Definitions.
2570.153 Parties.
2570.154 Filing and contents of petition.
2570.155 Service.
2570.156 Expedited proceedings.
2570.157 Allocation of burden of proof.
2570.158 Decision of the Administrative Law Judge.
2570.159 Review by the Secretary.

Sec. 2570.150 Scope of rules.

The rules of practice set forth in this subpart H apply to "section 3(40) Finding Proceedings" (as defined in Sec. 2570.152(g)), under section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA or the Act). Refer to 29 CFR 2510.3-40 for the definition of relevant terms of section 3(40) of ERISA, 29 U.S.C. 1002(40). To the extent that the regulations in this subpart differ from the regulations in subpart A of 29 CFR part 18, the regulations in this subpart apply to matters arising under section 3(40) of ERISA rather than the rules of procedure for administrative hearings published by the Department's Office of Administrative Law Judges in subpart A of 29 CFR part 18. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

Sec. 2570.151 In general.

If there is an attempt to assert state jurisdiction or the application of state law, either by the issuance of a state administrative or court subpoena to, or the initiation of administrative or judicial proceedings against, a plan or other arrangement that alleges it is covered by title I of ERISA, 29 U.S.C. 1003, the plan or other arrangement may petition the Secretary to make a finding under section 3(40)(A)(i) of ERISA that it is a plan established or maintained under or pursuant to an agreement or agreements that the Secretary finds to be collective bargaining agreements for purposes of section 3(40) of ERISA.

Sec. 2570.152 Definitions.

For section 3(40) Finding Proceedings, this section shall apply instead of the definitions in 29 CFR 18.2.

(a) ERISA means the Employee Retirement Income Security Act of 1974, et seq., 29 U.S.C. 1001, et seq., as amended.

(b) Order means the whole or part of a final procedural or substantive disposition by the administrative law judge of a matter under section 3(40) of ERISA. No order will be appealable to the Secretary except as provided in this subpart.

(c) Petition means a written request under the procedures in this subpart for a finding by the Secretary under section 3(40) of ERISA that a plan is established or maintained under or pursuant to one or more collective bargaining agreements.

(d) Petitioner means the plan or arrangement filing a petition.

(e) Respondent means:

(1) A state government instrumentality charged with enforcing the law that is alleged to apply or which has been identified as asserting jurisdiction over a plan or other arrangement, including any agency, commission, board, or committee charged with investigating and enforcing state insurance laws, including parties joined under Sec. 2570.153;

(2) The person or entity asserting that state law or state jurisdiction applies to the petitioner;

(3) The Secretary of Labor; and

(4) A state not named in the petition that has intervened under Sec. 2570.153(b).

(f) Secretary means the Secretary of Labor, and includes, pursuant to any delegation or sub-delegation of authority, the Assistant Secretary for Employee Benefits Security or other employee of the Employee Benefits Security Administration.

(g) Section 3(40) Finding Proceeding means a proceeding before the Office of Administrative Law Judges (OALJ) relating to whether the Secretary finds an entity to be a plan to be established or maintained under or pursuant to one or more collective bargaining agreements within the meaning of section 3(40) of ERISA.

Sec. 2570.153 Parties.

For section 3(40) Finding Proceedings, this section shall apply instead of 29 CFR 18.10.

(a) The term "party" with respect to a Section 3(40) Finding Proceeding means the petitioner and the respondents.

(b) States not named in the petition may participate as parties in a Section 3(40) Finding Proceeding by notifying the OALJ and the other parties in writing prior to the date for filing a response to the petition. After the date for service of responses to the petition, a state not named in the petition may intervene as a party only with the consent of all parties or as otherwise ordered by the ALJ.

(c) The Secretary of Labor shall be named as a "respondent" to all actions.

(d) The failure of any party to comply with any order of the ALJ may, at the discretion of the ALJ, result in the denial of the opportunity to present evidence in the proceeding.

Sec. 2570.154 Filing and contents of petition.

(a) A person seeking a finding under section 3(40) of ERISA must file a written petition by delivering or mailing it to the Chief Docket Clerk, Office of Administrative Law Judges (OALJ), 800 K Street, NW., Suite 400, Washington, DC 20001-8002, or by making a filing by any electronic means permitted under procedures established by the OALJ.

(b) The petition shall—

(1) Provide the name and address of the entity for which the petition is filed;

(2) Provide the names and addresses of the plan administrator and plan sponsor(s) of the plan or other arrangement for which the finding is sought;

(3) Identify the state or states whose law or jurisdiction the petitioner claims has been asserted over the petitioner, and provide the addresses and names of responsible officials;

(4) Include affidavits or other written evidence showing that:

(i) State jurisdiction has been asserted over or legal process commenced against the petitioner pursuant to state law;

(ii) The petitioner is an employee welfare benefit plan as defined at section 3(1) of ERISA (29 U.S.C. 1002(1)) and 29 CFR 2510.3-1 and is covered by title I of ERISA (see 29 U.S.C. 1003);

(iii) The petitioner is established or maintained for the purpose of offering or providing benefits described in section 3(1) of ERISA (29 U.S.C. 1002(1)) to employees of two or more employers (including one or more self-employed individuals) or their beneficiaries;

(iv) The petitioner satisfies the criteria in 29 CFR 2510.3-40(b); and

(v) Service has been made as provided in Sec. 2570.155.

