

DEPARTMENT OF LABOR**Pension and Welfare Benefits Administration****29 CFR Part 2510**

RIN 1210-AA48

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

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

ACTION: Proposed rule.

SUMMARY: This document contains a proposed 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 proposed 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 that meet the requirements of the proposed 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. If adopted, the proposed regulation would affect employee welfare benefit plans, their sponsors, participants, and beneficiaries, as well as service providers to plans. Proposed regulations are being published simultaneously with this proposed regulation that 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 would be 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 for plans established or maintained under or pursuant to one or more collective bargaining agreements.

DATES: Written comments concerning the proposed regulation must be received by December 26, 2000.

ADDRESSES: Interested persons are invited to submit written comments (preferably three copies) concerning this proposed regulation to: Pension and

Welfare Benefits Administration, Room N-5669, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210, (Attention: Proposed Regulation Under Section 3(40)). All submissions will be open to public inspection at the Public Documents Room, Pension and Welfare Benefits Administration, Room N-5638, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210.

FOR FURTHER INFORMATION CONTACT: Elizabeth A. Goodman, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, Room N-5669, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210, (202) 219-8671. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:**A. Background**

The Department is proposing a regulation, based on the report of the ERISA Section 3(40) Negotiated Rulemaking Advisory Committee convened by the Department for this purpose, that would implement section 3(40) of ERISA, 29 U.S.C. 1002(40). Section 3(40)(A) defines the term multiple employer welfare arrangement (MEWA) in pertinent part as follows:

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) [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—(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements. * * *

This provision was added to ERISA by the Multiple Employer Welfare Arrangement Act of 1983, Sec. 302(b), Pub. L. 97-473, 96 Stat. 2611, 2612 (29 U.S.C. 1002(40)), which also amended section 514(b) of ERISA. Section 514(a) of the Act provides that state laws which relate to employee welfare benefit plans are generally preempted by ERISA. Section 514(b) sets forth exceptions to the general rule of section 514(a) and subjects employee welfare benefit plans that are MEWAs to various levels of state regulation depending 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)).¹

¹ The Multiple Employer Welfare Arrangement Act of 1983 added section 514(b)(6) which provides a limited exception to ERISA's preemption of state laws that allows states to exercise regulatory

The Multiple Employer Welfare Arrangement Act was introduced to counter what the Congressional drafters termed abuse by the "operators of bogus 'insurance' trusts." 128 Cong. Rec. E2407 (1982) (Statement of Congressman Erlenborn). In his comments, Congressman Erlenborn noted that certain MEWA operators had been successful in thwarting timely investigations and enforcement activities of state agencies by asserting that such entities were ERISA plans exempt from state regulation by the terms of section 514 of ERISA. The goal of the bill, according to Congressman Erlenborn, was to remove "any potential obstacle that might exist under current law which could hinder the ability of the States to regulate multiple employer welfare arrangements to assure the financial soundness and timely payment of benefits under such arrangements." *Id.* This concern was also expressed by the Committee on Education and Labor in the Activity Report of the Pension Task Force (94th Congress, 2d Session, 1977), cited by Congressman Erlenborn:

It has come to our attention, through the good offices of the National

Association of State Insurance Commissioners, that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in the profiting from the provision of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that his enterprise is an ERISA benefit plan which is protected under ERISA's preemption provision from state regulation.

authority over employee welfare benefit plans that are NEWAs. Section 514(b) provides, in relevant part, that:

(6)(A) Notwithstanding any other provision of this section—(i) 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 subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that 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, and (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.

Thus, an employee welfare benefit plan that is a MEWA remains subject to state regulation to the extent provided in section 514(b)(6)(A). ERISA preemption applies only to MEWAs which are employee welfare benefit plans.

Id. As a result of the addition of section 514(b)(6), certain state laws regulating insurance may apply to employee welfare benefit plans that are MEWAs. However, the definition of a MEWA in section 3(40) provides that an employee welfare benefit plan is not a MEWA if it is established or maintained under or pursuant to an agreement or agreements which the Secretary finds to be a collective bargaining agreement. Such plans, therefore, are not subject to state insurance regulation under section 514(b)(6).

While the Multiple Employer Welfare Arrangement Act of 1983 significantly enhanced the states' ability to regulate MEWAs, problems in this area persist. Among other things, the exception for collectively bargained plans contained in section 3(40) is now being 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.² 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.

B. The August 1995 Notice of Proposed Rulemaking

On August 1, 1995, the Department published a Notice of Proposed Rulemaking on Plans Established or Maintained Pursuant to Collective Bargaining Agreements in the **Federal Register**. (60 FR 39209). (August 1995 NPRM). The Department proposed criteria for determining whether an employee welfare benefit plan is established or maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements for purposes of section 3(40) of ERISA. The proposed approach did not have a procedure for obtaining individual findings by the Department. The Department received numerous comments on the NPRM. Commenters expressed concerns about their ability to comply with the standards set forth in the NPRM, and to obtain data necessary to establish

compliance with the criteria proposed by the Department. Commenters also objected to having State regulators determine whether a particular agreement was a collective bargaining agreement.

C. Regulatory Negotiation

The Department continues to believe that regulatory guidance in this area is necessary. Based on the comments received in response to the August 1995 NPRM, the Department determined that negotiated rulemaking was an appropriate method of implementing a revised Notice of Proposed Rulemaking. On April 15, 1998, the Secretary published in the **Federal Register** (63 FR 18345) a notice of intent to establish a negotiated rulemaking advisory committee under the Negotiated Rulemaking Act. (5 U.S.C. 561 *et seq.*) (NRA). The NRA establishes a framework for the conduct of negotiated rulemaking and encourages agencies to use negotiated rulemaking to enhance the informal rulemaking process.

In September 1998, the Secretary established the ERISA Section 3(40) Negotiated Rulemaking Advisory Committee under the NRA and the Federal Advisory Committee Act (the FACA)(5 U.S.C. App. 2) (Notice of Establishment). (63 FR 5052). The Committee included a Department representative and its work has been assisted by a neutral facilitator. 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 the Notice of Intent. The Notice of Establishment outlined the rationale behind the final composition of the Committee. The members of the ERISA Section 3(40) Negotiated Rulemaking Advisory Committee are as follows:

Labor Unions: Kathy Krieger, American Federation of Labor and Congress of Industrial Organizations;

Multiemployer Plans: Gerald Feder (James Ray—alternate), National Coordinating Committee for Multiemployer Plans; Judith Mazo, Entertainment Industry Multiemployer Health Plans;

State Governments: Fred Nepple, National Association of Insurance Commissioners;

Employers/Management: James Kernan, The Associated General Contractors of America;

Railway Labor Act Plans: Benjamin W. Boley, National Railway Labor Conference;

Third-Party Administrators: David Livingston, TIC International Corporation;

Independent agents, brokers and advisors providing health care products and services to plans and individuals: Nancy Trenti, National Association of Health Underwriters;

Insurance carriers and managed care companies that finance and deliver health care: R. Lucia Riddle, Health Insurance Association of America;

Federal Government: Elizabeth A. Goodman, Pension and Welfare Benefits Administration.

The goal of the Committee was to reach consensus on pertinent issues and draft regulatory text for the purposes of developing a substantive rule to help the regulated community determine which plans are indeed established or maintained under or pursuant to one or more collective bargaining agreements, and therefore not subject to state regulation, under section 3(40) of ERISA. The Committee conducted eight public sessions held on October 26–27, 1998, December 16–17, 1998, February 9–10, 1999, April 20–21, 1999, July 7–8, 1999, August 25–26, 1999, October 13–14, 1999, and November 16–17, 1999. All meetings were held in Washington, D.C. and allocated time during the meetings for public participation and comment. In accordance with the FACA's requirements, minutes of all public Committee meetings have been kept in the public rulemaking record, together with the materials distributed among Committee members during such meetings and correspondence received by the Committee regarding the rulemaking. During the course of the Committee's deliberations, it received two written comments from the public. The Committee considered the comments in drafting its report and the proposed regulatory text.

