DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2510

RIN 1210–AA48

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

AGENCY: Employee Benefits Security Administration, Labor.

ACTION: Final rule.

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

EFFECTIVE DATE: June 9, 2003.

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

SUPPLEMENTARY INFORMATION:

A. Background

The Statute

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

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

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

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

The Proposed Regulations

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

The proposed regulations followed the recommendations of the ERISA section 3(40) Negotiated Rulemaking Advisory Committee (the Committee). The Committee was convened under the Negotiated Rulemaking Act (the NRA)

and the Federal Advisory Committee Act (the FACA), 5 U.S.C. App. 2, to assist the Department in developing proposed regulations to implement section 3(40)(A)(i) of ERISA, 29 U.S.C. 1002(40)(A)(i).

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

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

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

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

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

Public Comments

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

The following discussion summarizes the issues raised by the public comments, the Committee's discussion of those issues at the public meeting, and the Department's decisions, which are reflected in the final regulations.

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

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

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

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

The Department also declines to add to the factors, as suggested by one commenter, the fact that the plan is maintained on sound actuarial principles. Although maintaining a plan on sound actuarial principles is important in other regards, that a plan is actuarially sound does not necessarily

evidence the existence of a *bona fide* collective bargaining relationship.

The Department notes, however, that the final regulations are structured to take into account the possibility that a *bona fide* collective bargaining relationship might, in some case, fail to meet the ''safe harbor'' factors. In addition to including the ninth catch-all factor, the regulations permit entities that assert they are in fact established or maintained under or pursuant to *bona fide* collective bargaining, and against which state law or jurisdiction is asserted, to petition for an individualized finding from the Department as to their status.

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

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

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

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

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

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

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

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

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

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

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

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

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

One commenter expressed concern that the availability of administrative proceedings for an individualized section 3(40) finding in cases where the

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

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

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

Miscellaneous Changes

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

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

Independent of the Committee's review of the regulations, the Department considered whether the proposed 80% minimum coverage requirement for the ''nexus'' test is too low. In the August 1, 1995, proposed regulation, the Department proposed that no less than 85% of the individuals covered by a plan must be within the ''nexus'' group. A number of commenters on that regulation expressed concern that the percentage was too high. In developing a new proposal, the Committee recommended, and the Department proposed, an 80% test. In this regard, the preamble to the proposal indicated that ''[t]he Committee recommended a 20% margin for coverage of non-nexus people, even though it understood that the percentage of participants in collectively bargained plans who are not within one of the nexus categories is rarely likely to be that high.'' 65 FR 64485 (Oct. 27, 2000). While comments were specifically invited on the 80% test, no comments were received on that provision. Moreover, the Department received no comments suggesting that changing the 80% test to an 85% test would present a problem for affected plans. The Department further notes that H.R. 2563 of the 107th Congress, the ''Bipartisan Patients Protection Act,'' as passed by the U.S. House of Representatives, among other things, amends ERISA section 3(40)(A)(i) to clarify the standards applicable to determining whether a plan is established or maintained pursuant to collective bargaining agreements. *See* section 423 of H.R. 2563. Although similar in many respects to the regulatory standards proposed by the Department, H.R. 2563

limits the percentage of non-nexus group individuals to 15 percent.

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

B. Economic Analysis Under Executive Order 12866

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

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

Summary

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

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

Background

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

Confusion about whether a plan was established or maintained under or pursuant to an agreement which the Secretary finds to be a collective bargaining agreement has made it difficult for the states to enforce appropriate laws. The criteria regulation will reduce or eliminate this uncertainty. It will provide greater clarity for entities and states and reduce the time and expense attributable to court actions or requests to the Department for guidance.

Benefits of the Regulation—Reducing Uncertainty

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

Costs of the Regulation

Entities Potentially Affected. To estimate the number of entities potentially affected by the final rule, the Department examined available data on multiemployer welfare plans established or maintained under or pursuant to collective bargaining agreements, and the number of entities self-reporting as MEWAs. Under ERISA, multiemployer collectively bargained plans are required to file an annual financial report, the Form 5500. MEWAs are required to file the Form M–1 annually. The 1998 Form 5500 filings by

multiemployer collectively bargained plans numbered about 2,000 (with about 6 million participants). The MEWAs that filed Form M–1 for the year 2000, pursuant to section 101 of ERISA and related interim final rules (65 FR 7152, February 11, 2000) numbered about 600 (with about 2 million participants).[1] The total number of MEWAs and collectively bargained plans, which represents the total universe of arrangements that might have questions about their legal status and ''comparison test'' under this regulation, is estimated at about 2,600 (8 million participants).

