

# MEWAs

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

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U.S. Department of Labor  
Employee Benefits Security Administration



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U.S. Department of Labor  
Employee Benefits Security Administration  
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# Table of Contents

<b>Foreword</b>	<b>1</b>
<b>Introduction</b>	<b>3</b>
<b>Regulation of Multiple Employer Welfare Arrangements under ERISA</b>	<b>5</b>
What is an “employee welfare benefit plan”?	6
What is an “employer”?	7
What is an “employee organization”?	9
What types of plans are excluded from coverage under Title I of ERISA?	10
What requirements apply to an employee welfare benefit plan under Title I of ERISA?	11
To what extent does ERISA govern the activities of MEWAs that are not “employee welfare benefit plans”?	15
<b>Regulation of Multiple Employer Welfare Arrangements under State Insurance Laws</b>	<b>17</b>
What is the general scope of ERISA preemption?	17
What is a “multiple employer welfare arrangement”?	19
Does the arrangement offer or provide benefits to the employees of two or more employers?	20
Is the arrangement excluded from the definition of “MEWA”?	24
To what extent may States regulate ERISA-covered welfare plans that are MEWAs?	27
<b>Form M-1 Filing Requirement for MEWAs</b>	<b>31</b>
<b>ERISA Advisory Opinions</b>	<b>35</b>

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<b>ERISA Enforcement</b>	<b>37</b>
<b>Appendix A - Advisory Opinions and Information Letters</b>	<b>39</b>
Advisory Opinion 90-18A	
Advisory Opinion 92-05A	
Advisory Opinion 2007-06A	
UEVEBA Letter	
<b>Appendix B - Advisory Opinion Procedure</b>	<b>55</b>
<b>Appendix C - Regulations</b>	<b>59</b>

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## Foreword

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

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## Introduction

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

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

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

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

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

The Patient Protection and Affordable Care Act (ACA) established a multipronged approach to MEWA abuses. Improvements in reporting, together with stronger enforcement tools, are designed to reduce MEWA fraud and abuse. These include expanded reporting and required registration with the Department of Labor prior to operating in a State. The additional information provided will enhance the State and Federal governments' joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor authority to issue a cease and desist order when a MEWA engages in fraudulent or other abusive conduct and issue a summary seizure order when a MEWA is in a financially hazardous condition.

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

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

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## Regulation of Multiple Employer Welfare Arrangements under ERISA

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

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

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

Under current law, a MEWA that constitutes an ERISA-covered plan is required to comply with the provisions of Title I of ERISA applicable to employee welfare benefit plans, in addition to any State insurance laws that may be applicable to the MEWA. If a MEWA is determined not to be an ERISA-covered plan, the persons who operate or manage the MEWA may nonetheless be subject to ERISA’s fiduciary responsibility provisions if such persons are responsible for, or exercise control over, the assets of ERISA-covered plans. In both situations, the Department of Labor would have concurrent jurisdiction with the State(s) over the MEWA.

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

❑ **What is an “employee welfare benefit plan”?**

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

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

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

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

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

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

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

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

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

#### **□ What is an “employer”?**

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

*any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.*

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

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

The following factors are considered in determining whether a bona fide group or association of employers exists for purposes of ERISA: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed; the purposes for which it was formed and what, if any, were the pre-existing relationships of its members; the powers, rights and privileges of employer-members; and who actually controls and directs the activities and operations of the benefit program. In addition, employer-members of the group or association that participate in the benefit program must, either directly or indirectly, exercise control over that program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the benefit program. It should be noted that whether employer-members of a particular group or association exercise control in substance over a benefit program is an inherently factual issue on which the Department generally will not rule.

Where no bona fide group or association of employers exists, the benefit program sponsored by the group or association would not itself constitute an ERISA-covered welfare plan; however, the Department would view each of the employer-members that utilizes the group or association benefit program to provide welfare benefits to its employees as having established separate, single-

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employer welfare benefit plans subject to ERISA. In effect, the arrangement sponsored by the group or association would, under such circumstances, be viewed merely as a vehicle for funding the provision of benefits (like an insurance company) to a number of individual ERISA-covered plans.

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

### ❑ What is an “employee organization”?

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

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

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

The second part of the definition of “employee organization” includes:

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

While the term “employees’ beneficiary association” is not defined in Title I of ERISA, the Department of Labor applies the same criteria it utilized in construing that term under the Welfare and Pension Plans Disclosure Act, which preceded ERISA’s enactment. Applying those criteria, an organization or association would, for purposes of ERISA Section 3(4), be an “employees’ beneficiary association” only if: **(1)** membership in the association is conditioned on employment status (i.e., members must have a commonality of interest with respect to their employment relationships); **(2)** the association has a formal organization, with officers, by-laws, or other indications of formality;

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(3) the association generally does not deal with an employer (as distinguished from organizations described in the first part of the definition of “employee organization”); and (4) the association is organized for the purpose, in whole or in part, of establishing an employee benefit plan. In order to be an employee organization under either part of section 3(4) of ERISA, the functions and activities of the organization must be in fact controlled by its members, either directly or through the regular election of directors, officers, etc. See, e.g. Advisory Opinion 1992-19A (participation in employees beneficiary association means control).

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

#### **❑ What types of plans are excluded from coverage under Title I of ERISA?**

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

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

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

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

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

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

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

The plan administrator also is required, under Part 1, to file with the Department an annual report (the Form 5500 Series) each year which contains financial and other information concerning the operation of the plan. The Form 5500 Series is a joint Department of Labor - Internal Revenue Service - Pension Benefit Guaranty Corporation annual report form series. The forms are filed with the Department of Labor, which processes the forms and furnishes the data to the Internal Revenue Service. Pursuant to regulations issued by the Department, all welfare plans required to file a Form M-1, *Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)*, must file an annual report with the Department regardless of the plan size or type of funding, and include information on compliance with the Form M-1 filing requirements as part of the Form 5500 filing. (See: page 31 for information regarding the Form M-1 filing requirements.)

If a plan administrator is required to file an annual report, the administrator also generally is required to furnish participants and beneficiaries with a summary of the information contained in that annual report, i.e., a summary annual report.

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

Part 4 of Title I, 29 U.S.C. §§1101 - 1114, sets forth standards and rules governing the conduct of plan fiduciaries. In general, any person who exercises discretionary authority or control respecting the management of a plan or respecting management or disposition of the assets of a plan is a “fiduciary” for purposes of Title I of ERISA. Under ERISA, fiduciaries are required, among other things, to discharge their duties “solely in the interest of plan participants and beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan.” In discharging their duties, fiduciaries must act prudently and in accordance with documents governing the plan, insofar as such documents are consistent with ERISA. (See: ERISA Section 404.) Part 4 also describes certain transactions involving a plan and certain parties, such as the plan fiduciaries, which, as a result of the inherent conflicts of interest present, are specifically prohibited (See: ERISA Section 406). In certain instances there may be a statutory exemption or an administrative exemption, granted by the Department, which permits the parties to engage in what would otherwise be a prohibited transaction, if the conditions specified in the exemption are satisfied (See: ERISA Section 408).

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

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

Part 6 of Title I, 29 U.S.C. §§1161 - 1168, contains the “continuation coverage” provisions, also referred to as the “COBRA” provisions because they were enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. In general, the continuation coverage provisions require that participants and their covered dependents be afforded the option of maintaining coverage under their health benefit plan, at their own expense, upon the occurrence of

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certain events (referred to as “qualifying events”) that would otherwise result in a loss of coverage under the plan. “Qualifying events” include, among other things:

- *death of the covered employee, termination (other than by reason of an employee’s gross misconduct), or reduction of hours of covered employment;*
- *divorce or legal separation of the covered employee from the employee’s spouse;*
- *a dependent child ceasing to be a dependent under the generally applicable requirements of the plan.*

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

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

Part 7 of Title I of ERISA, 29 U.S.C. §1181 *et seq.*, contains provisions setting forth specific benefit requirements applicable to group health plans and health insurance issuers under the Health Insurance Portability and Accountability Act (HIPAA), the Newborns’ and Mothers’ Health Protection Act (Newborn’s Act), the Mental Health Parity Act (MHPA), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Women’s Health and Cancer Rights Act (WHCRA), the Genetic Information Nondiscrimination Act (GINA), Michelle’s Law, and the Patient Protection and Affordable Care Act (Affordable Care Act).

The HIPAA portability rules, at Section 701 of ERISA, place limitations on a group health plan’s ability to impose preexisting condition exclusions and provides special enrollment rights for certain individuals that lose other health coverage or who experience a life change. Section 702 contains HIPAA’s nondiscrimination rules that prohibit plans or issuers from establishing rules for eligibility to enroll in the plan or charging individuals higher premium amounts

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based on a health factor. In addition, Section 703 of Part 7 sets forth provisions for guaranteed renewability in MEWAs and multiemployer plans.

The Newborns' Act (in Section 711 of ERISA) generally requires group health plans that offer maternity hospital benefits for mothers and newborns to pay for at least a 48-hour hospital stay for the mother and newborn following normal childbirth or a 96-hour hospital stay following a cesarean. MHPA, at Section 712, provides for parity in the application of annual and dollar limits on mental health benefits with annual lifetime dollar limits on medical/surgical benefits. MHPAEA generally requires employment-based group health plans and health insurance issuers that provide group health coverage for mental health/substance use disorders to maintain parity between such benefits and their medical/surgical benefits. WHCRA, at Section 713, provides protections for patients who elect breast reconstruction or certain other follow-up care in connection with a mastectomy. GINA expands the genetic information nondiscrimination protections included in HIPAA. Under GINA, group health plans and health insurance issuers cannot base premiums for a plan or a group of similarly situated individuals on genetic information. GINA generally prohibits plans and issuers from requesting or requiring an individual to undergo genetic testing, and prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes. Michelle's Law prohibits group health plans and issuers from terminating coverage for a dependent child, whose enrollment in the plan requires student status at a postsecondary educational institution, if student status is lost as a result of a medically necessary leave of absence.

The Affordable Care Act added a new Section 715 of ERISA to incorporate the market reform provisions of the Public Health Service (PHS) Act into ERISA and the Code, and make them applicable to group health plans and health insurance issuers providing group health insurance coverage. The Affordable Care Act also amended Section 101(g) of ERISA to mandate that the Secretary of Labor require MEWAs to register prior to operating in a state. Section 6605 of the Affordable Care Act added Section 521 to ERISA which authorizes the Secretary to issue a cease and desist order without prior notice or hearing when it appears that the conduct of a MEWA is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. It also provides for issuance of a summary seizure order when it appears that a MEWA is in a financially hazardous condition.

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**❑ To what extent does ERISA govern the activities of MEWAs that are not “employee welfare benefit plans”?**

The Department’s authority is not limited to MEWAs that are employee welfare benefit plans. When the sponsor of an ERISA-covered single-employer plan purchases health care coverage for its employees from a MEWA the persons operating the MEWA typically exercise discretionary authority or control over the management of those ERISA-covered plans or control over the assets of such plans, such as in the payment of administrative expenses and in the making of benefit claim determinations. In doing so, the persons operating the MEWA would be performing fiduciary acts that are governed by ERISA’s fiduciary provisions. Where a fiduciary breaches statutorily mandated duties under ERISA, or where a person knowingly participates in such breach, the U.S. Department of Labor may pursue civil sanctions.

Moreover, a MEWA that offers benefits in connection with one or more ERISA-covered plans may be subject to other enforcement actions under ERISA. When it appears that a MEWA is engaging in conduct that is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury the Department may issue an ex parte cease and desist order. (See: ERISA Section 521(a) and 29 C.F.R. §2560.521-1(c).) MEWAs may also be subject to summary seizure orders if it appears that they are in a financially hazardous condition. (See: ERISA Section 521(e) and 29 C.F.R. §2560.521-1(f).) Criminal penalties may also apply, including if they make false statements in connection with the sale or marketing of the MEWA. (See: ERISA Sections 501(b) and 519.)

While the Department may pursue enforcement actions with respect to MEWAs, it is important to note that, in many instances, States may be able to take quicker action than the Department upon determining that the MEWA has failed to comply with licensing, contribution or reserve requirements under State insurance laws. Because of the factual and transactional nature of fiduciary breach determinations in particular, investigations of possible fiduciary breaches tend to be very complex and time-consuming and thus, may take considerably longer.



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## Regulation of Multiple Employer Welfare Arrangements under State Insurance Laws

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

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

### ❑ What is the general scope of ERISA preemption?

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

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

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

In determining whether a State law may "relate to" an employee benefit plan, the U.S. Supreme Court has determined that the words "relate to" should be construed expansively. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983), the Court held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." (See also: *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985)).

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

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

**(A)** Except as provided in subparagraph (B), nothing in this title [Title I] shall be construed to exempt or relieve any person from any law of any State which regulates insurance....

**(B)** Neither an employee benefit plan..., nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer... for purposes of any law of any State purporting to regulate insurance companies, insurance contracts,....

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

While plans purchasing insurance are, as a practical matter, indirectly affected by State insurance laws (inasmuch as the insurance contracts purchased by the plans are subject to State insurance law requirements), the “deemer clause,” prior to 1983, effectively prevented the direct application of State insurance laws to ERISA-covered employee benefit plans. In 1983, however, ERISA was amended, as part of Public Law 97-473 (January 14, 1983), to add Section 514(b)(6) to ERISA’s preemption provisions.