(5) The affidavits shall set forth such facts as would be admissible in evidence in a proceeding under 29 CFR part 18 and shall show affirmatively that the affiant is competent to testify to the matters stated therein. The affidavit or other written evidence must set forth specific facts showing the factors required under paragraph (b)(4) of this section.

Sec. 2570.155 Service.

For section 3(40) proceedings, this section shall apply instead of 29 CFR 18.3. (a) In general. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges (OALJ), 800 K Street, NW., Suite 400, Washington, DC 20001-8002, or to the OALJ Regional Office to which the proceeding may have been

transferred for hearing. Each document filed shall be clear and legible.

(b) By parties. All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing by first class, prepaid U.S. mail, a copy to the last known address. The Secretary shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA Section 3(40) Proceeding, PO Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents shall be made to all parties of record by regular mail to their last known address.

(d) Form of pleadings (1) Every pleading shall contain information indicating the name of the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the OALJ and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8\1/2\ x 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.Sec. 2570.156 Expedited proceedings. For section 3(40) Finding Proceedings, this section shall apply instead of 29 CFR 18.42.

(a) At any time after commencement of a proceeding, any party may move to advance the scheduling of a proceeding, including the time for conducting discovery.

(b) Except when such proceedings are directed by the Chief Administrative Law Judge or the administrative law judge assigned, any party filing a motion under this section shall:

(1) Make the motion in writing;

(2) Describe the circumstances justifying advancement;

(3) Describe the irreparable harm that would result if the motion is not granted; and

(4) Incorporate in the motion affidavits to support any representations of fact.

(c) Service of a motion under this section shall be accomplished by personal delivery, or by facsimile, followed by first class, prepaid, U.S. mail. Service is complete upon personal delivery or mailing.

(d) Except when such proceedings are required, or unless otherwise directed by the Chief Administrative Law Judge or the administrative law judge assigned, all parties to the proceeding in which the motion is filed shall have ten (10) days from the date of service of the motion to file an opposition in response to the motion.

(e) Following the timely receipt by the administrative law judge of statements in response to the motion, the administrative law judge may advance pleading schedules, discovery schedules, prehearing conferences, and the hearing, as deemed appropriate; provided, however, that a hearing on the merits shall not be scheduled with less than five (5) working days notice to the parties, unless all parties consent to an earlier hearing.

(f) When an expedited hearing is held, the decision of the administrative law judge shall be issued within twenty (20) days after receipt of the transcript of any oral hearing or within twenty (20) days after the filing of all documentary evidence if no oral hearing is conducted.

Sec. 2570.157 Allocation of burden of proof.

For purposes of a final decision under Sec. 2570.158 (Decision of the Administrative Law Judge) or Sec. 2570.159 (Review by the Secretary), the petitioner shall have the burden of proof as to whether it meets 29 CFR 2510.3-40.

Sec. 2570.158 Decision of the Administrative Law Judge.

For section 3(40) finding proceedings, this section shall apply instead of 29 CFR 18.57.

(a) Proposed findings of fact, conclusions of law, and order. Within twenty (20) days of filing the transcript of the testimony, or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge's discretion under 29 CFR 18.55, proposed findings of fact, conclusions of law, and order together with the supporting brief expressing the reasons for such proposals. Such proposals and brief shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) Decision based on oral argument in lieu of briefs. In any case in which the administrative law judge believes that written briefs or proposed findings of fact and conclusions of law may not be necessary, the administrative law judge shall notify the parties at the opening of the hearing or as soon thereafter as is practicable that he or she may wish to hear oral argument in lieu of briefs. The administrative law judge shall issue his or her decision at the close of oral argument, or within 30 days thereafter.

(c) Decision of the administrative law judge. Within 30 days, or as soon as possible thereafter, after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing

consent findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law, with reasons therefore, upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record. It shall be supported by reliable and probative evidence. Such decision shall be in accordance with the regulations found at 29 CFR 2510.3-40 and shall be limited to whether the petitioner, based on the facts presented at the time of the proceeding, is a plan established or maintained under or pursuant to collective bargaining for the purposes of section 3(40) of ERISA.

Sec. 2570.159 Review by the Secretary.

(a) A request for review by the Secretary of an appealable decision of the administrative law judge may be made by any party. Such a request must be filed within 20 days of the issuance of the final decision or the final decision of the administrative law judge will become the final agency order for purposes of 5 U.S.C. 701 et seq.

(b) A request for review by the Secretary shall state with specificity the issue(s) in the administrative law judge's final decision upon which review is sought. The request shall be served on all parties to the proceeding.

(c) The review by the Secretary shall not be a de novo proceeding but rather a review of the record established by the administrative law judge.

(d) The Secretary may, in his or her discretion, allow the submission of supplemental briefs by the parties to the proceeding.

(e) The Secretary shall issue a decision as promptly as possible, affirming, modifying, or setting aside, in whole or in part, the decision under review, and shall set forth a brief statement of reasons therefor. Such decision by the Secretary shall be the final agency action within the meaning of 5 U.S.C. 704.

Signed this 31st day of March, 2003.
Ann L. Combs, Assistant Secretary,
Employee Benefits Security Administration.
[FR Doc. 03-8114 Filed 4-7-03; 8:45 am]