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

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

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

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

Following a self-assessment of status, some fraction of these 54 entities might nonetheless find themselves in a situation leading them to seek an administrative determination from the Secretary under the procedural regulations, incurring attendant costs, perhaps because a state's jurisdiction or laws are asserted against the entity. The administrative process under the procedural regulations is, in the Department's view, an efficient and less costly process for resolving such disputes than would be available in the absence of the procedural regulations. The Department has elected to attribute the net benefit from these savings not to this regulation, but to the accompanying procedural regulations.

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

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

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

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

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

upper-bound estimated cost of about $75 million.[3]

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

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

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

C. Paperwork Reduction Act

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

D. Regulatory Flexibility Act

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

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

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

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

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

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

(3) *Estimate of Small Entities Affected.* Form 5500 filings and Form M–1 filings indicate that there are about 2,600 entities that could be classified as collectively bargained plans or MEWAs and that could be affected by the new criteria for defining collectively bargained plans. It is expected, however, that a very small number of these entities will have fewer than 100 participants. By their nature, the affected entities must involve at least two employers, which decreases the likelihood of their covering fewer than 100 participants. Also, the underlying goals behind the formation of these

entities, such as gaining purchasing and negotiating power through economies of scale, improving administrative efficiencies, and gaining access to additional benefit design features, are not readily accomplished if the group of covered lives remains small.

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

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

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

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

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

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

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

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

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

E. Small Business Regulatory Enforcement Fairness Act

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

on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

F. Unfunded Mandates Reform Act

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

G. Executive Order 13132

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

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

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

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

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

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

List of Subjects in 29 CFR Part 2510

Collective bargaining, Employee benefit plans, Pensions.

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

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

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

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

■ 2. Add new section 2510.3–40 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 that is established or maintained under or pursuant to one or more agreements that the Secretary of Labor (the Secretary) finds to be collective bargaining agreements. This section sets forth criteria that represent a finding by the Secretary whether an arrangement is an employee welfare benefit plan established or maintained under or pursuant to one or more collective bargaining agreements. A plan is established or maintained under or pursuant to collective bargaining if it meets the criteria in this section. However, even if an entity meets the criteria in this section, it will not be an employee welfare benefit plan established or maintained under or pursuant to a collective bargaining agreement if it comes within the exclusions in the section. Nothing in or pursuant to this section shall constitute a finding for any purpose other than the exception for plans established or maintained under or pursuant to one or more collective bargaining agreements under section 3(40) of ERISA. In a particular case where there is an attempt to assert state jurisdiction or the application of state law with respect to a plan or other arrangement that allegedly is covered under Title I of ERISA, the Secretary has set forth a procedure for obtaining individualized findings at 29 CFR part 2570, subpart H.

(b) *General criteria.* The Secretary finds, for purposes of section 3(40) of ERISA, that an employee welfare benefit

plan is ''established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements'' for any plan year in which the plan meets the criteria set forth in paragraphs (b)(1), (2), (3), and (4) of this section, and is not excluded under paragraph (c) of this section.

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

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

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

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

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

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

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

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

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

(vi) Individuals employed by:

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

(B) The plan or associated trust fund;

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

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

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

(viii) Individuals (other than individuals described in paragraph (b)(2)(i) of this section) who are employed by employers that are bound by the terms of an agreement described in paragraph (b)(3) of this section and that employ personnel covered by such agreement, and who are covered under the plan on terms that are generally no more favorable than those that apply to such covered personnel. For this purpose, such individuals in excess of 10% of the total population of participants in the plan are disregarded;

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

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

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

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

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

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

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

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

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

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

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

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

(iv) The predominant employee organization that is a party to the agreement referred to in paragraph (b)(3) of this section has been a national or international union, or a federation of

national and international unions, or has been affiliated with such a union or federation, since before January 1, 1983;

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

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

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

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

(ix) There are other objective or subjective indicia of actual collective bargaining and representation, such as that arm's-length negotiations occurred between the parties to the agreement described in paragraph (b)(3) of this section; that the predominant employee organization that is party to such agreement actively represents employees covered by such agreement with respect to grievances, disputes, or other matters involving employment terms and conditions other than coverage under, or contributions to, the employee welfare benefit plan; that there is a geographic, occupational, trade, organizing, or other rationale for the employers and bargaining units covered by such agreement; that there is a connection between such agreement and the participation, if any, of self-employed individuals in the employee welfare benefit plan established or maintained under or pursuant to such agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In determining whether at least 85% of Plan A's participant population is made up of individuals with the required nexus to the collective bargaining agreement as required by paragraph (b)(2) of this section, the Plan may count as part of the nexus group only