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

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❑ **What is a “multiple employer welfare arrangement”?**

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

(A) The term “multiple employer welfare arrangement” means **an employee welfare benefit plan, or any other arrangement** (other than an employee welfare benefit plan) which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) [welfare plan benefits] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or arrangement that is established or maintained -

- (i) *under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,*
- (ii) *by a rural electric cooperative, or*
- (iii) *by a rural telephone cooperative association\* (Emphasis supplied.)*

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

*-- the arrangement offers or provides welfare benefits to the employees of two or more employers or to the beneficiaries of*

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

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*such employees (i.e., the arrangement is not a single employer plan); and*

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

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

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

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

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

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

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

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

In the absence of regulations under section 3(40)(B)(iii), the Department would generally follow the Code and Title IV common control rules in interpreting ERISA’s MEWA preemption provisions. The Department, however, believes it is important in interpreting section 3(40)(B)(i) to keep in mind the different policies underlying the section 4001(b) single employer concept and the single employer provision in section 3(40) of ERISA. The effect of single employer treatment under ERISA section 4001(b) and Code section 414(c) is to ignore separate formal business structures of an employer and of businesses under common control with the employer in order to expand with respect to a particular plan the range of businesses subject to certain PBGC liabilities and the range of businesses to which the tax qualification rules would apply. See H. Conf. Rep. 1280, 93d Cong., 2d Sess. 266, 376 (1974); H. Rep. 807, 93d Cong., 2d Sess. 50 (1974). In contrast, Congress’s objective in enacting the MEWA preemption provisions was to remove impediments to the States’ ability to regulate multiple employer welfare arrangements and assure the financial soundness and timely payment of benefits under such arrangements. See 128 Cong. Rec. E2407 (1982) (statement of Congressman Ehrlenborn on the purpose of Pub. L. 97-473 which added ERISA section 3(40) and ERISA section 514(b) reducing the scope of ERISA preemption of State law applicable to ERISA-covered plans that are MEWAs). See Information Letter to The Honorable Mike Kreidler, Insurance Commissioner, Washington Office of Insurance Commissioner (March 1, 2006).

## **2. Plans maintained by groups or associations of unrelated employers**

Questions have been raised as to whether a plan sponsored by a group or association acting on behalf of its employer-members, which are not part of

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a control group, constitutes a “single employer” for purposes of the MEWA definition. The question is premised on the fact that the term “employer” is defined in Section 3(5), 29 U.S.C. §1002(5), to mean “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.” As discussed earlier, the Department has taken the position that a bona fide group or association of employers would constitute an “employer” within the meaning of ERISA Section 3(5) for purposes of having established or maintained an employee benefit plan. (See: page 8).

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

### **3. Plans maintained by employee leasing organizations**

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

Like a bona fide group or association of employers, an employee leasing organization may be an “employer” within the meaning of ERISA Section 3(5) to the extent it is acting directly or indirectly in the interest of an employer. However, as with bona fide groups or associations of employers, “employer” status under Section 3(5) does not in and of itself mean the individuals covered

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by the leasing organization plan are “employees” of the leasing organization. As discussed below, in order for an individual to be considered an “employee” of an “employer” for purposes of the MEWA provisions, an employer-employee relationship must exist between the employer and the individual covered by the plan. In this regard, the payment of wages, the payment of Federal, State and local employment taxes, and the providing of health and/or pension benefits are not solely determinative of an employer-employee relationship. Moreover, a contract purporting to create an employer-employee relationship will not be determinative where the facts and circumstances establish that the relationship does not exist.

#### 4. Determinations as to who is an “employee” of an employer

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

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

In general, whether an employer-employee relationship exists is a question that must be determined on the basis of the facts and circumstances involved. It is the position of the Department that, for purposes of Section 3(6), such determinations must be made by applying common law of agency principles.\*

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

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

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

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

**❑ Is the arrangement excluded from the definition of MEWA?**

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

**1. Plans maintained pursuant to collective bargaining agreements**

Section 3(40)(A)(i) of ERISA specifically excludes from the MEWA definition any plan or other arrangement that is established or maintained "under or pursuant

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

The regulation provides that the entity will be treated as established or maintained under or pursuant to collective bargaining for purposes of the exception in Section 3(40)(A)(i) if it meets three affirmative requirements and does not fall within three exclusions. The affirmative requirements are:

- the arrangement itself is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA;
- at least 85 percent of the participants in the plan who are employed under one or more collective bargaining agreements meeting the requirements of the regulation or who otherwise fall within one of the other categories of persons identified in the regulation as having a “nexus” to the bargaining unit or employers of the bargaining unit employees; and
- the plan is incorporated or referenced in a written agreement between one or more employers and one or more employee organizations, which agreement, itself or together with other agreements among the same parties, is the product of a bona fide collective bargaining relationship between the employer(s) and the employee organization(s) and contains certain terms that ordinarily are in collective bargaining agreements.

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

The regulation provides, however, that a plan will be deemed to be a MEWA even if it ostensibly meets the affirmative criteria described above, if: (1) the

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plan is self-funded or partially self-funded and is marketed to employers or sole proprietors; (2) the principal intent of the purported collective bargaining agreement is to evade compliance with State law and regulations applicable to insurance; or (3) there is fraud, forgery, or willful misrepresentation that the plan satisfies the affirmative criteria in the regulation.

The Department also has promulgated regulations at 29 CFR part 2570, subpart H, providing for administrative hearings to obtain a determination by the Secretary of Labor as to whether a particular entity is an employee welfare benefit plan established or maintained under or pursuant to one or more collective bargaining agreements for purposes of Section 3(40) of ERISA. The hearing procedure is available only in situations where the jurisdiction or law of a State has been asserted against a plan or other arrangement that contends it meets the exception in section 3(40)(A)(i) for collectively bargained plans. A petition for a hearing may be initiated only by the plan or other arrangement. The regulations specifically provide that filing a petition for a hearing is not intended to provide a basis for delaying or staying a State proceeding against the plan or arrangement.

## **2. Rural Electric Cooperatives**

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

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

- (I) any organization which is exempt from tax under Section 501(a) of the Internal Revenue Code of 1986 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and
- (II) any organization described in paragraph (4) or (6) of Section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under Section 501(a) of such Code and at least 80 percent of the members of which are organizations described in subclause (I).

## **3. Rural Telephone Cooperative Associations**

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

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

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

- (1) a single employer plan (which includes employers within the same control group);
- (2) a plan established or maintained under or pursuant to a collective bargaining agreement;
- (3) a plan established or maintained by a rural electric cooperative; or
- (4) a plan established or maintained by a rural telephone cooperative association.

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

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

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

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

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little, if any, practical effect on the ability of States to regulate MEWAs under their insurance laws.

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

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

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

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

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

- i. standards, requiring the maintenance of specified levels of reserves and specified levels of contributions**, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
- ii. provisions to enforce such standards... (Emphasis supplied.)**

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

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**❑ What is a “fully insured” MEWA?**

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

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

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

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

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

**❑ Under what circumstances might a State insurance law be “inconsistent” with Title I of ERISA?**

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

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

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

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

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

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## Form M-1 Filing Requirement for MEWAs

The Form M-1 is a reporting form of the Employee Benefits Security Administration (EBSA) for MEWAs and for certain collectively bargained arrangements, called entities claiming exception (ECEs). It was developed under the Health Insurance Portability and Accountability Act (HIPAA) and corresponding regulations to provide EBSA with information concerning compliance by MEWAs with the requirements of Part 7 of ERISA. MEWAs and ECEs have been required to submit annual filings on the Form M-1 since 2003. The Affordable Care Act extended reporting requirements for MEWAs. As a result, under the Affordable Care Act and corresponding regulations, MEWAs are also required to register prior to operating in a State.

For MEWAs, generally, the Form M-1 is required to be filed annually by March 1 following each calendar year during all or part of which the MEWA is operating. Filers will generally be granted an automatic 60-day extension if they request one. For ECEs, generally, the Form M-1 is required to be filed annually by March 1 for the three calendar years following an origination event, described below, during all or part of which the ECE is operating.

In addition to the annual filing requirement, administrators of both plan and non-plan MEWAs also must file the Form M-1 within a certain time upon the following five registration events:

1. 30 days prior to operating in any State.
2. Within 30 days of knowingly operating in any additional State or States that were not indicated on a previous Form M-1 filing.
3. Within 30 days of operating with regard to the employees of an additional employer (or employers, including one or more self-employed individuals) after a merger with another MEWA.
4. Within 30 days of the date the number of employees receiving coverage for medical care under the MEWA is at least 50 percent greater than the number of such employees on the last day of the previous calendar year.
5. Within 30 days of experiencing a material change as defined in the Form M-1 instructions.

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Administrators of ECEs are required to submit a Form M-1 within a certain time when an origination occurs:

1. 30 days prior to when the ECE begins operating with regard to the employees of two or more employers (including one or more self-employed individuals);
2. Within 30 days of when the ECE begins operating following a merger with another ECE (unless all of the ECEs that participate in the merger previously were last originated at least three years prior to the merger);
3. Within 30 days of when the number of employees receiving coverage for medical care under the ECE is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless the increase is due to a merger with another ECE under which all ECEs that participate in the merger were last originated three years prior to the merger).

Administrators of ECEs are generally required to file the Form M-1 for the first three years after an origination event only. However, two of these events will extend or restart the three year period:

1. the ECE experiences a merger with another ECE (unless all of the ECEs that participate in the merger previously were last originated at least three years prior to the merger);
2. the number of employees receiving coverage for medical care under the ECE increases by at least 50 percent based on number of employees on the last day of the previous calendar year. If either of these two events occur, an ECE must file a Form M-1 even if it falls outside of the three-year period.

ECEs must also update the Form M-1 within 30 days of experiencing a special filing event. A special filing event occurs if, during the three year origination period, the ECE experiences a material change or knowingly begins operating in an additional State or States that were not indicated on a previous Form M-1 filing.

For MEWAs that are not plans, ERISA Section 502(c)(5) provides for the assessment of civil penalties for failure to comply with the Form M-1 filing requirements. Welfare plans that are MEWAs or ECEs required to file the Form M-1 are required to file an annual report under the Form 5500 series, regardless of size or type of funding, and to complete the Form M-1 compliance questions. Failure to comply with these annual reporting requirements may subject the plan to civil penalties assessed pursuant to ERISA Section 502(c)(2).

The Form M-1 must be filed electronically at [www.askebsa.dol.gov/mewa](http://www.askebsa.dol.gov/mewa). More detailed information on the electronic filing system is available at <http://www.askebsa.dol.gov/mewa/Home/FAQ>. For questions regarding the electronic filing system, contact the EBSA computer help desk at (202) 693-8600. If you need any assistance in completing the Form M-1, please call the EBSA Form M-1 help desk at (202) 693-8360.

The Form 5500 also must be filed electronically. More information is available at the EFAST2 website at [www.efast.dol.gov](http://www.efast.dol.gov). For more information on electronically filing the Form 5500 or related questions, call the EFAST2 Help Line toll-free at 1-866-GO-EFAST (1-866-463-3278). The EFAST2 Help Line is available Monday through Friday from 8:00 am to 8:00 pm EST. You can access the EFAST2 website 24 hours a day.



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## ERISA Advisory Opinions

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

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

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

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

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

In most cases, *no*. While the MEWA exception to ERISA's preemption provisions does impose a few limitations on the ability of States to regulate

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

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

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

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

**❑ Where should advisory opinion requests be sent?**

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

**Office of Regulations and Interpretations  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, NW, Suite N-5655  
Washington, DC 20210**

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## ERISA Enforcement

Enforcement of the provisions of Title I of ERISA and related criminal sections of Title 18 of the United States Code is carried out by the Employee Benefits Security Administration (EBSA). EBSA's national office provides policy direction and technical and management support for regional and district offices which investigate potential violations. MEWA investigations are conducted by these regional offices under the supervision of a regional director with oversight and coordination provided by the national office.

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

For more information or to locate the regional office nearest you, contact EBSA electronically at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or by calling toll free **1-866-444-3272**.

View this and other free EBSA compliance assistance publications at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).



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**Appendix A  
Advisory Opinions  
and  
Information Letters**

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July 2, 1990

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

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

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

Dear Mr. Kyle:

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

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

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

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

Section 514(b)(6)(A) of ERISA provides an exception to preemption under ERISA section 514(a) for any ERISA-covered employee welfare benefit plan that is a MEWA. In general, the exception permits application of state insurance law to a MEWA as follows: If the MEWA is "fully insured" within the meaning of section 514(b)(6)(D) of ERISA, state insurance law may apply to the extent it provides standards requiring the maintenance of specified levels of reserves and contributions, and

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provisions to enforce such standards (See section 514(b)(6)(A)(i)). If the MEWA is not fully insured, any law of any state which regulates insurance may apply to the extent not inconsistent with title I of ERISA (See 514(b)(6)(A)(ii)). It appears from your letter that the parties do not dispute that MDPEBP is not fully insured within the meaning of ERISA section 514(b)(6)(D).

We hope the following is responsive to your request.

First, it is the view of the Department of Labor that section 514(b)(6)(A) saves from ERISA preemption any law of any state which regulates insurance, without regard to whether such laws specifically or otherwise reference MEWAs or employee benefit plans which are MEWAs, subject only to the limitations set forth in subparagraphs (A)(i) and (A)(ii) of that section. Similarly, while we are unable to rule on the specific application of the Texas Insurance Code to MDPEBP, a matter within the jurisdiction of the Texas State Board of Insurance, it is the view of the Department that, with the exception of the aforementioned limitations, there is nothing in ERISA which would preclude the application of the same state insurance laws which apply to any insurer which is not an ERISA-covered plan to ERISA-covered plans which constitute MEWAs within the meaning of ERISA section 3(40).

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

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

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

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

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

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

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

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

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

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

Sincerely,

Robert J. Doyle  
Director of Regulations  
and Interpretations

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January 27, 1992

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

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

Dear Mr. Huff:

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

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

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

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

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

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

ERISA section 3(40)(A) defines the term "multiple employer welfare arrangement" to mean:

... an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan) which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such arrangement does not include any plan or arrangement which is established or maintained --

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

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- (ii) by a rural electric cooperative, or
  - (iii) by a rural telephone cooperative association.

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

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

... any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

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

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

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

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

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

On the basis of the information provided, the Action health benefit program covered at least one client’s employees with respect to whom Action did not have an employer-employee relationship and, accordingly, were not “employees” of Action within the meaning of ERISA section 3(6). Therefore, in the absence of any indication that Action and its client employers constitute a “control group” within the meaning of ERISA section 3(40)(B)(i), it is the view of the Department that the Action health benefit program provides benefits to the employees of two or more employers and is, therefore, a multiple employer welfare arrangement within the meaning section 3(40)(A). Accordingly, the preemption provisions of ERISA would not preclude state regulation of the Action health benefit program to the extent provided in ERISA section 514(b)(6)(A). In this regard, we are enclosing, for your information, a copy of Opinion 90-18A (dated July 2, 1990) which discusses the scope of the states’ authority to regulate MEWAs pursuant to section 514(b)(6)(A) of ERISA.