Under the rules governing the negotiated rulemaking process, and in accordance with the organizational protocols adopted by the Committee, the Committee agreed to recommend to the Secretary consensus language in the form of a proposed rule developed by the Committee. Committee members agreed not to file adverse public comments on provisions of the proposed rule on which the Committee had reached consensus.

In the event that the Committee did not reach a full consensus on a proposed rule, the Committee members agreed to prepare a report to the Secretary outlining any consensus agreement reached, and summarizing the reasons for the failure to reach consensus on the complete rule. The

² In addition, the Department has received requests to make individual determinations concerning the status of particular plans under section 3(40). See, e.g., *Ocean Breeze Festival Park v. Reich*, 853 F. Supp. 906, 91 (1994), summary judgment granted sub nom. *Virginia Beach Policemen's Benevolent Association, et al. v. Reich*, 881 F. Supp. 1059 (E.D. Va. 1995), *aff'd*, 96 F.3d 1440 (1996); *Amalgamated Local Union No. 335 v. Gallagher*, No. 91 CIV 0193(RR) (E.D.N.Y. April 15, 1991).

Department was prepared to develop a proposed rule on its own, if the Committee could not reach consensus.

With the exception of sections E–K of the preamble, the text of the proposed rule and preamble is the Committee's consensus.

D. Description of Proposed Regulation

1. Structure of the Proposed Regulation

The proposed regulation establishes specific criteria that the Secretary finds must be present in order for one or more agreements to be collective bargaining agreements for purposes of section 3(40) of ERISA and also establishes certain criteria for determining when an employee welfare benefit plan is established or maintained under or pursuant to such an agreement or agreements for purposes of section 3(40). In drafting proposed regulatory language, the Committee took into account that section 3(40) not only requires the existence of one or more *bona fide* collective bargaining agreements, but also requires that the plan be “established or maintained” under or pursuant to such an agreement or agreements. The proposed regulation interprets the exception under section 3(40)(A)(i) as being limited to plans providing coverage primarily to those individuals with a nexus to the collective bargaining agreement or agreements under or pursuant to which the plan is established or maintained. Accordingly, the criteria in the proposed regulation relating to whether a plan qualifies as “established or maintained” are intended to ensure that the statutory exception is only available to plans whose participants are predominately the bargaining unit employees on whose behalf such benefits were negotiated and other individuals with a close nexus to the bargaining unit or to the employer(s) of the bargaining unit employees.

The proposed regulation also sets forth certain instances where, even if the specific criteria apparently are met, an entity will be deemed not to be established or maintained under or pursuant to one or more collective bargaining agreements. The proposed regulation also sets forth certain factors to be considered by a fact finder as to whether there is a *bona fide* collective bargaining relationship.

The proposed regulation would, upon adoption, constitute the Secretary's finding for purposes of determining whether a plan is established or maintained under or pursuant to one or more collective bargaining agreements pursuant to section 3(40) of ERISA. The criteria contained in the proposed

regulation are designed to enable entities and state insurance regulatory agencies to determine in the first instance whether the requirements of the Act are met. Unlike the August 1995 NPRM, under certain limited circumstances an entity may elect to petition the Secretary for an individual finding. However, the Secretary will not make individual findings or determinations as to whether an entity meets the criteria of the proposed regulation unless a state's law or jurisdiction is asserted in an administrative or judicial proceeding against that particular entity. For the procedure for petitioning for an individual finding and a description of the ALJ individual finding procedure, see *Notice of Proposed Rulemaking 29 CFR 2570 Subpart G (published simultaneously)*.

The principles and criteria in this proposed rule were developed solely for the purpose of determining whether or not a multiple employer welfare plan is a MEWA under section 3(40). In considering and drafting this proposed regulation, the Committee was not charged with interpreting or enforcing any other federal laws that relate to collective bargaining and employee benefits, such as the National Labor Relations Act, the Internal Revenue Code of 1986 or the Railway Labor Act. Therefore, nothing in this proposed regulation, or in any ALJ finding issued pursuant to it under the proposed rules at 29 CFR 2570 Subpart G, is intended to determine the rights and responsibilities of any party under such other laws. In drafting the proposed regulatory language, the Committee recognized that a finding by the Secretary that a plan is maintained pursuant to a collective bargaining agreement as defined for section 3(40) of ERISA may be considered by parties applying other laws, but did not believe that such a finding here would, given the narrow focus of the proposed regulation, conclude the analysis under such other law.

2. Specific Provisions of the Proposed Regulation

Section 2510.3–40(a)—Scope and Purpose

Section (a), Scope and Purpose, states that the purpose of the proposed regulation is to set forth a finding by the Secretary that an employee welfare benefit plan is established or maintained under or pursuant to one or more collective bargaining agreements if it meets the criteria in the proposed regulation and does not come within one of the exclusions.

Section 2510.3–40(b)—Who Is Covered by the Plan

Section (b), Criteria, is divided into four parts: subparagraph (1) requires that the entity in question be an employee welfare benefit plan within the meaning of ERISA section 3(1); subparagraph (2) looks at whether the preponderance of those participants covered by the plan have a nexus to the bargaining relationships under which the plan is established or maintained; subparagraph (3) describes the characteristics of agreements that will qualify them, for purposes of section 3(40) of ERISA only, as collective bargaining agreements; and subparagraph (4) sets forth factors to be considered, again for purposes of section 3(40) only, in determining whether there is a *bona fide* collective bargaining relationship underlying the agreements pursuant to which the plan is established or maintained. If an employee welfare benefit plan meets the general criteria and is not excluded under subsection (c), then the Secretary finds that such 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 it meets the criteria.

Section 2510.3–40(b)(1)—Entity Must Be a Plan

Subsection (b)(1) requires that an entity be an employee welfare benefit plan within the meaning of section 3(1) of ERISA in order to be deemed to be a plan established or maintained under or pursuant to collective bargaining.

Section 2510.3–40(b)(2)—“The Nexus Group”

Subsection (b)(2) requires that for any plan year 80% of the participants (as defined in section 3(7) of ERISA) in the plan have a nexus to the collective bargaining relationship (“the nexus group”). It also describes the categories of people who are considered to have that nexus. The numerical tests in the proposed regulation subsection (b)(2) look at individuals whose coverage is based on their employment, that is, the participants. The proposed regulation focuses on participants in order to reduce potential administrative difficulties for plans in having to account for beneficiaries (e.g., spouses, dependent children, etc.) who are covered solely by virtue of their relationship to a participant. Beneficiaries are not counted to determine whether the 80% test has been met.

The nexus group includes a broad group of participants—those commonly found in traditional multiemployer welfare benefit plans, due to their connection to the plan or the collective bargaining process—among those covered in the 80% test. This is a change from the August 1995 NPRM, which focused the numerical test on those individuals covered by the collective bargaining agreement.

In drafting proposed regulatory text, the Committee took into account that there are other categories of individuals, not specifically identified in subsection (b)(2), who traditionally may be covered by multiemployer plans because of their relationship to the plan or the sponsoring unions or employers, such as employees of an industry credit union or an administrative entity set up to collect and reconcile employer contributions and related payments. Based on the information available to the Committee, the number of such participants in any given situation is likely to be so small compared to the plan's total participant population that they would fit well within the 20% allowance for coverage of non-nexus people. Because plans are not likely to run the risk of being deemed to be a MEWA by virtue of covering these incidental categories, it did not appear necessary to attempt to promulgate an exhaustive list of such individuals for inclusion in the nexus group. However, the Department invites public comment identifying any other categories of participants who similarly have historically been covered under one or more multiemployer plans because of their traditional and close connection to the bargaining relationship, the bargaining unit or the employers that contribute to the plan, and whose participation is material enough to warrant specific inclusion in the nexus group.

The 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. The Committee believed that this percentage gives plans enough leeway so that they will not need to worry about detailed head counts, while offering coverage to, for instance, a limited number of union members who have not been covered by collective bargaining agreements because the union has not yet been recognized as their bargaining representative, or to parties providing services to the plan for whom health coverage under the plan is part of their compensation, such as the plan's legal

counsel, administrator, or persons providing computer maintenance or other contract services.