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

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

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

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

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

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

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

Example 5. Arthur is a licensed insurance broker, one of whose clients is Multiemployer Fund M, a partially self-funded plan. Arthur takes bids from insurance companies on behalf of Fund M for the insured portion of its coverage, helps the trustees to evaluate the bids, and places the Fund's health insurance coverage with the carrier that is selected. Arthur also assists the trustees of Fund M in preparing material to explain the plan and its benefits to the participants, as well as in monitoring the insurance company's performance under the contract. At the Trustees' request, Arthur meets with a group of employers with which the union is negotiating for their employees' coverage under Fund M, and he explains the cost structure and benefits that Fund M provides. Arthur is not engaged in marketing within the meaning of paragraph (c)(1) of this section, so the fact that he provides these administrative services and sells insurance to the Fund itself does not affect the plan's status as a plan established or maintained under or pursuant to a collective bargaining agreement. This is the case whether or how he is compensated.

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

Example 7. Union A represents thousands of construction workers in a three-state geographic region. For many years, Union A has maintained a standard written collective bargaining agreement with several hundred large and small building contractors, covering wages, hours, and other terms and conditions of employment for all work performed in Union A's geographic territory. The terms of those agreements are negotiated every three years between Union A and a multiemployer Association, which signs on behalf of those employers who have delegated their bargaining authority to the Association. Hundreds of other employers—including both local and traveling contractors—have chosen to become bound to the terms of Union A's standard area agreement for various periods of time and in various ways, such as by signing short-form binders or ''me too'' agreements, executing a single job or project labor agreement, or entering into a subcontracting arrangement with a signatory employer. All of these employ individuals represented by Union A and contribute to Plan A, a self-insured multiemployer health and welfare plan established and maintained under Union A's

standard area agreement. During the past year, the trustees of Plan A have brought lawsuits against several signatory employers seeking contributions allegedly owed, but not paid to the trust. In defending that litigation, a number of employers have sworn that they never intended to operate as union contractors, that their employees want nothing to do with Union A, that Union A procured their assent to the collective bargaining agreement solely by threats and fraudulent misrepresentations, and that Union A has failed to file certain reports required by the Labor Management Reporting and Disclosure Act. In at least one instance, a petition for a decertification election has been filed with the National Labor Relations Board. In this example, Plan A meets the criteria for a regulatory finding under this section that it is a multiemployer plan established and maintained under or pursuant to one or more collective bargaining agreements, assuming that its participant population satisfies the 85% test of paragraph (b)(2) of this section and that none of the disqualifying factors in paragraph (c) of this section is present. Plan A's status for the purpose of this section is not affected by the fact that some of the employers who deal with Union A have challenged Union A's conduct, or have disputed under labor statutes and legal doctrines other than ERISA section 3(40) the validity and enforceability of their putative contract with Union A, regardless of the outcome of those disputes.

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

Example 9. Assume the same facts as in Example 7. Union A undertakes an area-wide organizing campaign among the employees of all the health care providers who belong to the Medical Consortium. When soliciting individual employees to sign up as union members, Union A distributes Plan A's information materials and promises to bargain for the same coverage. At the same time, when appealing to the employers in the Medical Consortium for voluntary recognition, Union A promises to publicize the Consortium's status as a group of unionized health care service providers. Union A eventually succeeds in obtaining recognition based on its majority status among the employees working for Medical Consortium employers. The Consortium, acting on behalf of its employer members, negotiates a collective bargaining agreement with Union A that provides terms and conditions of employment, including coverage under Plan A. In this example, Plan A still meets the criteria for a regulatory finding that it is collectively bargained under section 3(40) of ERISA. Union A's recruitment and representation of a new occupational category of workers unrelated to the construction trade, its promotion of attractive health benefits to achieve organizing success, and the Plan's resultant growth, do not take Plan A outside the regulatory finding.

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

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

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

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

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

Signed this 31st day of March 2003.

Ann L. Combs,

Assistant Secretary, Employee Benefits Security Administration.

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DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2570

RIN 1210–AA48

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

AGENCY: Employee Benefits Security Administration, Department of Labor.

ACTION: Final rule.

SUMMARY: This document contains regulations under the Employee Retirement Income Security Act of 1974, as amended, (ERISA or the Act) describing procedures for administrative hearings to obtain a determination by the Secretary of Labor (Secretary) as to whether a particular employee welfare benefit plan is established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40) of ERISA. An administrative hearing is available