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

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

Sincerely,

Robert J. Doyle  
Director of Regulations  
and Interpretations  
Enclosure

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March 1, 2002

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

Dear Commissioner Pickens:

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

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

UEVEBA states that it is organized under section 501(c)(9) of the Internal Revenue Code as a tax-exempt, non-profit voluntary employees' beneficiary organization (VEBA) and as a VEBA trust.<sup>1</sup> The trustee of the VEBA trust is "The 4 Corners Company, LLC," which acts through its managing member John Rhondo aka John Ramirez.

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

<sup>1</sup> UEVEBA's name appears to have been changed in 1998 from the "California Association of Medical Professionals Voluntary Employees Beneficiary Association Trust."

<sup>2</sup> A trust joinder agreement attached to a January 10, 2002 letter from John Ramirez to the Colorado Commissioner of Insurance identified UEVEBA as the "United Employers Voluntary Employees Beneficiary Association I (Herein 'VEBA')" while copies of other trust joinder agreements identified UEVEBA as "United Vendors of America Chapter I Voluntary Employees' Beneficiary Association (the 'UEVEBA')...." We have assumed for purposes of this letter that these differences reflect different trade names under which UEVEBA conducts its operations.

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

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

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

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

Section 514(b)(6)(A)(i) of ERISA provides that, in the case of a MEWA that is itself a plan and is fully insured, states may apply to and enforce against the MEWA any state insurance law requiring the maintenance of specific reserves or contributions designed to ensure that the MEWA will be able to satisfy its

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

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

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

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benefit obligations in a timely fashion. In the Department's view, section 514(b)(6)(A)(i) enables states to subject such MEWAs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of state insurance law necessary to ensure compliance with state insurance reserve, contribution and funding requirements. Section 514(b)(6)(D) provides that a MEWA is "fully insured" for this purpose "only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service or insurance organization, qualified to conduct business in a State."

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

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

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

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

Sincerely,

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

Enclosure  
cc: John Rhondo aka John Ramirez

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August 16, 2007

Edward L. Wender  
Venable LLP  
Two Hopkins Plaza, Suite 1800  
Baltimore, MD 21201-2978

2007-06A  
ERISA Sec. 3(40) & 514(b)(6)(A)

Dear Mr. Wender:

This is in reply to your request on behalf of the Custom Rail Employer Welfare Trust Fund ("CREW" or "CREW Welfare Trust") for an advisory opinion regarding Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you asked for the view of the Department of Labor (Department) on whether CREW is an "employee welfare benefit plan" within the meaning of section 3(1) of ERISA, and whether it is a "multiple employer welfare arrangement" (MEWA), within the meaning of section 3(40), that is "fully insured" within the meaning of section 514(b)(6)(A) of ERISA.<sup>1</sup>

The following summary of facts and representations is based on the materials submitted in support of your request and information on CREW's web site at [www.crew-benefits.com](http://www.crew-benefits.com). CREW is marketed to members of the Small Railroad Business Owners Association of America, Inc. (Association) as an employee welfare benefit plan designed to provide medical, surgical, hospital, and disability benefits exclusively to members' employees and dependents. The Association's Articles of Incorporation provide that the Association "shall be operated exclusively as a nonstock not-for-profit organization and specifically for the following purposes: (i) To function as a trade association of short line and small railroads in the United States and Canada; . . . and (iv) To provide for insurance and other employee benefits and welfare plans to employees of members of the Association."<sup>2</sup> The Association's By-Laws provide that "[m]embership will be open to all railroads and railroad related entities that employ at least one (1) person and that otherwise are engaged in [activities]" including "the operation of interstate freight, and intrastate scenic and tourist railroads and who otherwise pursue the purposes of the Association. . . ." The Association's Articles of Incorporation and By-Laws have been construed "so that only (a) railroad contractors who maintain the railroad track right away [sic] and whose operations may result in them being subject to FELA [Federal Employment Liability Act] liability, and (b) a parent company or affiliate of a small railroad which leases track or employs the administrative personnel who supervise the operation of one or more small or short line railroads are eligible to participate in the New Association [Association] and CREW."<sup>3</sup>

You represent that the Association lobbies State and Federal agencies on matters affecting small and short line railroads, sponsors programs and distributes publications to publicize the importance of small and short line railroads, provides a forum for the exchange of ideas and facilitates the purchase and sale of equipment among members, develops briefing papers for use by members, and provides email alerts to members concerning the industry.

The Association is managed by a Board of Directors. The Board is required to have a minimum of three Directors, with up to a maximum of seven upon amendment of the By-laws to so provide. The materials you provided do not indicate how many Directors currently serve on the Board of Directors, and we did not see any amendment to the By-laws that would increase the number of Directors from three. Each Director may serve on the Board for a term of not more than three years. The By-Laws provide that "Directors shall be elected by a plurality of the votes cast provided that a quorum is present or that the requisite minimum number of votes is cast by written ballot, as the case may be." It is not clear from your submission how Directors are nominated to serve on the Board of Directors or what number constitutes a "requisite minimum number" of votes cast

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<sup>1</sup> The National Association of Insurance Commissioners (NAIC) submitted a letter urging the Department to conclude that the CREW Welfare Trust is subject to state insurance regulation, including state insurance laws that would require CREW to become licensed in the states where it operates as a MEWA and obtain insurance from a carrier or carriers licensed in each State in which CREW operates. The NAIC described itself as an organization that represents the chief insurance regulators from the 50 states, the District of Columbia, and four U.S. territories. We also received your supplemental submission responding to the NAIC's arguments and legal analyses.

<sup>2</sup> Included in the materials you submitted is a copy of a Certificate of Incorporation issued by the Government of the District of Columbia, Department of Consumer and Regulatory Affairs. The Certificate of Incorporation, dated October 11, 2001, certified that "all applicable provisions of the District of Columbia NonProfit Corporation Act have been complied with and accordingly, this Certificate of Incorporation is hereby issued to: Small Railroad Business Owners Association of America, Inc." The web site of the District of Columbia Department of Consumer and Regulatory Affairs ([www.mblr.dc.gov/corp/lookup/status.asp?id=26854](http://www.mblr.dc.gov/corp/lookup/status.asp?id=26854)), however, indicates that the Association's registration has been revoked.

<sup>3</sup> See Affidavit of Ronald J. Wilson, at 3 (August 7, 2006).

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by written ballot. Moreover, it is unclear from the materials you provided whether all Association members are entitled to vote. The Association's Articles of Incorporation provide that the Association shall have only one class of members, and both the Articles of Incorporation and the By-laws provide that "each member" gets one vote with respect to each vacancy on the Board of Directors. However, those two documents define "voting members" differently. The Articles of Incorporation provide that "the voting members of the Association shall be limited to employers (persons or entities who or which employ at least one (1) person for purposes of the provision of welfare and pension benefits)," but the By-Laws provide that "the voting members of the Association shall be limited to employers (persons or entities who or which employ at least five (5) persons for purposes of the provision of welfare and pension benefits)."

The CREW Welfare Trust is organized as a trust under the laws of the District of Columbia and is intended to operate as a "voluntary employees' beneficiary association" (VEBA) within the meaning of section 501(c)(9) of the Internal Revenue Code (Code). You represent that only "employer members" of the Association may participate in the CREW Welfare Trust. The Board of Directors of the Association initially selects the trustees of the CREW Welfare Trust who are responsible for the overall supervision of the CREW Welfare Trust, including approval of insurance policies. Thereafter, the Board presents a slate of trustee nominees to the employer members, and employer members may add additional nominees to the slate. According to CREW's trust agreement, if no employer adds nominees, the slate of trustees is "deemed elected." The trust agreement does not specify the process that ensues if an employer adds a nominee to the slate, and there appear to be discrepancies in the documents we reviewed regarding whether CREW trustees are appointed by the Association's Board of Directors or elected by the Association's members. Specifically, your March 27, 2006 letter to this office provides that "employer members elect the trustees." However, in the Application for Membership in the CREW Welfare Trust, prospective member rail employers must sign that they "understand that the elected Directors [of the Association] appoint the Officers of the Association and appoint the Trustees of the Custom Rail Employer Welfare Trust Fund ('CREW')."

CREW contracts with Medical Benefits Administrators of MD, Inc. (MBA) to undertake CREW's day-to-day administration, including claims processing and adjudication services, access to and management of provider networks, and compliance management. MBA uses an actuarial firm to establish the health insurance rates for employee and dependent coverage options available under the CREW Welfare Trust. Advance Benefit Services, an affiliate of MBA, "assists association member employers in the implementation, design, presentation, and enrollment of employees and dependents under national association benefit programs."<sup>4</sup>

You indicate that CREW has a certificate of insurance coverage (Certificate) with a group of underwriters (Underwriters) at Lloyd's, London. The Certificate was obtained through R. J. Wilson & Associates Ltd., a reinsurance brokerage firm and affiliate of MBA.<sup>5</sup> The Certificate is not covered by any state guaranty association. The Underwriters liable under the Certificate are admitted insurers in the States of Illinois and Kentucky.<sup>6</sup> The Certificate provides CREW with stop-loss coverage for individual claims in excess of \$50,000. In addition, in the event of CREW's insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution, or termination or non-renewal of the CREW Welfare Trust, the Underwriters are liable for claims incurred during the period of insurance in excess of a "terminal fund" which CREW must maintain in accordance with the Certificate. The terminal fund consists of current assets on hand to fund the actuarial value of all incurred but unpaid claims (including unreported claims). Individuals covered under the CREW Welfare Trust have the right to seek payment of benefits directly from the Underwriters by making a request through a designated U.S. based representative of the Underwriters after there is a final determination that an individual's claim is payable under the CREW Welfare Trust, and CREW fails to pay within thirty days of the determination. In this eventuality, CREW is required to assign its right of recovery under the Certificate to the claimant or his or her representative.<sup>7</sup>

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<sup>4</sup> See CREW's web site ([www.crew-benefits.com/faq/faq\\_list.asp](http://www.crew-benefits.com/faq/faq_list.asp)).

<sup>5</sup> The general organizational structure used in the CREW arrangement appears to be a prototype-like employee benefit structure that is being established and marketed under various designations. See, for example, the web sites for The Evangelical Benefit Trust ([www.ebt-benefits.com/overview.html](http://www.ebt-benefits.com/overview.html)) the ATA Archery & Bowhunting Industry Benefit Trust ([www.archerybenefits.com](http://www.archerybenefits.com)), and the IGA Group Employee Benefits Trust ([www.iga-benefits.com](http://www.iga-benefits.com)).

<sup>6</sup> Lloyd's web site ([www.lloyds.com](http://www.lloyds.com)) states that Lloyd's is an insurance market, not a single insurance company, consisting of a number of separate businesses (syndicates) that underwrite risks. Lloyd's underwriters are licensed in Kentucky, Illinois and the US Virgin Islands, and are eligible surplus lines insurers in all US jurisdictions except Kentucky and the US Virgin Islands. Lloyd's underwriters are also accredited reinsurers in all US states. Insurance policies issued by Lloyd's underwriters are not protected by state insurance guaranty associations or insolvency funds, except in states where licensed.

<sup>7</sup> Decisions regarding the method through which benefits are to be paid under an employee welfare benefit plan, including the selection of an insurer and the negotiation of the terms of any contractual arrangement obligating the plan, are matters that generally are subject to the fiduciary responsibility provisions of Title I of ERISA. This letter does not express any view on whether the CREW arrangements satisfy those fiduciary requirements.

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Your request for an advisory opinion focuses on provisions added to ERISA in 1983 that modified the scope of ERISA's preemption of state law to permit application of certain state insurance laws to employee welfare benefit plans that are MEWAs. Section 3(40)(A) of ERISA defines the term "MEWA," in pertinent part, to include: 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) [ERISA section 3(1)] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained -- (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, (ii) by a rural electric cooperative, or (iii) by a rural telephone cooperative association.

Under the general preemption clause of ERISA section 514(a), state laws are preempted to the extent that they "relate to" employee benefit plans subject to Title I of ERISA. There are, however, a number of exceptions to this broad preemption provision. Section 514(b)(2)(A), referred to as the "savings clause," provides in pertinent part that "nothing in this title [Title I of ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ." While section 514(b)(2)(A) saves from ERISA preemption state laws regulating insurance, section 514(b)(2)(B) of ERISA, referred to as the "deemer clause," provides that a state law "purporting to regulate insurance" generally cannot deem an employee benefit plan to be an insurance company (or in the business of insurance) for the purpose of regulating such a plan as an insurance company. An additional piece of analysis, however, is needed if the ERISA welfare plan is a MEWA as defined in section 3(40) of ERISA. ERISA section 514(b)(6)(A) creates a partial exception to the deemer clause for employee welfare benefit plans that are also MEWAs. Specifically, if the employee benefit plan MEWA is "fully insured," then, under section 516(b)(6)(A)(i), any state law that regulates insurance may apply to the MEWA to the extent the law provides standards, or provisions to enforce those standards, requiring the maintenance of specified levels of reserves and contributions in order to be considered able to pay benefits. If the employee benefit plan MEWA is not "fully insured," then, under section 514(b)(6)(A)(ii), "any law of any State which regulates insurance" may apply to the extent it is "not inconsistent with" the provisions of ERISA. The limitations set forth in section 514(b)(6)(A) of ERISA on state insurance regulation of MEWAs only apply to MEWAs that are also employee welfare benefit plans as defined in section 3(1) of ERISA. If a MEWA is not an ERISA-covered plan, ERISA's preemption provisions do not limit the ability of states to regulate the arrangement in accordance with applicable state insurance law.

It is the view of the Department based on the information we reviewed that CREW is a MEWA within the meaning of section 3(40) of ERISA. CREW is an arrangement that has been established and is maintained for the purpose of offering and providing welfare benefits to employees of two or more separate employers and does not fall within any of the exceptions listed in section 3(40). Thus, unless the CREW Welfare Trust is itself an ERISA-covered employee benefit plan, ERISA would impose no limit on the application of state insurance law to the CREW benefit arrangement and trust.