Whether a plan or other arrangement meets the criteria for the finding that it is established or maintained under or pursuant to a collective bargaining agreement within the meaning of section 3(40) is to be determined based on its characteristics 'for a plan year.' A plan's status 'for a plan year' is to be determined as of a point or points during the plan year that is reasonably representative with respect to that plan.

Unlike the 1995 NPRM, the proposed regulation does not prescribe the specific measurement dates. Among other things, the Committee believed that formal procedures governing the calculation of the level of non-nexus participation are not needed under this proposal. That is because the Committee expected that few multiemployer plans would even cover people who do not fit any of the nexus categories and that plans should not find it difficult to identify and keep track of the small number of non-nexus participants. Moreover, the Committee recognized that, given the wide variety of employment patterns in the industries covered by multiemployer plans and the potential that unforeseen events could distort the coverage picture temporarily, no single set of fixed determination dates was likely to capture a fair picture for the universe of affected plans.

In the Committee's judgment, attempting to prescribe specific times and procedures for making the 80% coverage determination could place undue emphasis on the mechanics of the head count, and would make the regulation more complex and costly to administer, since the rule should have to include a wide range of variations and alternatives. At the same time, mechanical rules broad enough to take care of the spectrum of plans that are undeniably maintained pursuant to collective bargaining would lend themselves to relatively easy evasion. MEWA operators could manipulate participants' coverage dates to make it appear that the test for collective bargaining status was met on the official measuring date.

Public comments, plus specific suggestions, are invited on whether the regulation should be more precise as to the 'for a plan year' determination.

Section 2510.3-40(b)(2)(i)—Participants Covered by the Collective Bargaining Agreement

The primary component of the nexus group is individuals employed under one or more of the collective bargaining agreements pursuant to which

contributions are made or coverage is provided under the plan. Determining who is an employed individual relies on general common law principles.

Section 2510.3-40(b)(2)(ii)—Retirees

The nexus group includes retired participants who either (a) participated in the welfare benefit plan at least five of the last 10 years preceding their retirement, or (b) are receiving benefits under a multiemployer pension plan maintained under the same agreement as the welfare benefit plan and had at least five years of service (or the equivalent for plans that determine pension eligibility or entitlement in a different manner) under that employee pension benefit plan.

Section 2510.3-40(b)(2)(iii)—Statutory Extended Coverage

The nexus group includes participants who were active participants and are on extended coverage under the plan under legally required coverage extensions. This includes people whose coverage is based on the continuation coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act. It also includes coverage required to be provided by a court, arbitration or administrative decision and coverage that remains in place, pursuant to the National Labor Relations Act, or other applicable law, after expiration of a collective bargaining agreement.

Section 2510.3-40(b)(2)(iv)—Extended Coverage Under the Terms of the Plan

Participants with extended coverage under the terms of the plan (even where the extended coverage opportunity is not required by statute) are also in the nexus group. This includes common types of coverage extensions following a period of eligibility based on active participation, such as self-payment, hour bank, long- or short-term disability, furlough, or temporary unemployment, as long as the participant is not required to pay more than the applicable COBRA premium for the coverage in question.

Section 2510.3-40(b)(2)(v)—Reciprocity Agreements

The nexus group includes participants who are covered under the plan pursuant to a reciprocal agreement with one or more other multiemployer welfare plans. Reciprocal agreements are most common in construction and other industries where union-represented workers tend to travel from

area to area, following the availability of jobs. They enable workers to establish or maintain coverage under the plan in their home jurisdiction based on work in another plan's jurisdiction, under a collective bargaining agreement that requires contributions to that other plan.

However, subparagraph (b)(2)(v), does not permit a plan to circumvent the percentage test by arranging reciprocal agreements with other plans to shield each plan's non-nexus individuals. Participants covered under reciprocal agreements are considered part of the nexus group for the "receiving" plan only if they are part of the nexus group under the "sending" plan. The percentage limitations of the rule may not be avoided by purporting to cover individuals under "reciprocal" agreements who do not have a nexus (as defined under 2510.3-40(b)(2)) to the "sending" plan.

Section 2510.3-40(b)(2)(vi)—Union, Plan and Fund Employees

Employees of the sponsoring labor organization, the welfare benefit plan or trust itself and related employee benefit plans, are in the nexus group as well.

Section 2510.3-40(b)(2)(vii)—“Bargaining Unit Alumni”

Also in the nexus group are so-called "bargaining unit alumni," that is, participants who once were covered under the plan due to their employment under a collective bargaining agreement, but who (1) are no longer working in a bargaining-unit capacity; (2) work for one or more employers that are parties to the agreement; and (3) are covered under the plan on terms that are generally no more favorable than those that apply to the bargaining-unit employees. This includes former union-represented workers who are now in a management capacity.

Section 2510.3-40(b)(2)(viii)—“Special-Class Participants”

The nexus group includes so-called "special-class participants," that is, individuals who are neither union-represented nor bargaining-unit alumni, but who are employed by employers that contribute to the plan for their union-represented employees pursuant to the collective bargaining agreement, and who are covered under the plan on terms that are generally no more favorable than those that apply to the bargaining-unit personnel. Some multiemployer plans traditionally have allowed contributing employers to cover their office staff, along with their union-represented workforce. Special-class participants totaling no more than 10% of the total plan participant population

are counted in the nexus group. A plan will not be deemed to be a MEWA merely because it covers additional special-class participants above that 10% level, so long as the additional special-class participants, together with any other participants who are not in the nexus group, constitute no more than 20% of the total plan participant population.

The Committee believed that special-class participants ordinarily would constitute no more than 10% of the plan's total participant population, and so included only a 10% allowance for them in the nexus group. However, the Committee also recognized that the 10% allowance might not be adequate in some situations, because, for example, the ratio of signatory employers' supervisors and office workers to their union-represented counterparts is subject to fluctuation, particularly in certain industries. Part of the reason that the proposed regulation allows plans a 20% margin for coverage of people who are neither covered by a collective bargaining agreement nor included in one of the other nexus categories was the potential for special class participants in excess of the 10% nexus number.

Section 2510.3-40(b)(2)(ix)—Individuals Covered by the Railway Labor Act

The nexus group includes participants who are, or were for a period of at least three years, employed under one or more agreements under the Railway Labor Act 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, 29 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.

Section 2510.3-40(b)(2)(x)—Licensed Marine Pilots

Individuals who are licensed marine pilots operating in United States ports as a state-regulated enterprise are included as part of the nexus group with respect to a qualified merchant marine plan, as defined in section 415(b)(2)(F) of the Internal Revenue Code of 1986.

Section 2510.3-40(b)(3)—Nature of the Collective Bargaining Agreement

Subsection (b)(3) requires that the plan be incorporated or referenced in at least one written agreement between at least one employee organization and two or more employers. The written agreement must satisfy five listed

criteria. The Committee recognized that the substance of the agreement among the parties to collective bargaining often is embodied in more than one document, and not every aspect of their agreement necessarily is reduced to writing. The Committee also recognized that a multiemployer plan often is incorporated or referenced in more than one collective bargaining agreement among different employers and employee organizations, including but not limited to project labor agreements, labor harmony agreements, "me-too" or "one-line" agreements. For these reasons, the term "agreement" necessarily includes the constellation of documents and understandings that make up the parties' contract, and it automatically includes multiple agreements, where applicable.

Section 2510.3-40(b)(3)(i)

The first criterion for an agreement under subsection (b)(3) is that the agreement is the product of a *bona fide* collective bargaining relationship. Subsection (b)(4), as described *infra*, sets forth a nonexhaustive list of factors relevant for determining whether such a relationship in fact exists.

Section 2510.3-40(b)(3)(ii)

The second criterion under subsection (b)(3) is that the agreement in question identifies employers and employee organization(s) that are parties to and bound by the agreement. The Committee took into consideration that, in many industries, employers bargain collectively through multiemployer associations, and the resulting agreement may identify the association, as agent for the many employers for which the association bargained. Also, many employers routinely adopt the master agreement by reference in their collective bargaining agreements to what are often referred to as "short-form agreements" or "binders." Additionally, a written collective bargaining agreement may bind employers who are neither signatory to that agreement nor identified in any document, but who are nonetheless legally bound. Therefore, the criterion that the agreement identify the parties may be satisfied even if not every one of the employers who are bound by the agreement to contribute to the plan is named specifically.