Although it appears that the CREW Welfare Trust provides benefits described in section 3(1) of ERISA, to be an employee welfare benefit plan, the Trust must also, among other criteria, be established or maintained by an employer, an employee organization, or both an employer and an employee organization. There is no indication in your submission that the Fund was established or is maintained by an employee organization within the meaning of section 3(4) of ERISA. Therefore, this letter will only address whether the CREW Welfare Trust is established or maintained by an "employer" within the meaning of section 3(5) of ERISA. Section 3(5) of ERISA defines an employer as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity."

The definitional provisions of ERISA recognize that a single employee welfare benefit plan might be established or maintained by a cognizable, bona fide group or association of employers acting in the interests of its employer members to provide benefits for their employees. A determination whether there is a bona fide employer group or association must be made on the basis of all the facts and circumstances involved. Among the factors considered are the following: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers; and who actually controls and directs the activities and operations of the benefit program. The employers that participate in a benefit program must, either directly or indirectly, exercise control over the program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the program.

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The Department has expressed the view that where several unrelated employers merely execute identically worded trust agreements or similar documents as a means to fund or provide benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association exists for purposes of ERISA section 3(5). Similarly, where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of their status as employers (i.e., the group or association members include persons who are not employers) or where control of the group or association is not vested solely in employer members, the group or association is not a bona fide group or association of employers for purposes of ERISA section 3(5). *See, e.g.*, Advisory Opinion 95-01A, and Advisory Opinion 88-07A. In that regard, the Department has previously concluded that sole proprietors without common-law employees are not eligible to be treated as “employers” for purposes of participating in a bona fide group or association of employers within the meaning of ERISA section 3(5). *See* Advisory Opinion 94-07A (“[A]lthough USA represents that its membership is composed of employers, the Articles and Bylaws indicate that USA’s membership class includes self-employed persons. Because self-employed persons are not necessarily employers of common-law employees, it appears that membership eligibility in USA is not limited to ‘employers.’”).

If the Association membership is limited to employers, and if control of the CREW Welfare Trust is vested solely in its employer members that participate in the CREW Welfare Trust, the Department would find that the Association constitutes a bona fide employer group or association acting as an employer in relation to the CREW Welfare Trust within the meaning of ERISA section 3(5).

However, even if the Crew Welfare Trust is an employee welfare benefit plan within the meaning of section 3(1), it would be a plan covering multiple employers, not a single employer plan, and a MEWA subject to state insurance regulation at least to the extent permitted under section 514(b)(6)(A) of ERISA. Assuming for purposes of this letter that the CREW Welfare Trust is itself an ERISA-covered plan, it is the view of the Department based on the information we reviewed that CREW is not fully insured within the meaning of section 514(b)(6)(D) of ERISA.

Under section 514(b)(6)(D) of ERISA, a MEWA “shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of which the Secretary [of Labor] determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.”<sup>8</sup> ERISA’s requirement that a fully insured MEWA have *benefits* guaranteed under a contract, or policy of insurance does not refer merely to a financial guaranty running to the plan, but rather requires the insurance company or organization that issued the insurance contract to unconditionally guarantee, upon receipt of the required premium or consideration, to pay all benefits due under the plan, and each participant must have a right to those guaranteed benefits which is legally enforceable directly against the insurance company or organization. In the Department’s view, the Certificate is not such a contract or policy of insurance. Rather, the financial arrangement between CREW and Lloyd’s, London represented by the Certificate’s stop-loss coverage, the CREW Welfare Trust’s terminal fund, and the Trust’s promise to assign rights to payment under the Certificate to participants and beneficiaries, is fundamentally one where, until the occurrence of a triggering event—CREW’s failure to pay a claim within thirty days of a final determination that an individual’s claim is payable under the CREW Welfare Trust—the insurance risk for the benefits remains primarily with CREW and the employers and employees funding the program and the terminal fund.<sup>9</sup>

We were unable to conclude that the participants would, upon the Underwriters’ receipt of the required premium, have rights to guaranteed benefits legally enforceable directly against the Underwriters. For example, it is unclear whether a failure by CREW to meet its commitments regarding the terminal fund would affect the ability of plan participants to make a claim against the Underwriters. Further, since the Underwriters’ liability

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<sup>8</sup> In the Department’s view, section 514(b)(6)(D) requires the insurer to be qualified to do business in “a State,” not in every State where the plan offers or provides benefits. A central purpose of the “qualified to do business” requirement, however, is to ensure that the policy insuring the plan benefits is subject to insurance regulation by a State that authorized the insurer to sell its residents the type of insurance purchased by the plan. Nonetheless, a consequence of the insurance savings clause in ERISA section 514(b)(2)(A), under which the application of State insurance laws to insurance companies is saved from preemption, is that even in the case of a fully insured MEWA, ERISA would not limit any State in which the MEWA’s insurance risk is resident or located or to be performed from enforcing state insurance law requirements directly against the insurance company, insurance service or insurance organization insuring the MEWA.

<sup>9</sup> *See generally John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank*, 510 US 86 (1993) (in interpreting the definition of “guaranteed benefit policy” in ERISA section 401, the Court concluded that a contract “provides for benefits the amount of which is guaranteed by the insurer” in the context of insured pension benefits “only if it allocates investment risk to the insurer.” The Court explained that “[s]uch an allocation is present when the insurer provides a genuine guarantee of an aggregate amount of benefits payable to retirement plan participants and their beneficiaries.”).

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under the Certificate does not arise until after there is a final determination that a participant's claim is payable under the CREW Welfare Trust, it is unclear when a liability would arise, if ever, for the Underwriters if CREW refused to make such a determination. It would appear that a participant in such a case might have to obtain an enforceable court order concluding that a particular claim was payable under the CREW Welfare Trust before being able to make a claim against the Underwriters.

Thus, even if the CREW Welfare Trust is an ERISA-covered plan within the meaning of section 3(1) of ERISA, CREW as a MEWA that is not fully insured would be subject to state insurance regulation subject to the limitation in section 514(b)(6)(A)(ii) of ERISA that the state law is "not inconsistent" with Title I of ERISA.

The relationship between CREW, the participants, and the Underwriters is distinguishable from the arrangement in Advisory Opinion 93-11A, which the Department concluded was a fully insured MEWA. In that advisory opinion, the insurance agreement obligated the insurer to pay participants and beneficiaries of the plan, directly or through its agent, and in a timely manner, all of the benefits under the Plan. The insurer's obligation to pay benefits directly to participants and beneficiaries was backed by the insurer's general assets and was not conditioned on whether the insurer received reimbursements from the plan. Although agreements between the plan and the insurer limited the insurer's actual risk of loss in various ways, such as by providing that the insurer would be reimbursed by the plan on a daily basis for its benefit payments, by requiring the plan to maintain a substantial balance in a trust used to reimburse the insurer for benefit payments, and by permitting the insurer to terminate insurance agreements unilaterally if these conditions were not met, the insurer was unconditionally liable to the participants and beneficiaries for payment of all claims for benefits incurred while the insurance agreement was in effect. Further, the insurer's obligation to pay benefits survived termination of those agreements with respect to all claims for benefits incurred prior to their termination. *See also* Advisory Opinion 2005-20A.

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

Sincerely,

Lisa M. Alexander  
Chief, Division of Coverage, Reporting and Disclosure  
Office of Regulations and Interpretations

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# **Appendix B Advisory Opinion Procedure**

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

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

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

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

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

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

**SEC. 3. Definitions.** .01 An “information letter” is a written statement issued either by the Pension and Welfare Benefit Programs (Office of Employee Benefits Security), U.S. Department of Labor, Washington, D.C. or a Regional Office or an Area Office of the Labor-Management Services Administration, U.S. Department of Labor, that does no more than call attention to a well-established interpretation or principle of the Act, without applying it to a specific factual situation. An information letter may be issued to any individual or organization when the nature of the request from the individual or the organization suggests that it is seeking

general information, or where the request does not meet all the requirements of section 6 or 7 of this procedure, and it is believed that such general information will assist the individual or organization.

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

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

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

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

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

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

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

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

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

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

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

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

.02(g) Section 202 (other than section 202(a)(3) and (b)(1)) relating to minimum participation standards;

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

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

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

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

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

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

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

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

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

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

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

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

.03(b) If an inquiry presents an issue on which the answer seems reasonably certain but not entirely free from doubt, an advisory opinion will be issued only if it is established to the satisfaction of the Department, that a business emergency requires an advisory opinion or that unusual hardship to the plan or its participants and beneficiaries will result from failure to obtain an advisory opinion. In any case in which the individual or organization believes that a business emergency exists or that an unusual hardship to the plan or its participants and beneficiaries will result from the failure to obtain an advisory opinion, the individual or organization should submit with the request a separate letter setting forth the facts necessary for the Department to make a determination in this regard. In this connection, the Department will not deem a “business emergency” to

result from circumstances within the control of the individual or organization such as, for example, scheduling within an inordinately short time the closing date of a transaction or a meeting of the Board of Directors or the shareholders of a corporation.

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

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

SEC. 6. Instructions to individuals and organizations requesting advisory opinions from the Department. .01 If an advisory opinion is desired, a request should be submitted to: U.S. Department of Labor, Employee Benefits Security Administration, Office of Regulations and Interpretations, 200 Constitution Avenue, NW, Suite N-5655, Washington, DC 20210.

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

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

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

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

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

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

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must include a statement that the representative is authorized to represent the individual or organization.

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

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

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

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

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

.01 [Reserved]

.02 [Reserved]

.03 [Reserved]

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

SEC. 9. Withdrawal of requests. The individual or organization's request for an advisory opinion may be withdrawn at any time prior to receipt of notice that the Department intends to issue an adverse opinion,

or the issuance of an opinion. Even though a request is withdrawn, all correspondence and exhibits will be retained by the Department and will not be returned to the individual or organization.

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

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

SEC. 12. Public Inspection.

.01 Advisory opinions shall be open to public inspection at the Public Disclosure Room, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

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

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

SEC. 13. Effective Date. This advisory opinion procedure consists of rules of agency procedure and practice, and is therefore excepted under 5 U.S.C. 552(b)(3)(A) of the Administrative Procedure Act from the ordinary notice and comment provisions for agency rulemaking. Accordingly, the procedure is effective August 27, 1976, the date of its publication in the Federal Register.

Signed at Washington, DC, this 24<sup>th</sup> day of  
August 1976  
James D. Hutchinson  
*Administrator of Pension and  
Welfare Benefit Programs  
U.S. Department of Labor*



# **Appendix C Regulations**

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DEPARTMENT OF LABOR  
Employee Benefits Security Administration

29 CFR Part 2510 and 2570

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.

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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

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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.

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### 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

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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

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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 laws 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.

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### 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).<sup>1</sup> 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

<sup>1</sup> 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.

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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.<sup>2</sup> The cost may be substantially more if a state regulates premium rates and the entity otherwise would have benefited from insuring a population whose health costs are far lower than average. However, these added costs are transfers and not true economic costs because they serve as cross-subsidies that reduce costs for populations that are costlier than average.

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

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.

### 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).

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<sup>2</sup> 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 vary 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. Morrissey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance* (Washington, DC: HIAA 1999)).

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<sup>3</sup> 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.

#### 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

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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:

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

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

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

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

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

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

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

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

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

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

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

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

(vi) Individuals employed by:

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

(B) The plan or associated trust fund;

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

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

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

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

(ix) Individuals who are, or were for a period of at least three years, employed under one or more agreements between or among one or more “carriers” (including “carriers by air”) and one or

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more “representatives” of employees for collective bargaining purposes and as defined by the Railway Labor Act, 45 U.S.C. 151 et seq., providing for such individuals’ current or subsequent participation in the plan, or providing for contributions to be made to the plan by such carriers; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

plan established or maintained under or pursuant to such agreement.

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

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

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

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

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

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

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

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

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

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

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

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

(3) Individual employed means any natural person who furnishes services to another person or entity in the capacity of an employee under common law, without regard to any specialized definitions or interpretations

of the terms “employee,” “employer,” or “employed” under federal or state statutes other than ERISA.

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

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

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

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

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

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%)

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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

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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 informational 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

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

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

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

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

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

Signed this 31st day of March 2003.

Ann L. Combs,

Assistant Secretary,

Employee Benefits Security Administration.

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

DEPARTMENT OF LABOR  
Employee Benefits Security Administration

29 CFR Part 2570

RIN 1210-AA48

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

**AGENCY: Employee Benefits Security Administration, Department of Labor.**

**ACTION: Final rule.**

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

**EFFECTIVE DATE:** June 9, 2003.

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

**SUPPLEMENTARY INFORMATION:**

**A. Background**

These final rules set forth an administrative procedure for obtaining a determination by the Secretary of Labor (the Secretary) as to whether a particular employee benefit plan is established or maintained under or pursuant to one or more agreements that are collective bargaining agreements

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

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

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

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

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

#### B. Economic Analysis Under Executive Order 12866

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

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

#### Summary

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

#### Background

When state law or jurisdiction is asserted over an entity that claims to be excepted from state regulation

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

#### Benefits of the Regulation

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

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

#### Determining Jurisdiction Accurately and Consistently

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

Employers and employees will benefit from an administrative decision that provides greater assurance that the entity will comply with applicable federal and state laws designed to protect welfare benefits. In addition, both the petitioner and the state whose authority is being asserted will benefit from the uniform application of criteria by the ALJ, avoiding any confusion that would result from inconsistent decisions. Finally, state insurance departments that receive a timely resolution about an entity’s status as a MEWA will be able to swiftly deal with sham MEWAs and then re-direct saved resources to other areas. Because an ALJ decision will be based on the criteria regulation, the Department has attributed the net benefit from the reclassification of currently inaccurately classified plans or arrangements (and the consequent application of appropriate state or federal protections) to that regulation.