Section 2510.3-40(b)(3)(iii)

The third criterion is that the agreement identify the personnel, job classifications and/or work jurisdiction covered by the agreement. In the Committee's experience, collective bargaining agreements generally delineate the personnel covered by the

agreement by reference to the trade, craft or class, industry or geographic area in which the employer operates or the job classifications utilized by the employer.

Section 2510.3-40(b)(3)(iv)

The fourth criterion is that the agreement provides for terms and conditions of employment in addition to coverage under, or contributions to, the plan.

Section 2510.3-40(b)(3)(v)

The fifth criterion is that the agreement is not unilaterally terminable or automatically terminated solely for nonpayment of benefits under, or contributions to, the plan. This criterion is met even if the plan trustees have authority to terminate a delinquent employer's ability to contribute to or otherwise participate in the plan, as long as the underlying collective bargaining agreement remains in full force and effect with respect to that employer. Similarly, the fact that the employee organization may have the right to suspend performance of its obligations under the agreement in the event of specified occurrences, which may include the employer's failure to pay required contributions, does not mean that the agreement is unilaterally terminable for purposes of this criterion.

Section 2510.3-40(b)(4)—Factors Indicative of a Bona Fide Collective Bargaining Relationship

Subsection (b)(4) sets forth various factors to be considered in determining whether there is a *bona fide* collective bargaining relationship. In any given case, the decision is to be based on all of the facts and circumstances. The Committee first had attempted to develop a list of criteria that could serve as reliable proxies for what all Committee members recognized were legitimate multiemployer plans not subject to state insurance regulation. To avoid being classified as a MEWA, a plan would have to satisfy certain objective criteria, and it could not have one of the disqualifying characteristics. That approach eventually gave rise to the flexible facts and circumstances test proposed here. The Committee realized that imposing a fixed, bright line profile to define "collective bargaining" for the purposes of this regulation would create more unintended issues for multiemployer plans without addressing the problems at which section 3(40) of ERISA was aimed. Those intent on mimicking real collectively bargained plans as a way to avoid state insurance regulation would have a blueprint for doing so, while

parties actually involved in collective bargaining, which is sometimes not tidy and compliance-driven in real life, might inadvertently negotiate a health or welfare coverage arrangement that simply failed to fit familiar models or patterns.

Under the proposed rule, the presence or absence of the factors listed in subsection (b)(4) is to be taken into account in judging whether an actual collective bargaining relationship exists for purposes of section 3(40) of ERISA, but no one factor or set of factors is intended to be determinative in every case. Indeed, some of these factors can, by their nature, apply only in specialized circumstances, and few plans are likely to satisfy all of them. That is why the proposal includes a range of circumstances commonly associated with collectively bargained plans. In addition, information on factors not included in this list may be relevant in individual cases. The Department invites public comments on the factors listed here, and suggestions for other factors to be listed.

While the proposed regulation does not define collective bargaining in terms of specific uniform requirements, it does recognize that where a significant number of the first eight factors exist, the resultant plans are more likely than not to be established or maintained under or pursuant to a collective bargaining agreement within the meaning of section 3(40) of ERISA. Accordingly, in a Section 3(40) Finding Proceeding before a Department of Labor ALJ to determine whether a plan or other arrangement is maintained under or pursuant to a collective bargaining agreement for this purpose, it is presumed that if at least four of the first eight listed factors are present, a *bona fide* collective bargaining relationship exists, that is, that the requirements of subsection (b)(3)(i) are met. That shifts the burden to the party claiming that the arrangement is *not* the product of a *bona fide* collective bargaining relationship to persuade the ALJ to the contrary (or, to the extent that it meets all of the other criteria in addition to subsection (b)(3)(i), to show in some other way, such as by the presence of one of the disqualifying criteria, that the arrangement does not qualify for a finding under the proposed regulation).

Section 2510.3-40(b)(4)(i)

The first factor to be considered under subsection (b)(4) is that the agreement provides for contributions to a labor-management trust fund designed and operated in accordance with the Taft-Hartley Act or to a plan lawfully

negotiated under the Railway Labor Act. A plan can meet the requirement that the trust be "structured in accordance" with the Taft-Hartley Act even if the plan has a minor violation of that Act's technical requirements. However, there must be more than just a paper recital of the formalities of the Taft-Hartley Act, the trust must function as a labor-management trust within the spirit of the Taft-Hartley Act.

Section 2510.3-40(b)(4)(ii)

The second factor provides that the collective bargaining agreement under which contributions are made to the employee welfare benefit plan also requires that substantially all of the participating employers contribute to a multiemployer pension plan designed and operated in accordance with the Taft-Hartley Act and the plan qualification requirements in section 401 of the Internal Revenue Code. In addition, substantially all of the active participants covered by the employee welfare benefit plan must be eligible to become participants in that pension plan. Because the length of service requirements may be different for the pension plan and the welfare plan, this factor does not require that substantially all of the welfare plan participants in fact become pension plan participants, as long as they are eligible to do so if they meet the pension plan's participation requirements.

Section 2510.3-40(b)(4)(iii)

The third factor applies if the predominant employee organization that is a party to the collective bargaining agreement relating to the employee welfare benefit plan has maintained a series of agreements incorporating or referencing the plan since before January 1, 1983, the effective date of ERISA section 3(40). The term "predominant employee organization," which is specifically defined in the regulation, is used because it is not unusual for a multiemployer plan to be maintained under agreements with more than one labor union. "Predominant employee organization" refers to the union that represents the plurality of the plan's participants employed under the agreement. This factor is included as an indicator of the *bona fides* of collective bargaining in recognition of the fact that, if the union has negotiated for health and welfare coverage under the plan since before the enactment of ERISA section 3(40), the plan and the collective bargaining agreement underlying it were not created for the purposes of avoiding the MEWA amendment to ERISA.

The Committee received written comments during the course of its negotiations suggesting that a trust providing health coverage that had been in existence for a certain period of time be “grandfathered,” regardless of the percentage of participants covered by collective bargaining agreements. The Committee determined that a grandfather that serves as an indicator of the *bona fides* of the underlying collective bargaining process was warranted. See subsections (b)(4)(iii) and (b)(4)(iv). The purpose of the regulatory finding, however, is not to determine what plans or arrangements should or could be the subject of State enforcement action, but rather to define what employee welfare benefit plans are established or maintained under or pursuant to collective bargaining within the meaning of section 3(40) of ERISA. The Committee agreed that, for that purpose, the 80% nexus standard is appropriate regardless of the length of time the plan or trust has been in operation. If a plan or arrangement is not established or maintained under or pursuant to one or more collective bargaining agreements, whether or not ERISA preemption applies is beyond the scope of this regulation.

Section 2510.3–40(b)(4)(iv)

Under the fourth factor, the predominant employee organization that is a party to the agreement relating to the employee welfare benefit plan must have been a national or international union, or a federation of national and international unions, or affiliated with such a union or federation, since before January 1, 1983.

Section 2510.3–40(b)(4)(v)

The fifth factor is that there has been a determination, following a government-supervised election or a contested proceeding, that the predominant employee organization that is a party to the agreement relating to the employee welfare benefit plan is the lawfully recognized or designated collective bargaining representative with respect to one or more bargaining units of personnel covered by such agreement.

Section 2510.3–40(b)(4)(vi)

The sixth factor applies to plans where the employees’ coverage (but not necessarily coverage for employees’ dependents) is, in large part, employer-funded. It applies where employers pay at least 75% of the premiums or contributions required for the coverage of active participants under the plan, or 75% of the premiums or contributions for retirees in the case of a retiree-only

plan. For this purpose, coverage for dental or vision care, or coverage for excepted benefits under the Health Insurance Portability and Accountability Act is disregarded, unless the employer pays at least 75% of the premiums or contributions for that coverage. This calculation is illustrated in the proposed regulation at subsection (e), Example 4.