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## Resolving Disputes Efficiently

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

The Department's analysis of costs involved in adjudication in a federal or state court versus an administrative hearing assumes that parties seeking to establish regulatory authority incur a baseline cost to resolve the question of status in federal or state court proceeding. This baseline cost includes, but is not limited to, expenditures for document production, attorney fees, filing fees, depositions, etc. Because regulatory authority may be decided in motions or pleadings in cases where that issue is not primary, the direct cost of using only the courts as a decision-maker for such issues is too variable to specify; however, custom and practice indicate that the cost of an administrative hearing is similar to or represents a cost savings compared with the baseline cost of litigating in federal or state court.

Because the procedures and evidentiary rules of an administrative hearing generally track the Federal Rules of Civil Procedure and of Evidence, document production is similar for both an administrative hearing and for a federal or state court proceeding. Documents such as by-laws, administrative agreements, collective bargaining agreements, and other documents and instruments governing the entity are generally kept in the normal course of business, and it is likely that the cost for an administrative hearing will be no more than that which would be incurred in preparation for litigation in a federal or state court. Certain administrative hearing practices and other new procedures initiated by this regulation may, however, represent a cost savings over litigation. For example, neither party need employ an attorney; the prehearing exchange is short and general; either party may move to shorten the time for the scheduling of a proceeding, including the time for conducting discovery; the general formality of the hearing may vary, particularly depending on whether the petitioner is appearing pro se; an expedited hearing is possible; and, the ALJ generally has 30 days after receipt of the transcript of an oral hearing or after the filing of all documentary evidence if no oral hearing is conducted to reach a decision.

The Department cannot predict that any or all of these conditions will exist, nor can it predict that any of these factors represent a cost-savings. However, it is likely that the specialized knowledge of ERISA that the ALJ will bring to the process will facilitate a prompt decision, reduce costs, and introduce a consistent standard to what has been a confusion of decisions on regulatory authority. ALJ case histories will educate

MEWAs and states by articulating the characteristics of a collectively bargained plan, which clarity will in turn promote compliance with appropriate federal and state regulations. Participants and beneficiaries of arrangements that are newly identified as MEWAs will especially benefit from appropriate state oversight that provides for secure contributions and paid-up claims. In its Notice of Proposed Rulemaking, the Department solicited comments on the comparative cost of a trial in federal or state court versus an administrative hearing on the issue of whether an entity is a plan established or maintained under or pursuant to an agreement or agreements that the Secretary finds to be collective bargaining agreements for purposes of section 3(40) of ERISA. No comments concerning the comparative costs of a trial versus an administrative hearing were received.

## C. Regulatory Flexibility Act

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

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

Further, while some large employers may have small plans, in general most small plans are maintained by small employers. Thus, EBSA believes that assessing the impact of this final rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business

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Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). In its Notice of Proposed Rulemaking, EBSA requested comments on the appropriateness of the size standard used; no comments were received.

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

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

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

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

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

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

represent a very small portion of all small group health plans. Even if all 2,600 potentially affected entities were to have fewer than 100 participants, they would represent approximately one-tenth of one percent of all small group health plans.

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

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

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

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

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

(6) *Alternatives.* The regulations are based on the consensus report of the Committee. Recognizing that

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

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

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

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

#### D. Paperwork Reduction Act

In accordance with the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3501 et seq.), the Department submitted the information collection request (ICR) included in the Procedures for Administrative Hearings Regarding Plans Established or Maintained Pursuant to Collective Bargaining

Agreements under section 3(40)(A) of ERISA to the Office of Management and Budget (OMB) for review and clearance at the time the NPRM was published in the Federal Register (65 FR 64498). A request for comments on the ICR was included in the NPRM. No comments were received about the ICR, and no changes have been made to the ICR in connection with this Notice of Final Rulemaking. OMB subsequently approved the ICR under control number 1210-0119. The approval will expire on January 31, 2004.

Agency: Employee Benefits Security Administration, Department of Labor.

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

OMB Number: 1210-0119.

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

Respondents: 45.

Responses: 45.

Average Time Per Response: 32 hours.

Estimated Total Burden Hours: 1.

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

#### E. Small Business Regulatory Enforcement Fairness Act

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

#### F. Unfunded Mandates Reform Act

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

#### G. Executive Order 13132

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

of their concerns and the agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of the State have been met.

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

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

#### List of Subjects in 29 CFR Part 2570

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

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

#### PART 2570--[AMENDED]

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

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

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

Sec.

2570.150 Scope of rules.

2570.151 In general.

2570.152 Definitions.

2570.153 Parties.

2570.154 Filing and contents of petition.

2570.155 Service.

2570.156 Expedited proceedings.

2570.157 Allocation of burden of proof.

2570.158 Decision of the Administrative Law Judge.

2570.159 Review by the Secretary.

#### Sec. 2570.150 Scope of rules.

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

#### Sec. 2570.151 In general.

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

#### Sec. 2570.152 Definitions.

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

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

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

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

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

(e) Respondent means:

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

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

(3) The Secretary of Labor; and

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

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

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

#### **Sec. 2570.153 Parties.**

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

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

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

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

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

#### **Sec. 2570.154 Filing and contents of petition.**

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

(b) The petition shall--

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

(2) Provide the names and addresses of the plan

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

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

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

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

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

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

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

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

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

#### **Sec. 2570.155 Service.**

For section 3(40) proceedings, this section shall apply instead of 29 CFR 18.3.

(a) In general. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges (OALJ), 800 K Street, NW., Suite 400, Washington, DC 20001-8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

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

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents

shall be made to all parties of record by regular mail to their last known address.

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

(2) Illegible documents, whether handwritten, typewritten, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

**Sec. 2570.156 Expedited proceedings.**

For section 3(40) Finding Proceedings, this section shall apply instead of 29 CFR 18.42.

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

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

- (1) Make the motion in writing;
- (2) Describe the circumstances justifying advancement;
- (3) Describe the irreparable harm that would result if the motion is not granted; and
- (4) Incorporate in the motion affidavits to support any representations of fact.

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

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

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

(f) When an expedited hearing is held, the decision of the administrative law judge shall be issued within twenty (20) days after receipt of the transcript of any oral hearing or within twenty (20) days after the filing

of all documentary evidence if no oral hearing is conducted.

**Sec. 2570.157 Allocation of burden of proof.**

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

**Sec. 2570.158 Decision of the Administrative Law Judge.**

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

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

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

(c) Decision of the administrative law judge. Within 30 days, or as soon as possible thereafter, after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing consent findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law, with reasons therefore, upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record. It shall be supported by reliable and probative evidence. Such decision shall be in accordance with the regulations found at 29 CFR 2510.3-40 and shall be limited to whether the petitioner, based on the facts presented at the time of the proceeding, is a plan established or maintained under or pursuant to collective bargaining for the purposes of section 3(40) of ERISA.

**Sec. 2570.159 Review by the Secretary.**

(a) A request for review by the Secretary of an appealable decision of the administrative law judge

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

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

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

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

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

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

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DEPARTMENT OF LABOR  
Employee Benefits Security Administration

**29 CFR Parts 2560 and 2571**

**RIN 1210-AB48**

**Ex Parte Cease and Desist and Summary Seizure Orders--Multiple Employer Welfare Arrangements**

**AGENCY:** Employee Benefits Security Administration, Department of Labor.

**ACTION:** Final rules.

**SUMMARY:** This document contains two final rules under the Employee Retirement Income Security Act of 1974 (ERISA) to facilitate implementation of new enforcement authority provided to the Secretary of Labor by the Patient Protection and Affordable Care Act (Affordable Care Act). The Affordable Care Act authorizes the Secretary to issue a cease and desist order, ex parte (i.e. without prior notice or hearing), when it appears that the alleged conduct of a multiple employer welfare arrangement (MEWA) is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. The Secretary may also issue a summary seizure order when it appears that a MEWA is in a financially hazardous condition. The first regulation establishes the procedures for the Secretary to issue ex parte cease and desist orders and summary seizure orders with respect to fraudulent or insolvent MEWAs. The second regulation establishes the procedures for use by administrative law judges and the Secretary when a MEWA or other person challenges a temporary cease and desist order.

**DATES:** *Effective date.* These final regulations are effective April 1, 2013.

**FOR FURTHER INFORMATION CONTACT:** Stephanie Lewis, Plan Benefits Security Division, Office of the Solicitor, Department of Labor, at (202) 693-5588 or Suzanne Bach, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335. These are not toll-free numbers.

**SUPPLEMENTARY INFORMATION:**

I. Executive Summary

A. *Purpose of the Regulatory Action*

1. Need for Regulatory Action

The Patient Protection and Affordable Care Act (Affordable Care Act) gives the Secretary authority to issue a cease and desist order when a multiple employer welfare arrangement (MEWA) engages in conduct that is fraudulent, creates an immediate danger to the public safety or welfare, or causes or can be

reasonably expected to cause significant, immediate, and irreparable injury. The act also gives the Secretary authority to issue a summary seizure order when a MEWA is in a financially hazardous condition. These new powers strengthen the Secretary's ability to protect plan participants, beneficiaries, employers, employee organizations, and other members of the public from fraudulent, abusive, and financially unstable MEWAs.

These two regulations are necessary to set forth the criteria for determining whether the statutory grounds for issuing an order have been met, and, in the case of a cease and desist order, to establish reasonable administrative review procedures. The Secretary will generally obtain judicial authorization before issuing a summary seizure order. The substantive criteria for issuing an order are based on several decades of enforcement experience by the Department and the States regarding fraudulent or financially hazardous conduct of MEWAs (and persons acting as their agents and employees). The administrative procedures will allow affected persons to challenge a cease and desist order and obtain expeditious review, including the right to a hearing.

2. Legal Authority

Section 521 of ERISA, 29 U.S.C. 1151, sets out the Secretary's authority to issue cease and desist orders and summary seizure orders. Section 521(f) provides that "the Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out" this new enforcement authority. Section 505 of ERISA, 29 U.S.C. 1135, also provides the Secretary with authority to prescribe such regulations as necessary or appropriate to carry out the provisions of Title I of ERISA, which includes the new section 521.

*B. Summary of the Major Provisions of This Regulatory Action*

These rules generally set forth the statutory criteria under which the Secretary may issue cease and desist orders and summary seizure orders. They also specify that orders may apply to MEWAs and to persons having custody or control of assets of a MEWA, any authority over management of a MEWA, or any role in the transaction of a MEWA's business. Paragraph (b) of this section contains key definitions. Most notably, this paragraph sets forth the criteria for determining if it appears that the MEWA or any person acting as an agent or employee of the MEWA has engaged in conduct that would support issuance of an order under the statute. The regulations address the scope of the cease and desist order and the process for a person who is the subject of a temporary cease and desist order to request an administrative hearing to show cause why the order should be modified or set aside. The regulations also establish the procedures for such hearings.

Although the Secretary may issue a cease and desist order without first seeking court approval, the procedure for a summary seizure order is somewhat different. The regulations generally require that the Secretary obtain

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judicial authorization before issuing a summary seizure order. They also require that the Secretary seek court appointment of a receiver or independent fiduciary and obtain court authorization for other actions to assert control over the MEWA's and plan assets.

Orders issued under these final rules are effective upon service and remain in effect until modified or set aside by the Secretary, an administrative law judge, or a reviewing court. Issued final orders will be made available to the public as will modifications and terminations of such final orders. Further, to facilitate coordination with the States, Federal agencies, and foreign authorities, the Secretary may disclose the issuance of any order (whether temporary or final) and any information and evidence of any proceedings and hearings related to the order to other Federal, State, or foreign authorities. (The sharing of such information, however, does not constitute a waiver of any applicable privilege or claim of confidentiality.)

The Secretary remains committed to helping MEWAs and plan officials comply with legal requirements and serve plan participants and beneficiaries properly. These new enforcement tools will enhance the Department's ability to protect plan participants and beneficiaries when MEWAs and plan actors fail to comply with their obligations. The Secretary will also continue to use any other investigatory and enforcement tools available under title I of ERISA.

### C. Costs and Benefits

These final regulations will improve MEWA compliance and deter abusive practices. They will also enable the Secretary to take enforcement action against fraudulent, abusive, and financially unstable MEWAs more effectively. The Department's primary judicial remedy for violations of ERISA by MEWAs is court-ordered relief based on a breach of fiduciary duty. Gathering sufficient evidence to prove a fiduciary breach may be very time-consuming and labor intensive, even where it is clear that the MEWA is insolvent or unable to meet its financial commitments. In many MEWA cases, important financial records are poor or non-existent. The new authority implemented by these regulations provides an additional, more flexible tool for the Secretary to use, when appropriate, to combat fraudulent and abusive conduct by MEWAs and financially hazardous arrangements. Moreover, these regulations will enable the enforcement process to be more efficient because the subject of a cease and desist order can seek review of the order in an administrative hearing rather than a court. Since the rules do not require any action or impose any requirements on MEWAs, these regulations do not impose any major costs.

## II. Background

Multiple employer welfare arrangements (MEWAs)<sup>1</sup> that are properly operated provide an additional option for small employers seeking affordable health coverage for their employees. Nevertheless, fraudulent and abusive practices and financial instability are recurrent themes in ERISA enforcement.<sup>2</sup> Congress enacted section 6605 of the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148, 124 Stat. 119, 780 (2010), which adds section 521 to ERISA, to give the Secretary of Labor additional enforcement authority to protect plan participants, beneficiaries, employees or employee organizations, or other members of the public against fraudulent, abusive, or financially hazardous MEWAs.

This section authorizes the Secretary to issue ex parte cease and desist orders when it appears to the Secretary that the alleged conduct of a MEWA is "fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury." 29 U.S.C. 1151(a). A person that is adversely affected by the issuance of a cease and desist order may request an administrative hearing regarding the order. 29 U.S.C. 1151(b). This section also allows the Secretary to issue an order to seize the assets of a MEWA that the Secretary determines to be in a financially hazardous condition. 29 U.S.C. 1151(e).

On December 6, 2011, the Department published in the **Federal Register** proposed regulations (76 FR 76235) implementing new ERISA section 521 and setting forth the procedures for administrative hearings on the issuance of an ex parte cease and desist order. The Department received three (3) comment letters on these proposed rules. After consideration of the comments received, the Department is publishing these final regulations with little modification of the proposed rules.

## III. Overview of the Final Regulations

### A. Ex Parte Cease and Desist and Summary Seizure Order Regulations (29 CFR 2560.521)

#### Purpose and Definitions

Pursuant to section 6605 of the Affordable Care Act, these rules set forth criteria and procedures for the Secretary to issue cease and desist orders and summary seizure orders and procedures for administrative review of the cease and desist orders. The rules apply to any cease and desist order and any summary seizure order issued under section 521 of ERISA. Paragraph (a) of section 2560.521-1 of the rules generally sets forth

<sup>1</sup> The term "multiple employer welfare arrangement" is defined at ERISA Sec. 3(40), 29 U.S.C. 1002(40).

<sup>2</sup> See, e.g., *Chao v. Graf*, 2002 WL 1611122 (D. Nev. 2002), *In re Raymond Palombo, et al.*, 2011 WL 1871438 (Bankr. C.D. CA 2011) and *Solis v. Palombo*, No. 1:08-CV-2017 (N.D. Ga 2009); *Chao v. Crouse*, 346 F.Supp.2d 975 (S.D. Ind. 2004).

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the statutory criteria under which the Secretary may issue orders. It also specifies that orders may apply to MEWAs and to persons having custody or control of assets of a MEWA, any authority over management of a MEWA, or any role in the transaction of a MEWA's business.

One commenter expressed concern that applying cease and desist and summary seizure orders to third party administrators (TPAs) would threaten their ability to perform their services, which may include helping MEWAs recover when they are in financial peril. TPAs perform critical services for the plan community. As the commenter notes, an important service TPAs do or can provide is to educate MEWAs about their duty to pay claims and provide promised benefits. TPAs also play an important role in informing the Department about MEWAs that ask them to deceive or defraud plan participants. The Department recognizes the role that conscientious and knowledgeable TPAs and other service providers may play in protecting plans and their participants and beneficiaries. Where the functions of a service provider are essential to the operation of a MEWA, cease and desist orders will need to cover these functions, whether or not the service provider engaged in conduct giving rise to the order. Moreover, in some cases a service provider may be integrally involved in conduct evidencing an intent to deceive or defraud plans and their participants and beneficiaries or other actions that endanger the public welfare. As an example, in *U.S. v. William Madison Worthy*, No. 7:11-cr-00487-HMH (D. S.C. 2011), Mr. Worthy, who owned the TPA providing services to the MEWA, pleaded guilty for diverting almost \$1 million in premium contributions for coverage provided in connection with the MEWA. Ultimately, about \$1.7 million in claims either went unpaid or had to be paid by plan members.

Moreover, it should be emphasized that orders may often be issued to persons, who were not involved in improper conduct, but whose cooperation is necessary to carry out the purpose of the order. For instance, a bank holding assets of a MEWA may receive a court-approved summary seizure order that directs the bank to freeze those assets. See, e.g., 29 CFR 2560.521-1(f)(4).

Paragraph (b) contains key definitions. ERISA section 521 applies the Secretary's cease and desist and seizure order authority to MEWAs, as defined under section 3(40) of ERISA, 29 U.S.C. 1002(40). As stated in the proposed regulations, Congress did not limit the Secretary's authority to issue orders to MEWAs that are ERISA-covered employee welfare benefits plans (ERISA-covered plans). Section 521 of ERISA also applies if the MEWA provides health coverage to one or more ERISA-covered plans, even if it also provides coverage to other persons unconnected to an ERISA-covered plan. These rules do not, however, apply to MEWAs that provide coverage only in connection with governmental plans, church plans, and plans maintained solely for the purpose of complying with workers' compensation laws, which are not covered by ERISA. They also do not apply to arrangements that only provide coverage to individuals other than

in connection with an employee welfare benefit plan (e.g., individual market coverage). The proposed rules also noted that they did not apply to arrangements licensed or authorized to operate as a health insurance issuer. Though the Department has not changed the substance of the regulations in this regard, it has revised paragraph (b)(1) for the sake of clarity. The definition of a MEWA in ERISA section 3(40) is very broadly worded. Read literally, it could be interpreted to include traditional health insurance issuers (including health maintenance organizations) that are fully licensed (i.e., subject to stringent and comprehensive insurance regulation) to offer health insurance coverage to the public and employers at large in every State in which they offer health insurance coverage. The Department has never, however, applied ERISA's provisions on MEWAs to such organizations. These organizations do not pose the same level of risk for fraud, abuse, and financial instability that ERISA's provisions on MEWAs, including the new ERISA section 521 and these final rules, are designed to address. Consequently, these final rules do not apply to these entities. This exclusion applies to any arrangement that could fall within the definition of MEWA but is covered by the same level and scope of stringent and comprehensive insurance laws of a State (such as laws on licensure, solvency, reporting, anti-fraud, appeals, premium assessment, and guaranty funds) as traditional health insurance issuers (including health maintenance organizations) and that offers health insurance coverage to the public and employers at large.

ERISA section 514(b)(6) makes clear that the States can regulate any MEWA, even a MEWA that is an ERISA-covered plan. The Department retains shared jurisdiction with the States. In some States, some MEWAs are permitted to operate if they have obtained a limited license from the State (e.g. a license that, for instance, allows them to operate subject to lower requirements or less extensive examination and oversight and/or to offer and provide coverage to a limited population.). These arrangements remain subject to ERISA section 521 and these final rules.

One commenter encouraged the Department to focus its enforcement actions on abusive and fraudulent MEWAs that are self-funded or not fully insured (within the meaning of ERISA section 514(b)(6)(D)). The Department recognizes that fully insured MEWAs have raised fewer concerns than other MEWAs. Nevertheless, a fully insured MEWA that engages in the conduct meeting the statutory criteria could be subject to an order.

ERISA section 521 provides three statutory grounds upon which the Secretary may issue a cease and desist order. Paragraphs (b)(2)-(4) of the final regulations clarify the scope and meaning of the statutory language. The first statutory ground, fraudulent conduct, is described in paragraph (b)(2) of the final rules as an act or omission intended to deceive or defraud plan participants, plan beneficiaries, employers or employee organizations, or other members of the public, the Secretary or a State about the MEWA's financial condition or regulatory status, benefits, management,

control, or administration, and other aspects of its operation (e.g. claims review, marketing, etc.) that the Secretary determines are material.<sup>3</sup>

One commenter expressed concern about the definition of fraudulent conduct. In particular, the commenter was concerned that a focus on omissions regarding the financial condition of the MEWA, including the management of plan assets, could inadvertently target service providers that adjudicate or pay claims. The commenter also expressed concern that service providers would be adversely implicated simply because they interacted with the MEWA and others with respect to claims or marketing. The new enforcement tools under ERISA section 521 are designed to prevent or address serious harm to plan participants, plan beneficiaries, employers, employee organizations, and other members of the public. Fraudulent conduct, as defined in the proposed rules and under these final regulations, requires knowledge and intentionality or a reckless disregard on the part of the MEWA or agent or employee of the MEWA. As stated previously, however, even though an order is based on the conduct of a person other than the service provider, the service provider's activities may be affected simply because the order prohibits all or certain activities with respect to the MEWA, such as marketing, to continue.

The second ground for issuing a cease and desist order, conduct that creates an immediate danger to the public safety or welfare, is described in paragraph (b)(3) of the final rules. Conduct meets this standard if it impairs, or threatens to impair, the MEWA's ability to pay claims or otherwise unreasonably increases the risk of nonpayment of benefits. The third ground, conduct that causes or can be reasonably expected to cause significant, imminent, and irreparable injury, is described in paragraph (b)(4). Conduct meets this statutory standard if it has, or can be reasonably be expected to have, a significant and imminent negative effect that the Secretary reasonably believes will not be fully rectified on one or more of the following: (a) An employee welfare benefit plan that is, or offers benefits in connection with, a MEWA, (b) plan participants and plan beneficiaries, or (c) employers or employee organizations.

Paragraphs (b)(2)-(4) also provide examples of conduct that falls within those standards. A single act or omission within the categories of conduct set forth in the regulation may provide the basis for a cease and desist order. However, because the categories set forth

in the statute are broad and overlapping, the examples may provide more than one basis for a cease and desist order.

The new ERISA section 521 also further expands the Secretary's enforcement options with respect to MEWAs by authorizing the Secretary to issue a summary seizure order to remove plan assets and other property from the management, control, or administration of a MEWA when it appears that the MEWA is in a financially hazardous condition. Under paragraph (b)(5) a MEWA is in a financially hazardous condition when the Secretary has probable cause to believe that a MEWA is, or is in imminent danger of becoming, unable to pay benefit claims as they become due, or that a MEWA has sustained, or is in imminent danger of sustaining, a significant loss of assets. Under the definition, a MEWA may also be in a financially hazardous condition if the Secretary has issued a cease and desist order to a person responsible for the management, control, or administration of the MEWA or plan assets associated with the MEWA.

Paragraph (b)(6) defines a person, for purposes of these regulations, to be an individual, partnership, corporation, employee welfare benefit plan, association, or other entity or organization. One commenter posited that the definition of person in the proposed rules was too broad because it reached service providers to MEWAs. The Department does not agree that the definition of person is overbroad. As discussed above, persons that provide services to MEWAs may engage in conduct that is grounds for the issuance of an order. Moreover, as previously noted, if a MEWA is being operated in a fraudulent or financially hazardous manner, an order may need to apply to persons providing services to a MEWA in order to achieve its purpose. For example, it may be necessary for a cease and desist order to apply to an individual performing marketing services for a fraudulent MEWA even if the individual was not engaged in fraudulent conduct. In addition, the Department observes that the definition of person in ERISA section 3(9), while different from that in the proposed and these final rules, already encompasses service providers.

#### Cease and Desist Order

Paragraph (c) of §2560.521-1 addresses the scope of the cease and desist order. This paragraph is structured the same as in the proposed rules. Paragraph (c)(2)(i) notes that the Secretary may enjoin a MEWA or person from the conduct that served as the basis for the order and from activities in furtherance of that conduct though a cease and desist order. In addition, the cease and desist order may provide broader relief as the Secretary determines is necessary and appropriate to protect the interests of plan participants, plan beneficiaries, employers or employee organizations, or other members of the public. Paragraph (c)(2)(ii) provides that an order may prohibit a person from taking any specified actions with respect to, or exercising authority over, specified funds of any MEWA or of any welfare or pension plan. Paragraph (c)(2)(iii) provides that an order may

<sup>3</sup> Similarly, section 519 of ERISA, 29 U.S.C. 1149, (also enacted as part of the Affordable Care Act) prohibits false statements and representations by any person, in connection with a MEWA's marketing or sales, concerning the financial condition or solvency of the MEWA, the benefits provided by the MEWA, and the regulatory status of the MEWA. Under ERISA section 501(b), 29 U.S.C. 1131(b), (as amended by the Affordable Care Act) criminal penalties may apply to a violation of ERISA section 519. Other criminal penalties may apply under other federal provisions as well. See e.g., 29 U.S.C. 1131(a) (willful violations of ERISA reporting and disclosure requirements), 18 U.S.C. 1001 (knowingly and willfully false statements to the U.S. government), and 18 U.S.C. 1027 (knowingly false statement or knowing concealment of facts in relation to documents required by ERISA).

also bar a person from acting as a service provider to MEWAs or plans. This provision allows the Secretary to issue an order preventing a person from, for example, performing any administrative, management, financial, or marketing services for any MEWA or any welfare or pension plan. A cease and desist order containing such a prohibition against transacting business with any MEWA or plan would prevent the MEWA or a person from avoiding the cease and desist order by shutting the MEWA down and re-establishing it in a new location or under a new identity. Such a prohibition may be necessary in cases of serious harmful conduct where it would be contrary to the interests of plan participants, plan beneficiaries, employers or employee organizations, or other members of the public for a person whose conduct gave rise to the order to gain a position with other MEWAs or welfare or pension plans where they could repeat that conduct. The Department has added paragraph (c)(3) to clarify that it may require documentation from the subject of the order confirming compliance with the cease and desist order. Paragraph (d) of this section preserves the Secretary's existing ability to seek additional remedies under ERISA.

Under the new section 521(b) of ERISA, a person who is the subject of a temporary cease and desist order may request an administrative hearing to show cause why the order should be modified or set aside. Under the statute, the burden of proof rests with the person requesting the hearing. The process for the administrative hearing, set forth in paragraph (e) of §2560.521-1 in these final regulations, is basically the same process set forth in the proposed rules. If parties subject to a cease and desist order fail to request a hearing before an administrative law judge within 30 days after receiving notice of the order, the order becomes final. If a party makes a timely request for an administrative hearing, the order is not final until the conclusion of the process set forth in 29 CFR part 2571. It remains, however, in effect and enforceable throughout the administrative review process unless stayed by the Secretary, an administrative law judge, or a court. The section was slightly revised to clarify the nature of evidence the Secretary and the person requesting the hearing must provide to the administrative law judge. The proposed rules simply stated that the Secretary must offer evidence supporting the findings made in issuing the order. The final rules were revised to clarify the findings that must be supported by evidence, *i.e.*, the Secretary's findings that she had reasonable cause to believe that the MEWA (or a person acting as an employee or agent of the MEWA) engaged in the conduct specified in the new ERISA section 521(a) and §2560.521-1(c)(1) of the proposed and these final rules. The proposed rules further stated that the person requesting the hearing has the burden of proof to show that the order was not necessary to protect the interests of the plan, plan participants, plan beneficiaries, and others. The final rules were revised to state that the person requesting the hearing has the burden of proof to show that the MEWA (or a person acting as an employee or agent of the MEWA) did not engage in the conduct specified in the new ERISA section 521(a) and §2560.521-1(c)(1) of the proposed

and these final rules or that the requirements imposed by the order are arbitrary and capricious. This revision clarifies how the person requesting the hearing shows that the order was not necessary.