Section 2510.3–40(b)(4)(vii)

The seventh factor applies where the predominant employee organization provides, sponsors or jointly sponsors a hiring hall and/or a state certified apprenticeship program, the services of which are available to substantially all active participants in the plan. The actual nature of the services offered by the employee organization will control, rather than the existence of self-serving paper formalities that purport to document the existence of such services.

Section 2510.3–40(b)(4)(viii)

The eighth and last factor relevant to the presumption of the *bona fides* of the collective bargaining relationship underlying the plan applies to collective bargaining agreements in the building and construction industry, where some states have prevailing wage statutes for public works projects. This factor applies where a state agency has made an investigation and a determination about whether the collective bargaining agreement is *bona fide* in the course of making a prevailing wage determination, such as under Article 8 of NYS Labor Law, section 220.

Section 2510.3–40(b)(4)(ix)

Subsection (b)(4)(ix) sets forth additional subjective and objective indicia that may be considered in determining the existence of a *bona fide* collective bargaining relationship. This provision gives examples of some of the kinds of indicia that the Committee considered relevant and probative of the existence of a *bona fide* collective bargaining relationship. The examples given, which were not meant to be exhaustive, reflect the Committee’s understanding of the realities of collective bargaining. For example, where a collectively bargained plan covers self-employed participants, there is usually a reason grounded in the employment patterns and bargaining structures in that industry, such as owner-operators who remain in the plan whether or not they are currently working under an agreement.

Section 2510.3–40(c)—Exclusions

Section (c), Exclusions, sets forth specific circumstances where, regardless of whether an employee welfare benefit plan meets the general criteria provisions in section (b), 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 where the circumstances are present.

Section 2510.3–40(c)(1)

Subsection (c)(1)(i) addresses the use of insurance agents and brokers (referred to in the regulation as “insurance producers”) to market self-funded or partially self-funded plans to employers. Many of the problems in this area involved commercial schemes marketed by (1) insurance producers; or (2) by individuals who are disqualified or ineligible for a license to serve as insurance producers; or (3) by other individuals who are paid on a commission-type basis.

Subsection (c)(1)(i) provides that where a plan is self-funded or partially self-funded, and it is marketed by insurance producers or by individuals who are disqualified from, ineligible for, or have failed to obtain a license to serve as an insurance producer, but who engage in activities for which such a license is required, it will be excluded from the regulatory finding in subsection (b), regardless of the method of compensation for marketing. Subsection (c)(1)(i) also takes a plan out of the regulatory finding if individuals other than those described above are paid on a commission basis to market the plan. This was designed to prevent avoidance of the above limitation by use of people other than insurance producers. The qualification involving payment on a commission basis was intended to distinguish this kind of commercial enterprise from union organizing that features health or other welfare benefits.

Subsection (c)(1)(ii) addresses the concept of “marketing” for the purposes of subsection (c)(1)(i). The Committee recognized that insurance producers have a role in the administration of multiemployer plans, and they can be compensated appropriately for those services. Those services—including offering or selling those services to the plan—do not trigger the exclusion, and the regulation makes this clear. The regulation is not intended to preclude insurance producers from selling insurance coverage to the trustees of a multiemployer plan, *i.e.*, marketing

insurance products to a plan that is or seeks to become partly or fully insured. Nor is union organizing among insurance producers the kind of marketing that this regulation addresses. On the other hand, marketing to employers does include selling health coverage under the guise of enrolling their employees in union membership. This subsection does not purport to provide an exhaustive list of what is or is not "marketing." The Department seeks suggestions on whether there should be further clarification of the definition of "marketing."

The Committee also recognized that enterprises that are not really operating pursuant to a *bona fide* collective bargaining relationship may attempt to market health coverage commercially under the guise of union organizing, using media such as the Internet, and without using insurance producers or paying other individuals on a commission-type basis. While such a situation would not come within the subsection (c)(1) exclusion for marketing, if the facts indicated that the primary objective was not to achieve broader representation of workers in regard to their employment, but rather to provide health coverage without having to comply with state regulation, that conduct could be evidence of a scheme, sham or artifice intended to evade state regulation that would cause the undertaking to be treated as a MEWA under subsection (c)(2).

Section 2510.3-40(c)(2)

Subsection (c)(2) is a general provision excluding arrangements that on the surface meet the affirmative criteria of the regulation, but that in fact are designed to evade compliance with state law and insurance regulation. This exclusion recognizes that sophisticated entities might mimic the characteristics of collective bargaining as set forth in the regulation, but in fact be providing commercial health coverage without complying with state law.

Such a scheme might be present, for example, if parties who collaborate in a project to sell self-funded health coverage to otherwise unrelated members of the public set up an organization that they label a labor union, advertise broadly in commercial venues and have people who pay premiums sign forms that are labeled "union membership cards." The attempt to camouflage their commercial enterprise as a collectively bargained arrangement would be a scheme to evade state law that would cause it to be a MEWA, even if on its face it appears to meet the criteria that would

qualify it for a finding under subsection (b) of the proposed regulation.

Section 2510.3-40(c)(3)

Subsection (c)(3) provides an exclusion in the event of fraud, forgery, or willful misrepresentation regarding the plan's conformance with the affirmative criteria of the regulation. The Committee was aware of situations where documentation of collective bargaining had been manufactured for the purposes of misleading state regulators as to the availability of federal preemption.

Section 2510.3-40(d)—Definitions

The following terms are defined in the regulation: "active participant," "agreement," "individual employed," "insurance producer," and "predominant employee organization."

Economic Analysis Under Executive Order 12866

Under Executive Order 12866, the Department must determine whether the 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" and therefore subject to review by the Office of Management and Budget (OMB). OMB has determined that this proposed rulemaking is significant within the meaning of section 3(f)(4) of the Executive Order. Consistent with the Executive Order, the Department of Labor (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 the Department has analyzed the economic impact of this proposed regulation and has concluded that the proposed regulation's benefits exceed its costs although neither is quantified. The proposed regulation yields positive benefits by reducing uncertainty over which health, life, disability or other welfare benefit arrangements are multiple employer welfare arrangements under section 3(40) and therefore not subject to state regulation. It also yields positive benefits by clarifying when state regulation applies and when it is preempted.

The regulation sets forth a substantive standard for distinguishing whether a welfare plan sponsored by more than one employer is established or maintained under or pursuant to one or more collective bargaining agreements. Plans so established or maintained are excluded from the definition of multiple employer welfare arrangements (MEWAs) and consequently are not subject to state regulation. The regulation will serve to distinguish multiemployer collectively bargained plans, which are not subject to state regulation, from MEWAs, which are so subject.

The regulation, which is a product of negotiated rulemaking, is designed so that the benefits outweigh the costs. The adoption of this regulation will limit uncertainty in determining whether certain plans are established or maintained under or pursuant to one or more collective bargaining agreements. Although the criteria established in this proposal should generally reduce disputes over applicability of state laws, a very small number of entities may still become involved in disputes over assertions of state law jurisdiction and, in certain circumstances, may seek administrative determinations by the Secretary. The Department has concluded that the cost of such determinations will be small relative to the cost of settling such disputes through litigation or other currently available means.

The regulation's elements are grounded in documentation that plans or their agents generally maintain as part of usual business practices. The regulation also has some elements of flexibility, allowing plans 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 embrace all plans established or

maintained under or pursuant to one or more collective bargaining agreements and exclusive enough to ensure the applicability of state regulation wherever such is not the case. Only a very small number of entities are likely to be treated differently under the regulation than they are now. Plans will be determined to be MEWAs only when they are not established or maintained under or pursuant to a collective bargaining agreement, in which case the additional cost attributable to state regulation will be outweighed by the benefit of additional protections for participants and beneficiaries.

Background

For the protection of welfare benefit plan participants and beneficiaries, multiple employer welfare arrangements (MEWAs) providing health insurance are subject to both state and federal regulation. An exception to the rule applies to MEWAs established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements. Because collectively bargained employee welfare benefit plans are not subject to state insurance regulation, unscrupulous operators have created arrangements which purport to offer health, life, disability or other welfare benefit insurance and are promoted as plans established or maintained pursuant to one or more collective bargaining agreements, but in fact are not. These operators have sold insurance to employers, usually for reduced premiums, and then have been unable to pay the insurance claims filed by the employees. At the same time, they have retained large administrative fees for themselves.