#### Summary Seizure Order

The new section 521(e) of ERISA and paragraph (f)(1) of §2560.521-1 of these rules authorize the Secretary to issue a summary seizure order when it appears that a MEWA is in a financially hazardous condition. Pursuant to the Fourth Amendment of the U.S. Constitution, the Secretary will generally obtain judicial authorization before issuing a summary seizure order. (See *Colonnade Catering Corp. v. U.S.*, 397 U.S. 72 (1970): "Where Congress has authorized inspection but made no rules governing the procedures that inspectors must follow, the Fourth Amendment and its various restrictive rules apply.") As in the proposed rules, paragraph (f)(2) provides for such judicial authorization. A court's authorization may be sought *ex parte* when the Secretary determines that prior notice could result in removal, dissipation, or concealment of plan assets. On its own initiative, the Department has slightly revised paragraph (f)(2) to clarify that it may seek appointment of a receiver or independent fiduciary by the court and other relief at the time it obtains judicial authorization. Paragraph (f)(3) clarifies that the Secretary may act on a summary seizure order prior to judicial authorization, however, if the Secretary reasonably believes that delay in issuing the order will result in the removal, dissipation, or concealment of assets. Under these circumstances, the Secretary will promptly seek judicial authorization after service of the order.

Paragraph (f)(4) of §2560.521-1 describes the general scope of a seizure order.<sup>4</sup> Under paragraph (f)(4), the Secretary may seize books, documents, and other records of the MEWA. She may also seize the premises, other property, and financial accounts for the purpose of transferring such property to a court-appointed receiver or independent fiduciary. In addition, the order may prohibit the MEWA and its operators from transacting any business or disposing of any property of the MEWA. This paragraph also clarifies that the order may be directed to any person holding assets that are the subject of the order, including banks or other financial institutions.

The principal purpose of a seizure order is to preserve the assets of an employee welfare benefit plan that is a MEWA, and assets of any employee welfare benefit plans under the control of a MEWA, that is in a hazardous financial condition so that such assets are available to pay claims and other legitimate expenses of the MEWA and its participating plans. The Secretary will also issue summary seizure orders to prevent abusive operators from illegally using or acquiring plan assets. Seized assets are not deposited with the U.S.

<sup>4</sup> The scope of the summary seizure order in this rule is similar to that provided for in section 201(B) in the National Association of Insurance Commissioners (NAIC) Insurer Receivership Model Act (October 2007).

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Treasury. Instead they are managed by a court-appointed receiver or independent fiduciary. Paragraph (f)(5) states that the Secretary may also, in connection with or following the execution of a summary seizure order, among other things, obtain court appointment of an independent fiduciary or receiver to perform any necessary functions of the MEWA, and court authorization for further actions in the best interest of plan participants, plan beneficiaries, employers or employee organizations, or other members of the public, including the liquidation and winding down of the MEWA, if appropriate. There were no comments on the procedures for issuing summary seizure orders or implementing other actions. With the minor exception noted above, and certain clarifying changes in paragraph (f)(5), the provisions in the proposed rules have been adopted without further modification.

The provisions related to effective date of orders (paragraph g), disclosure (§2560.521-2), and effect of ERISA section 521 on other enforcement authority (§2560.521-3) have not changed from the proposed rules. Paragraph (h) of §2560.521-1 of the proposed rules regarding the service of orders on persons who are corporations, associations, or other entities or organizations, was slightly revised for these final rules to state that service could also be made to any person designated for service of process under State law or the applicable plan document. Orders issued under these final rules are effective upon service and remain in effect until modified or set aside by the Secretary, an administrative law judge, or a reviewing court. Issued final orders will be made available to the public, as will modifications and terminations of such final orders.

Further, coordination and collaboration with other Federal agencies and the States are integral and instrumental to successful MEWA enforcement efforts. The Secretary remains committed to working closely with them to help detect, prevent, and address MEWA fraud, abuse, and financial insolvency. To facilitate this collaborative approach to MEWA enforcement, the Secretary may disclose the issuance of any order (whether temporary or final) and any information and evidence of any proceedings and hearings related to the order to other Federal, State, or foreign authorities. The sharing of such information, however, does not constitute a waiver of any applicable privilege or claim of confidentiality as to the information so shared.

The Secretary also remains committed to helping MEWAs and plan officials comply with legal requirements and serve plan participants and beneficiaries properly. Section 521 is not, however, the only enforcement tool available to the Secretary with regard to MEWAs. She will continue to use the other investigatory and enforcement tools which were available to the Secretary under title I of ERISA prior to the enactment of ERISA section 521.

#### Cross-Reference

These rules finalize the standards for the issuance of ex parte cease and desist and summary seizure orders. The Department has also finalized in this Notice rules

for administrative hearings on ex parte cease and desist orders. In addition, elsewhere in this issue of the **Federal Register** is a separate regulation amending 29 CFR 2520-101.2, 2520.103-1, 2520.104-20, and 2520.104-41 to implement section 101(g), as amended by the Affordable Care Act, and to enhance the department's ability to enforce requirements under 29 CFR 2520-101.2.

#### *B. Procedures for Administrative Hearings on the Issuance of Cease and Desist Orders Regulation (29 CFR Part 2571)*

##### Purpose and Definitions

These final procedural rules apply only to adjudicatory proceedings before administrative law judges of the U.S. Department of Labor. Under these procedural rules, an adjudicatory proceeding before an administrative law judge is commenced only after a person who is the subject of a temporary cease and desist order timely requests a hearing and files an answer showing cause why the temporary order should be modified or set aside. These procedural regulations are largely consistent with rules of practice and procedure under 29 CFR part 18 that generally apply to matters before the Department's Office of Administrative Law Judges (OALJ). At the same time, they reflect the unique nature of orders issued under ERISA section 521. The definitional section of this rule, for instance, incorporates the basic adjudicatory principles set forth at 29 CFR part 18, but includes terms and concepts of specific relevance to proceedings under ERISA section 521. These rules are controlling to the extent they are inconsistent with 29 CFR part 18.

The authority of the Secretary with respect to the orders and proceedings covered by this rule has been delegated to the Assistant Secretary for the Employee Benefits Security Administration pursuant to Secretary's Order 1-2011, 77 FR 1088 (Jan. 9, 2012). With respect to appeals of administrative law judge decisions to the Secretary, the Assistant Secretary has redelegated this authority to the Director of the Office of Policy and Research of the Employee Benefits Security Administration. As required by the Administrative Procedure Act (5 U.S.C. 552(a)(2)(A)) all final decisions of the Department under section 521 of ERISA shall be maintained, and available for public inspection, in the Public Disclosure Room of the Employee Benefits Security Administration, Room N-1513, U.S. Department of Labor, 200 Constitution Ave. NW., Washington, DC 20210.

There were no comments on the proposed administrative procedures. The proposed rules are being published as final rules with only minor clarifying changes. Of note, under §2571.4(d) of the proposed rules, if the administrative law judge denies a petition to participate in the hearing by persons not named in a temporary order, the administrative law judge shall treat the petition as a request for participation as an amicus curiae. The final rules give the administrative law judge discretion on the treatment of denied petitions and state

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that the administrative law judge may consider whether to treat the petition as a request for participation as *amicus curiae*. In addition, as stated in the preamble and §2571.7 of the proposed rules, the fiduciary exception to the attorney-client and work product privileges applies. Consequently, the administrative law judge may not protect from discovery nor from use in the proceedings communications between an attorney and a plan administrator or other plan fiduciary, or work product, that fall under the fiduciary exception. The final rules clarify that the fiduciary exception applies to communications and work product between an attorney and plan fiduciary concerning plan administration and other fiduciary activities, and not to communications made or documents prepared to aid the fiduciary personally or for settlor acts. See *Solis v. The Food Employers Labor Relations Ass'n*, 644 F.3d 221 (4th Cir. 2011). This provision should not be interpreted as excluding consideration by the administrative law judge of other relevant exceptions to the privileges.

#### IV. Economic Impact and Paperwork Burdens

##### A. Summary

These final regulations implement amendments made by section 6605 of the Affordable Care Act, which added ERISA section 521. As discussed earlier in this preamble, ERISA section 521 provides the Secretary of Labor with new enforcement authority over MEWAs. Specifically, ERISA section 521(a) authorizes the Secretary to issue cease and desist orders, without prior notice or a hearing, when it appears to the Secretary that a MEWA's alleged conduct is fraudulent, creates an immediate danger to the public safety or welfare, or causes or can be reasonably expected to cause significant, imminent, and irreparable public injury. This section also authorizes the Secretary to issue a summary order to seize the assets of a MEWA the Secretary determines to be in a financially hazardous condition. These final regulations implement ERISA section 521(a) by setting forth procedures the Secretary will follow to issue *ex parte* cease and desist and summary seizure orders.

ERISA section 521(b), as added by Affordable Care Act section 6605, provides that a person that is adversely affected by the issuance of a cease and desist order may request an administrative hearing regarding the order. These final regulations also implement the requirements of ERISA section 521(b) by describing the procedures before the Office of Administrative Law Judges (OALJ) that will apply when a person seeks an administrative hearing for review of a cease and desist order. These regulations maintain the maximum degree of uniformity with rules of practice and procedure under 29 CFR part 18 that generally apply to matters before the OALJ. At the same time, these regulations reflect the unique nature of orders issued under ERISA section 521, and are controlling to the extent they are inconsistent with 29 CFR part 18.

##### B. Executive Order 12866 and 13563 Statement

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing and streamlining rules, and of promoting flexibility. It also requires federal agencies to develop a plan under which the agencies will periodically review their existing significant regulations to make the agencies' regulatory programs more effective or less burdensome in achieving their regulatory objectives.

Under Executive Order 12866, a regulatory action deemed "significant" is subject to the requirements of the Executive Order and review by the Office of Management and Budget (OMB). Section 3(f) of the Executive 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.

These regulatory actions are not economically significant within the meaning of section 3(f)(1) of the Executive Order. However, OMB has determined that the actions are significant within the meaning of section 3(f)(4) of the Executive Order, and the Department accordingly provides the following assessment of their potential benefits and costs.

##### 1. Need for Regulatory Action

Properly structured and managed MEWAs that are licensed to operate in a State provide a viable option for some employers to purchase affordable health insurance coverage. However, some MEWAs are marketed by unlicensed entities attempting to avoid State insurance reserve, contribution, and consumer protection requirements. By avoiding these requirements, such entities often are able to market insurance coverage at lower rates than licensed insurers, making them particularly attractive to some small employers that find it difficult to obtain affordable health insurance coverage for their employees. Due to insufficient funding and inadequate reserves, and in some situations, fraud, some MEWAs have become insolvent and unable to pay benefit claims. In addition, certain

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promoters set up arrangements that they claim are not MEWAs subject to state insurance regulation, because they are established pursuant to collective bargaining agreements. Often, however, these collective bargaining agreements are nothing more than shams designed to avoid state insurance regulation.

Employees and their dependents have become financially responsible for paying medical claims they presumed were covered by insurance after paying health insurance premiums to fraudulent MEWAs.<sup>5</sup> The impact, financial and otherwise, on individuals and families can be devastating when MEWAs become insolvent. Moreover, employees and their dependents may be deprived of medical services if they cannot afford to pay medical claims out-of-pocket that are not paid by the MEWA.

Before the enactment of ERISA section 521, the Department's primary enforcement tool against fraudulent and abusive MEWAs was court-ordered injunctive relief. In order to obtain this relief, the Department must present evidence to a federal court that an ERISA fiduciary breach occurred and that the Department is likely to prevail based on the merits of the case. Gathering sufficient evidence to prove a fiduciary breach is time-consuming and labor-intensive, in most cases, because the Department's investigators must work with poor or nonexistent financial records and uncooperative parties. As a result, the Department at times has been unable to shut down fraudulent and abusive MEWAs quickly enough to preserve their assets and ensure that outstanding benefit claims are timely paid.

States also encountered problems in their enforcement efforts against MEWAs in the absence of federal authority to shut down fraudulent and abusive MEWAs nationally. When one State succeeded in shutting down an abusive MEWA, in some cases, its operators continued operating in another State.<sup>6</sup> ERISA section 521 provides the Department with stronger legal remedies to combat fraudulent and abusive MEWAs.

ERISA section 521(f) provides the Secretary of Labor with the authority to promulgate regulations that may be necessary and appropriate to carry out the Department's authority under ERISA section 521. These regulations are necessary, because they set forth standards and procedures the Department would use to implement this new enforcement authority. They also are necessary to provide procedures that a person who is adversely affected by the issuance of a cease and desist order may follow to request an administrative hearing regarding the order pursuant to ERISA section 521(b).

## 2. ERISA Section 521(a) and (e), Ex Parte Cease and Desist and Summary Seizure Orders--Multiple Employer Welfare Arrangements (29 CFR 2560.521-1)

### a. Benefits of Final Rules

As discussed earlier in this preamble, ERISA section 521(a) authorizes the Secretary to issue an ex parte cease and desist order if it appears to the Secretary that the alleged conduct of a MEWA is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can reasonably be expected to cause, significant, imminent, and irreparable public injury. ERISA section 521(e) allows the Secretary to issue a summary seizure order if it appears that a MEWA is in a financially hazardous condition. These final regulations implement the Department's enhanced enforcement authority by setting forth the standards and procedures the Department will follow in issuing cease and desist and summary seizure orders. They also define important statutory terms and clarify the scope of the Department's authority under ERISA sections 521(a) and (e).

ERISA section 521 and these final regulations will potentially benefit approximately two million MEWA participants<sup>7</sup> by ensuring that MEWA assets are preserved and benefits timely paid. In some cases, individuals have incurred significant medical claims before they learn that their claims are not being paid by improperly operated MEWAs and that they are responsible for paying these claims out-of-pocket. These regulations will help such individuals avoid the financial hardship and adverse health effects that result from unpaid health claims. They also will benefit health care providers that are detrimentally impacted when they are not paid for services they have performed. ERISA section 521 and these final regulations also will improve MEWA compliance and deter abusive practices of fraudulent MEWAs, potentially lessening the need for future use of these provisions. As a result of these statutory and regulatory provisions, the Department will be able to take enforcement action against fraudulent and abusive MEWAs much more quickly and efficiently than under prior law. Common examples of such fraudulent and abusive conduct include a systematic failure to pay benefits claims or a diversion of premiums for personal use. For example, Employers Mutual, a MEWA covering 22,000 individuals which turned out to be a nationwide health insurance fraud, advertised deceptively low premium rates that were far less than necessary to pay promised benefits and misrepresented that the benefits were fully insured. Operators of this MEWA misused and misappropriated premiums so extensively that by the time the Department was able to shut down the MEWA and appoint an independent fiduciary to take over, the fraud left \$27 million in unpaid benefits. With this new authority, the Department can take steps to protect plan participants and small employers much earlier in the process and before a MEWA's assets have been exhausted. In addition, the Department will be able to take action against fraudulent and abusive MEWAs

<sup>5</sup> GAO Report, *supra* note 2.