The General Accounting Office, in a March 1992 Report titled "*Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*," (GAO/HRD-92-40) estimated that sham MEWAs owed \$124 million in claims, affecting 398,000 participants and beneficiaries. State insurance offices, however, were only able to recover \$10 million, often as a result of dissolution of the MEWAs following their insolvency.

At various times, both Congress and the Department have published guidelines in an attempt to help states regulate MEWAs, but, without a definition for a collective bargaining agreement, sham MEWAs have continued to operate and to claim the collective bargaining agreement exception when confronted with state regulation. In order to establish jurisdiction, states initiated administrative or legal proceedings

contesting the defendant's status as a collectively bargained plan or were themselves the subject of declaratory judgment or removal actions by entities claiming the exception. Likewise, for both MEWAs and some plans established or maintained under collective bargaining agreements, there was uncertainty about their legal status and, consequently, about the applicability of insurance regulations and the recordkeeping and reporting required.

Reducing Uncertainty

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. With this proposed regulation pertaining to the collective bargaining agreement exception applicable to MEWAs (ERISA section 3(40)(A)(i)), the Department is promulgating a set of guidelines which will aid employers, third parties, and participants and beneficiaries of plans, as well as state agencies, in determining the legal status of a welfare benefit plan. Specifically, the proposed regulation sets out the various factors indicative of when a plan is established or maintained under or pursuant to a *bona fide* collective bargaining agreement.

The regulation proposed today will benefit states and plans by providing a tool with which to independently determine the legal status of a welfare benefit plan or arrangement without recourse to the Department or to the courts. The result will be a positive limitation of uncertainty for plans and arrangements and the states, and a reduction in time and expense attributable to court actions or requests to the Department for guidance. Plans and arrangements will benefit from the assurance of knowing their correct legal status, and states, through warranted intervention, will be better able to protect employers, participants, and beneficiaries from unscrupulous MEWA operators.

For the majority of plans established or maintained under or pursuant to collective bargaining agreements, this regulation will serve to codify the manner in which the plans are currently operating. Plan status under the regulation generally will be clear based on signed agreements, filings with the IRS, participation in related industries, or other design features which categorize a plan as a collectively bargained plan or a MEWA. Most plans, therefore, will not perceive any need to reassess their status systematically. It is

possible, however, that some plans will undertake such an assessment and comparison test. The Department has estimated below the number of plans likely to comparison test.

Under ERISA, multiemployer collectively bargained plans are required to file an annual financial report, the Form 5500. Data from the 1995 filings showed 2,180 filings (6.0 million participants) from ERISA multiemployer welfare benefit plans established or maintained under or pursuant to collective bargaining agreements. The Department also examined the number of MEWAs. Preliminary findings of an analysis conducted by the RAND Corporation of data from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey, indicate that there are approximately 2,000 MEWAs (both ERISA-plan and non-ERISA-plan MEWAs), covering 4.1 million employees. The total number of MEWAs and collectively bargained plans, which represents the total universe of arrangements that might question their legal status and comparison test under this proposed regulation, is 4,180. (10.1 million participants).

The Department was unable to identify any direct measure of the number of plans or arrangements whose status is uncertain or whose status would remain uncertain under the proposed regulation. Therefore, in order to assess the economic impact of reduced uncertainty under the proposed regulation, the Department examined proxies for the number of arrangements that might be subject to such uncertainty. First, the Department estimated the total number of MEWAs and collectively bargained plans, taking this to reflect the universe of arrangements which would encompass the small subset of arrangements subject to uncertainty. 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 arrangements that have been subject to uncertainty in the past.

Department data indicate that for the ten-year period from 1990 to 1999, the Department received 88 MEWA-related inquiries. These include inquiries received from state and federal agencies and the private sector. On an annualized basis, this represents approximately 9 MEWA-related requests for information per year. The Department also considered the number of MEWA-related lawsuits which were filed during the years 1990-1999. Department data indicate that it has been a party to 375

civil and 75 criminal cases from 1990–1999. The total number of lawsuits would be 450 lawsuits, or 45 lawsuits annually. For purposes of this analysis, it has been assumed that each case involves a different arrangement. Accordingly, the estimated number of arrangements that historically may have demonstrated uncertainty over their legal status would be 9 plus 45, or 54 plans per year. The estimated 54 plans, as a percentage of the total number of 4,180 MEWAs and collectively bargained plans, amounts to approximately 1.3 percent.

In one sense, this historical number of plans and arrangements may represent only a subset of all those that faced uncertainty over their status. Some plans and arrangements may have confronted uncertainty but not become the subject of an inquiry to the Department or a lawsuit to which the Department was party. On the other hand, this number overstates the number of plans and arrangements that faced uncertainty because it is known that only a portion of miscellaneous inquiries and civil and criminal actions involved issues related to collective bargaining agreements or other MEWA-related matters. The number may also overstate the number of plans or arrangements likely to face uncertainty because the issue of whether federal preemption applies is not presented in suits brought by the federal government; ERISA generally applies both to plans and to MEWAs. The Department therefore views 54 plans per year as a conservatively high estimate of the number of plans or arrangements that might perceive a need to systematically assess their status under the proposed regulation.

The cost to the 54 plans of conducting such an assessment is expected to be small. It will largely be attributed to reviewing records kept by third parties or by the plan or arrangement in the ordinary course of business. The Department assumes that this review requires 16 hours of a lawyer's or comparable professional's time plus 5 hours clerical staff time. Department data suggest that average compensation costs for lawyers and clerical workers amount to \$72 per hour and \$21 per hour respectively. Third party service providers to plans or arrangements, such as private law firms, typically bill at higher rates than this. However, it is expected that the cost of an in-house attorney will equate to the cost of a firm attorney due to firms' efficiencies of time and resources attributable to specialists' greater expertise and experience in a given field. The total cost then would be \$1,173 per plan or

arrangement, or about \$63,342 on aggregate per year for 54 plans. This cost would be incurred only once for a given plan or arrangement unless its circumstances changed substantially relative to the standard. It is expected that this cost will be far outweighed by savings to plans and arrangements from avoiding 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 from this proposed regulation.

Following such assessments, some fraction of these 54 plans or arrangements might nonetheless dispute a state's assertions of jurisdiction and consequently seek an administrative determination from the Secretary, incurring attendant costs. The Department has elected to attribute the net benefit from these savings not to this proposed regulation, but to the accompanying proposed regulation that established an administrative process for determining such plans' or arrangements' status.

Reclassifying Incorrectly Classified Plans and Arrangements

Some number of plans, but unlikely any more than the same fraction of the 54 estimated to face uncertainty over status, will be reclassified as a result of comparison testing against the proposed regulation's standard. Plans formerly classified (either by error or intentionally self-classified in an attempt to avoid state law requirements) as collectively bargained plans may be newly classified as MEWAs under this proposed regulation. These MEWAs will incur costs to comply with newly applied protective state regulations. Applicable regulations 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 reserving, 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.

The Department considered an estimate of the cost to plans newly classified as MEWAs as follows. Relevant literature suggests that in the upper range these costs can amount to 10 percent of premium. (The cost may be substantially more than this if the arrangement would otherwise have benefitted from insuring a population whose health costs are far lower than average. However, these added costs

would be transfers and not true economic costs, because they would serve as cross-subsidies which reduce costs for populations that are costlier than average.) As noted above, the universe of 4,180 plans and arrangements that includes those potentially subject to uncertainty covered 10.1 million participants, or about 2,400 participants per arrangement 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 plans or arrangements that might face uncertainty over status—an upper bound on the number likely to be reclassified—produces an upper-bound estimate cost of about \$58 million.

The Department has concluded that actual costs will be far lower than this, and will be outweighed by the benefit of the associated protections. As noted above, it is likely that the true number of arrangements that are reclassified will be a fraction of the estimated 54 that might face uncertainty over status. Among those that are reclassified, some would have voluntarily elected to comply with state regulatory requirements and therefore would not incur any cost from the application of state law. For those that would not have provided such benefits, the cost of providing them would largely be offset by the benefits themselves. Most important, the added cost from state regulation would be offset by the benefits from the protections that state regulation provide. GAO in 1992 identified \$124 million in unpaid claims owed by sham MEWAs. Department enforcement actions separately identified MEWA monetary violations of \$84 million, and more than 100 investigations remain open. 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 \$84 million in violations would most likely not have occurred.

It is also possible that some plans or arrangements heretofore classified as MEWAs will be reclassified as collectively bargained plans. However, it seems unlikely that many will, because those that can qualify as collectively bargained plans have an economic incentive to do so. Any that are so classified may choose to benefit from savings, there being no obligation to comply with state regulatory requirements. There will be no meaningful loss of benefits from the removal of state protections in such cases because the combination of a legitimate collective bargaining

agreement and the application of ERISA provides adequate protections.

Paperwork Reduction Act

This Notice of Proposed 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).

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 proposed rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of analysis under the RFA, PWBA proposes to continue 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 the Employee Retirement Income Security Act of 1974 (ERISA), which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which 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 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, PWBA believes that assessing the impact of this proposed 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 which 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.*). PWBA therefore requests comments on the appropriateness of the size standard used in evaluating the impact of this proposed rule on small entities.

On this basis, however, PWBA has preliminarily 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, PWBA has prepared the following regulatory flexibility analysis.

(1) Reasons for Action. PWBA is proposing this regulation because it believes that regulatory guidance in determining criteria for what is 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), 29 U.S.C. § 1002(40)(a)(1) is necessary to ensure: (a) That state insurance regulators have ascertainable guidelines to help regulate MEWAs operating in their jurisdictions, and; (b) that sponsors of employee welfare benefit plans will be able to determine independently whether their plans are excepted plans under section 3(40) of ERISA. A more detailed discussion of the agency's reasoning for issuing the proposed regulation is found in the Background section, above.

(2) Objective. The objective of the proposed regulation is to provide criteria for the application of an exception to the definition of the term "multiple employer welfare arrangement" (MEWA) which is found in ERISA section 3(40). An extensive list of authority may be found in the Statutory Authority section, below.

(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. The basis of this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. For this purpose, it is assumed that arrangements with fewer than 100 participants and which are: (1) Multiemployer collectively bargained group health plans; (2) non-collectively

bargained multiple employer group health plans, or; (3) other multiple employer arrangements which provide medical benefits, are small plans. PWBA believes that assessing the impact of this proposed rule on small plans is an appropriate substitute for evaluating the effect on small entities as that term is defined in the RFA. No small governmental jurisdictions will be affected.

IRS filings and Department data indicate that there are a possible 4,180 plans that could be classified as a collectively bargained plan or a MEWA and that could be affected by the new criteria for defining what is a collective bargaining agreement. It is expected, however, that a very small number of these arrangements will have fewer than 100 participants. By their nature, the affected arrangements must involve at least two employers, which decreases the likelihood of coverage of fewer than 100 participants. Also, underlying goals of the formation of these arrangements, such as gaining purchasing and negotiating power through economies of scale, improving administrative efficiencies, and gaining access to additional benefit design features, are not readily accomplished if the group of covered lives remains small. While there are no statistics to determine the number of small plans among the 4,180, 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, research data indicates that there are more than 2.5 million private group health plans with fewer than 100 participants. Thus, even if every one of the 4,180 plans included fewer than 100 participants, which is highly unlikely, the number of plans 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 arrangements are expected to be affected by this proposal, it is known that the employers typically involved in these plans or arrangements 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)). The Department knows of no data that would support a direct measure of the number of small employers potentially impacted by the proposed regulation. However, because

these plans and arrangements involve at least two employers, and assuming conservatively that each is small, it can be estimated that at least 8,360 small employers may be affected. The Department seeks comments and supporting data with respect to the number of small employers potentially impacted by the establishment of a standard for determining whether a welfare plan is established or maintained under or pursuant to one or more collective bargaining agreements.

In addition, any one of the employers participating in a MEWA or plan established or maintained under or pursuant to a collective bargaining agreement may find that it has unknowingly participated in a sham MEWA and will need to join a new plan. By restricting fraudulent and financially unsound MEWAs, therefore, the proposed regulation may limit the sources of health care, life, disability or other welfare benefit coverage offered to some small businesses, requiring them to seek alternative coverage for their employees. The greater benefit for employers, however, is that there is an increased certainty that the remaining MEWAs will meet state regulatory standards and will be capable of providing 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. No identical reporting or recordkeeping is required under the proposed rule. 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 will be routinely prepared and held by a collectively bargained multiemployer plan in the ordinary course of business. For any plans which are newly determined to be MEWAs, there will be an economic impact related to the start-up costs of compliance with state regulations. Start-up costs may include expensing 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 proposed rule.

(6) Alternatives. The proposed regulation represents the consensus report of a committee established to provide an alternative to a Department Notice of Proposed Rulemaking on Plans Established or Maintained pursuant to Collective Bargaining Agreements, published in the **Federal Register** in 1995. At that time, recognizing that guidance was needed to clarify the collective bargaining exception to the MEWA regulation, the Department proposed certain criteria related to describing the collective bargaining agreement. Commenters on the proposal expressed concerns related to plan compliance and the issue of state regulation.

Based on the comments received, the Department turned to negotiated rulemaking as an appropriate alternative to implementing a revised Notice of Proposed Rulemaking. In September 1998, the Secretary established the ERISA Section 3(40) Negotiated Rulemaking Advisory Committee under the Negotiated Rulemaking Act. (5 U.S.C. 561 *et seq.*) The Committee membership 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. This regulation represents the Committee's consensus, in the form of a proposed rule, for guiding state governments and plans in determining whether an entity has been established or maintained under or pursuant to one or more collective bargaining agreements and is therefore not subject to state regulation. Based on the fact that this Notice of Proposed Rulemaking is the result of a Committee decision by consensus, and the fact that the Committee represents a cross section of the state, federal, association, and private sector health care universe, the Department believes that as an alternative to the 1995 NPRM this regulation will accomplish the stated objectives of the Secretary and will have a beneficial impact on small employer participation in MEWAs. The Department has concluded that the proposed regulation is less costly in comparison with alternative methods of determining compliance with section 3(40), such as case-by-case analysis by PWBA of each employee welfare plan or litigation. In addition, not defining specific guidelines for compliance with section 3(40) and permitting sham MEWAs to continue to function would raise costs to small businesses in terms

of loss of coverage and unpaid claims. No other significant alternatives which would minimize economic impact on small entities have been identified.

It would be inappropriate to create an exemption under the proposed regulation for small MEWAs because small MEWAs are not less likely to be underfunded or otherwise have inadequate reserves to meet the benefit claims submitted for payment than are large MEWAs.

Small Business Regulatory Enforcement Fairness Act

The rule being issued here is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and, if finalized, will be 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.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub.L. 104-4), 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.

Executive Order 13132

When an agency promulgates a regulation that has federalism implications, Executive Order 13132 (64 FR 43255, August 10, 1999), requires that the Agency 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 proposed regulation has federalism implications because it sets forth standards and procedures for determining whether certain entities

may be regulated under certain state law 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 representative from the National Association of Insurance Commissioners (NAIC), which represents the interests of state governments in the regulation of insurance, participated in this rulemaking from the inception of the Negotiated Rulemaking Committee.

In the course of this rulemaking, the NAIC raised the following concerns: (1) That the rule allow MEWAs to be easily distinguishable from collectively bargained plans so that MEWAs may be properly subjected to state jurisdiction and regulation; (2) that the rule prevent the unlicensed sale of health insurance; and; (3) that losses to individuals in the form of unreimbursed and denied medical claims be stopped.

The Department's position with regard to this rulemaking is that there is an overwhelming need for this regulation. Sham operators have been exploiting the lack of regulation in this area by claiming to be established or maintained pursuant to collective bargaining, thereby avoiding state regulation. These operators have marketed unlicensed health insurance to small employers free of state solvency and reserve requirements and have therefore offered health insurance at significantly cheaper rates than state-licensed insurance companies. Ultimately these operations have gone bankrupt, leaving participants with significant unpaid claims and without health insurance. This regulation will provide objective criteria to distinguish collectively bargained plans from arrangements subject to state insurance law. It will also provide entities that claim to be exempt from state regulation, an expedited procedure to obtain a finding from the Department under certain conditions.

By providing objective criteria distinguishing collectively bargained plans from arrangements subject to state insurance law, the regulation should facilitate state enforcement efforts against arrangements attempting to misuse the collectively bargained exception in section 3(40) of ERISA. In that regard, the regulation should make more difficult the sale of unlicensed insurance under the guise of collectively bargained plans and limit the losses to individuals in the form of unreimbursed and denied medical and other welfare benefit insurance claims resulting from that type of sham arrangement.

Statutory Authority

This regulation is proposed pursuant to the authority in sections 107, 209, 504, and 505 of ERISA (Pub. L. 93-406, 88 Stat. 894, 29 U.S.C. 1027, 1059, 1134, 1135) and under Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

List of Subjects in 29 CFR Part 2510

Collective bargaining, Employee benefit plans, Pensions.

Proposed Regulation

For the reasons set out in the preamble, the Department proposes to amend Part 2510 of Chapter XXV of Title 29 of the Code of Federal Regulations as follows:

PART 2510—[AMENDED]

1. The authority citation for Part 2510 is revised to read as follows:

Secs. 3(2), 3(40), 111(c), 505, Pub. L. 93-406, 88 Stat. 852, 894, (29 U.S.C. 1002(2), 1002(40), 1031, 1135); Secretary of Labor's Order No. 27-74, 1-86, 1-87, and Labor Management Services Administration Order No. 2-86.

Section 2510.3-101 is also issued under sec. 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978), effective December 31, 1978 (44 FR 1065, January 3, 1978); 3 CFR, 1978 Comp., p. 332, and sec. 11018(d) of Pub. L. 99-272, 100 Stat. 82.

Section 2510.3-102 is also issued under sec. 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978), effective December 31, 1978 (44 FR 1065, January 3, 1978); 3 CFR, 1978 Comp., p. 332, and sec. 11018(d) of Pub. L. 99-272, 100 Stat. 82.

2. Section 2510.3-40 is added to read as follows:

§ 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 which is established or maintained under or pursuant to one or more agreements which the Secretary of Labor (the Secretary) finds to be collective bargaining agreements. This section sets forth a finding by the Secretary that an arrangement is an employee welfare benefit plan established or maintained under or pursuant to one or more collective bargaining agreements if the plan meets the criteria in this section. This section also sets forth a finding by the Secretary that certain arrangements are not employee welfare benefit plans established or maintained under or

pursuant to a collective bargaining agreement, regardless of whether they purport to meet the regulatory criteria. No finding by the Secretary 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. The procedure for obtaining a finding by the Secretary 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, is set forth in 29 CFR part 2570, subpart G.

(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 80% 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 welfare benefit 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 agreement referred to in paragraph (b)(2)(i) 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, 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 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, or

(C) Other employee benefit plans or trust funds to which contributions are made pursuant to the same agreement described in paragraph (b)(2)(i) 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)(i) 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 two 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 G, 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:

(i) The agreement referred to in paragraph (b)(3) of this section provide(s) 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 employer pays 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, or coverage for excepted benefits under 29 CFR 2590.732(b), is disregarded;

(vii) The predominant employee organization that is a party to the agreement described in paragraph (b)(3) of this section (b)(3) provides, sponsors or jointly sponsors a hiring hall(s) and/or a state-certified apprenticeship program(s) that provide 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.* (1) 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:

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

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

(B) By an individual who is disqualified from or ineligible for, or has failed to obtain, such 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

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

(ii) For the purposes of this paragraph (c):

(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 types of participants under paragraph (b)(2) of this section:

Type of participants	Total number	Nexus group	Non-nexus
1. Individuals working under CBAs	320 (64%)	320 (64%)	0
2. Retirees	50 (10%)	50 (10%)	0
3. "Special Class"—Non-CBA, non-alumni	100 (20%)	50 (10%)	50 (10%)
4. Non-nexus participants	30 (6%)	0	30 (6%)
Total	500 (100%)	420 (84%)	80 (16%)

(2) In determining whether at least 80% 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 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 those individuals who are deemed to be nexus individuals because they are the type of individuals described in paragraph (b)(2)(viii) 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 80% criterion under paragraph (b)(2) because a total of 420 (320 individuals covered by the collective bargaining agreement, plus 50 retirees, plus 50 individuals employed by signatory employers), or 84%, 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 80% test has been met.

Example 2. (1) 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 prior to January 1, 1983.

(2) Assume the same facts, except that on January 1, 1999, International Union MG merged with International Union RE to form International Union 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.

Example 3. Assume the same facts as in paragraph (2) 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, dating back to before January 1, 1983.

Example 4. (1) 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)(3)(vi) of this section.

(2) 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 unrelated to the employees covered by or the employers bound to the collective bargaining agreement, whose insurance carrier has withdrawn from the market in their locality. He persuades them to retain him to find them other coverage. The group of clients 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, which makes Fund M a MEWA under paragraph (c)(1) of this section.

Example 7. (1) 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.

(2) In this example, Plan A qualifies for the regulatory finding 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 80% 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. (1) 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 websites publicizing the new arrangement with the Medical Consortium. Concurrently, Medical Consortium's website 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.

(2) 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. (1) 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.

(2) 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. (1) 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 23% of the population of Plan A during the current Plan Year.

(2) In this example, Plan A now fails to meet the criteria in paragraphs (b)(2) and (b)(3) of this section, because more than 20% of its participants are individuals who are not employed under agreements that are the product of *bona fide* collective bargaining relationship and who do not fall within any of the other nexus categories set forth in paragraph (b)(2). Moreover, even if the number of additional participants enrolled through the Medical Consortium, together with any other participants that did not fall within any of the nexus categories, did not exceed 20% 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 part 2570, subpart G of this chapter 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 part 2570, subpart G of this chapter, will constitute a finding that the employee welfare benefit plan at issue in that proceeding is 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 part 2570, subpart G 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 of a subpoena.

(h) *Effective date.* This regulation is effective December 26, 2000.

Signed this 16th day of October 2000.

Leslie B. Kramerich,

Acting Assistant Secretary, Pension and Welfare Benefits Administration.

[FR Doc. 00-27044 Filed 10-26-00; 8:45 am]

BILLING CODE 4510-29-P

DEPARTMENT OF LABOR

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

ACTION: Proposed rule.

SUMMARY: This document contains proposed rules under the Employee Retirement Income Security Act of 1974, as amended (ERISA), 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. The procedure for administrative hearings would be 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 for plans established or maintained under or pursuant to one or more collective bargaining agreements. Under Section

3(40) of ERISA, the Secretary may make a determination that an employee welfare benefit plan is a collectively bargained plan, and thereby excluded from the definition of "multiple employer welfare arrangements" under section 3(40) of ERISA, which are otherwise subject to state regulation of multiple employer welfare arrangements as provided for by ERISA. A separate document is being published today in the **Federal Register** containing proposed rules 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. If adopted, these proposed rules would affect employee welfare benefit plans, their sponsors, participants, and beneficiaries as well as service providers to plans.

DATES: Written comments concerning the proposed regulation must be received by December 26, 2000.

ADDRESSES: Interested persons are invited to submit written comments (preferably three copies) concerning this proposed regulation to: Pension and Welfare Benefits Administration, Room N-5669, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210, (Attention: Proposed Regulation Under Section 3(40)). All submissions will be open to public inspection at the Public Documents Room, Pension and Welfare Benefits Administration, Room N-5638, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210.

FOR FURTHER INFORMATION CONTACT: Elizabeth A. Goodman, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, Room N-5669, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210, (202) 219-8671. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

A. Background

This document contains proposed rules describing procedures for administrative hearings to obtain a determination by the Secretary as to whether a particular 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. The procedure for administrative hearings would be 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 for plans established or maintained under or pursuant to one or