<sup>6</sup> *Id.*

<sup>7</sup> The Department's estimate is based on the number of MEWA participants reported on the 2010 Form M-1. Please note that this is an undercount, because the Form M-1 definition of participants specifically excludes dependents.

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nationally, which will prevent unscrupulous MEWA operators from moving their operations to another State when they are shut down in a State.

b. Costs of the Final Rules

As discussed earlier in this preamble, the final rules provide standards and procedures the Department would follow to issue ex parte cease and desist and summary seizure orders with respect to MEWAs. The Department does not expect the rules to impose any significant costs, because it does not require any action or impose any requirements on MEWAs as defined in ERISA section 3(40). Therefore, the Department concludes that the final rules would enhance the Department's ability to take immediate action against fraudulent and abusive MEWAs without imposing major costs.

3. ERISA Section 521(b), Procedures for Administrative Hearings on the Issues of Cease and Desist Orders--Multiple Employer Welfare Arrangements (29 CFR 2571.1 Through 2571.12)

a. Benefits of Final Rule

The Department expects that administrative hearings held pursuant to ERISA section 521(b) and the procedures set forth in the final regulations would benefit the Department and parties requesting a hearing. The Department foresees improved efficiencies through use of administrative hearings, because such hearings should allow the parties involved to obtain a decision in a more timely and efficient manner than is customary in federal court proceedings, which would be the alternative adjudicative forum. The Department expects that these final rules setting forth the standards and procedures the Department would use to implement its cease and desist authority under ERISA section 521 will allow it to take action against fraudulent and abusive MEWAs much more quickly and efficiently than under prior law. These benefits have not been quantified.

To access the benefit of improved efficiencies that would result from an administrative proceeding, the Department compared the cost of contesting a cease and desist order under the final regulations to the cost of contesting an action taken against a MEWA by the Department before the enactment of the Affordable Care Act. The Department's primary enforcement tool against fraudulent and abusive MEWAs before Congress enacted ERISA section 521 was court-ordered injunctive relief. In order to obtain this relief, the Department must present evidence to a court that an ERISA fiduciary breach occurred and that the Department likely would prevail based on the merits of the case. Gathering sufficient evidence to prove a fiduciary breach is very time-consuming and labor-intensive, in most cases, because the Department's investigators must work with poor or nonexistent financial records and uncooperative parties.

The Department believes that an administrative hearing should result in cost savings compared with the baseline cost of litigating in federal court. Because the

procedures and evidentiary rules of an administrative hearing generally track the Federal Rules of Civil Procedure and Evidence, document production will be similar for both an administrative hearing and a federal court proceeding. It is unlikely that any additional cost will be incurred for an administrative hearing than would be required to prepare for federal court litigation. Moreover, certain administrative hearing practices and other new procedures initiated by these regulations are expected to result in cost savings over court litigation. For example, parties may be more likely to appear pro se; the prehearing exchange is expected to be short and general; a motion for discovery only will be granted upon a showing of good cause; the general formality of the hearing may vary, particularly depending on whether the petitioner is appearing pro se; and the administrative law judge would be required to make its decision expeditiously after the conclusion of the ERISA section 521 proceeding. The Department cannot with certainty predict that any or all of these conditions will exist nor that any of these factors represent a cost savings, but it is likely that the administrative hearing process will create a consistent legal standard for section 521 proceedings.

The Department invited public comments on the comparative cost of a federal court proceeding versus an administrative hearing. The Department did not receive any comments that addressed this issue.

b. Costs of Final Rule

The Department estimates that the cost of the final regulation would total approximately \$548,900 annually. The total hour burden is estimated to be approximately 20 hours, and the dollar equivalent of the hour burden is estimated to be approximately \$564. The data and methodology used in developing these estimates are described more fully in the Paperwork Reduction Act section, below.

C. Paperwork Reduction Act

This issuance of the cease and desist order final regulation 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). The Final Rule on Procedures for Administrative Hearings Regarding the Issuance of Cease and Desist Orders under ERISA section 521--Multiple Employer Welfare Arrangements contains a collection of information and the associated hour and cost burden are discussed below.

In accordance with the requirements of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)), the Department submitted an information collection request (ICR) to OMB in accordance with 44 U.S.C. 3507(d), contemporaneously with the publication of the proposed regulation, for OMB's review and solicited public comment. No public comments were received related to the administrative hearing procedures for cease and desist orders. OMB

assigned OMB control number 1210-0148 to the ICR but did not approve the ICR at the proposed rule stage.

In connection with publication of these final rules, the Department submitted a revision to the ICR under OMB Control Number 1210-0116. OMB approved the revised ICR, which is scheduled to expire on February 29, 2016. A copy of the revised ICR may be obtained by contacting the PRA addressee shown below or at <http://www.RegInfo.gov>.

PRA ADDRESSEE: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW., Room N 5647, Washington, DC 20210. Telephone (202) 693-8410; Fax: (202) 219-4745. These are not toll free numbers.

This final regulation establishes procedures for hearings and appeals before an administrative law judge and the Secretary when a MEWA or other person challenges a temporary cease and desist order. As stated in the Regulatory Flexibility Act analysis below, the Department estimates that, on average, a maximum of 10 MEWAs would initiate an adjudicatory proceeding before an administrative law judge to revoke or modify a cease and desist order.<sup>8</sup> Most of the factual information necessary to prepare the petition should be readily available to the MEWA and is expected to take approximately two hours of clerical time to assemble and forward to legal professionals resulting in an estimated total hour burden of approximately 20 hours.

The Department believes that MEWAs will hire outside attorneys to prepare and file the appeal, which is estimated to require 120 hours at \$457 per hour.<sup>9</sup> The majority of the attorneys' time is expected to be spent drafting motions, petitions, pleadings, briefs, and other documents relating to the case. Based on the foregoing, the total estimated legal cost associated with the information collection would be approximately \$54,840 per petition filed. Additional costs material and mailing costs are estimated at approximately \$50.00 per petition.

*Type of Review:* New.

*Agency:* Employee Benefits Security Administration

*Title:* Final Rule on Procedures for Administrative Hearings Regarding the Issuance of Cease and Desist

<sup>8</sup> As stated in the Department's December 1, 2011 Fact Sheet on MEWA Enforcement, the Department has filed 99 civil complaints against MEWAs since 1990, which averages approximately five complaints per year. With the expanded enforcement authority provided to the Department under the Affordable Care Act, the number of civil complaints brought against MEWAs by the Department could increase. Therefore, for purposes of this Paperwork Reduction Act analysis, the Department assumes that twenty complaints will be filed as an upper bound. The Department is unable to estimate the number of cease and desist orders that will be contested; therefore, for purposes of this analysis it assumes that half of the MEWAs will contest cease and desist orders. The Department's fact sheet on MEWA enforcement can be found on the EBSA Web site at <http://www.dol.gov/ebsa/newsroom/fsMEWAenforcement>.

<sup>9</sup> The Department's estimate for the attorney's hourly rate is taken from the Laffey Matrix which provides an estimate of legal service for court cases in the DC area. It can be found at <http://www.laffeymatrix.com/see.html>. The estimate is an average of the 4-7 and 8-10 years of experience rates. The proposed rule included an estimate of 40 hours of outside attorney time for an administrative appeal. Though no comments were submitted on that estimate and we cannot state an estimate with certainty, after further consideration of the potential tasks involved we determined that a higher number would be more appropriate.

Orders under ERISA section 521--Multiple Employer Welfare Arrangements.

*OMB Number:* 1210-0148.

*Affected Public:* Business or other for profit; not for profit institutions; State government.

*Respondents:* 10.

*Responses:* 10.

*Estimated Total Burden Hours:* 20 hours.

*Estimated Total Burden Cost (Operating and Maintenance):* \$548,900.

#### D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) applies to most 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.*). Unless an agency certifies that such a rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires the agency to present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations and governmental jurisdictions. In accordance with the RFA, the Department prepared an initial regulatory flexibility analysis at the proposed rule stage and requested comments on the analysis. No comments were received. Below is the Department's final regulatory flexibility analysis and its certification that these final regulations do not have a significant economic impact on a substantial number of small entities.

The Department does not have data regarding the total number of MEWAs that currently exist. The best information the Department has to estimate the number of MEWAs is based on filing of the Form M-1, which is an annual report that MEWAs and certain collectively bargained arrangements file with the Department. Form M-1 was filed with the Department by 436 MEWAs in 2010, the latest year for which data is available.

The Small Business Administration uses a size standard of less than \$7 million in average annual receipts to determine whether businesses in the finance and insurance sector are small entities.<sup>10</sup> While the Department does not collect revenue information on the Form M-1, it does collect data regarding the number of participants covered by MEWAs that file Form M-1 and can use average premium data to determine the number of MEWAs that are small entities because they do not exceed the \$7 million dollar threshold. For 2009, the average annual premium for single coverage was \$4,717 and the average annual premium for family coverage was \$12,696.<sup>11</sup> Combining these premium estimates with estimates from the Current Population Survey regarding the fraction of policies that are for single or family coverage at employers with less than

<sup>10</sup> U.S. Small Business Administration, "Table of Small Business Size Standards Matched to North American Industry Classification System Codes." [http://www.sba.gov/sites/default/files/Size\\_Standards\\_Table.pdf](http://www.sba.gov/sites/default/files/Size_Standards_Table.pdf).

<sup>11</sup> Kaiser Family Foundation and Health Research Educational Trust "Employer Health Benefits, 2009 Annual Survey." The reported numbers are from Exhibit 1.2 and are for the category Annual, all Small Firms (3-199 workers).

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500 workers, the Department estimates approximately 60 percent of MEWAs (258 MEWAs) are small entities.

In order to develop an estimate of the number of MEWAs that could become subject to a cease and desist order, the Department examined the number of civil claims the Department filed against MEWAs since FY 1990. During this time, the Department filed 99 civil complaints against MEWAs, an average of approximately five complaints per year. For purposes of this analysis, the Department believes that an average of twenty complaints a year is a reasonable upper bound estimate of the number of MEWAs that could be subject to a cease and desist order<sup>12</sup> and that half this number, or an average of ten complaints a year, is a reasonable upper bound estimate of the number of MEWAs that could be expected to request an administrative hearing in a year.

Based on the foregoing, the Department estimates that the greatest number of small MEWAs likely to be subject to a cease and desist order (20/258 or 7.8 percent) and the greatest number of MEWAs likely to petition for an administrative hearing (10/258 or 3.9 percent) represents a small fraction of the total number of small MEWAs.

Accordingly, the Department hereby certifies that these final regulations will not have a significant economic impact on a substantial number of small entities.

#### *E. 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, these final rules do 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 adjusted for inflation since 1995.

#### *F. 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 the States and the Federal Government share dual jurisdiction over MEWAs that are employee benefit

plans or hold plan assets. Generally, States are primarily responsible for overseeing the financial soundness and licensing of MEWAs under State insurance laws. The Department enforces ERISA's provisions, including its fiduciary responsibility provisions against MEWAs that are ERISA plans or that hold or control plan assets.

Over the years, the Department and State insurance departments have worked closely and coordinated their investigations and other actions against fraudulent and abusive MEWAs. For example, EBSA regional offices have met with State officials in their regions and provided information necessary for States to obtain cease and desist orders to stop abusive and insolvent MEWAs. The Department also has relied on States to obtain cease and desist orders against MEWAs in individual States while it pursued investigations to gather sufficient evidence to obtain injunctive relief in the federal courts to shut down MEWAs nationally. States have often lobbied for stronger federal enforcement tools to help combat fraudulent and insolvent MEWAs. By providing procedures and standards the Department would follow to issue *ex parte* cease and desist and summary seizure orders and providing procedures for use by administrative law judges and the Secretary of Labor when a MEWA or other person challenges a temporary cease and desist order, these final rules address the States' concerns and enhance the State and Federal Government's joint mission to take immediate action against fraudulent and abusive MEWAs and limit the losses suffered by American workers and their families when abusive MEWAs become insolvent and fail to reimburse medical claims.

#### **List of Subjects**

##### *29 CFR Part 2560*

Administrative practice and procedure, Employee welfare benefit plans, Employee Retirement Income Security Act, Law enforcement, Pensions, Multiple employer welfare arrangements, Cease and desist, Seizure.

##### *29 CFR Part 2571*

Administrative practice and procedure, Employee benefit plans, Employee Retirement Income Security Act, Multiple employer welfare arrangements, Law enforcement, Cease and desist.

For the reasons set out in the preamble, 29 CFR chapter XXV is amended as follows:

#### **PART 2560--RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT**

■ 1. The authority citation for part 2560 is revised to read as follows:

**Authority:** 29 U.S.C. 1002(40), 1132, 1133, 1134, 1135, and 1151; and Secretary of Labor's Order 1-2011, 77 FR 1088 (Jan. 9, 2012).

<sup>12</sup> With the expanded enforcement authority provided to the Department under the Affordable Care Act, the number of civil complaints brought against MEWAs by the Department could increase. Therefore, for purposes of this analysis, the Department assumes that twenty complaints will be filed as an upper bound. The Department is unable to estimate the number of cease and desist orders that will be contested; therefore, it assumes that half the MEWAs will contest cease and desist orders.

■ 2. Sections 2560.521-1 through 2560.521-4 are added to read as follows:

**§2560.521-1 Cease and desist and seizure orders under section 521.**

(a) *Purpose.* Section 521(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1151(a), authorizes the Secretary of Labor to issue an ex parte cease and desist order if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement (MEWA) under section 3(40) of ERISA is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. Section 521(e) of ERISA authorizes the Secretary to issue a summary seizure order if it appears that a MEWA is in a financially hazardous condition. An order may apply to a MEWA or to persons having custody or control of assets of the subject MEWA, any authority over management of the subject MEWA, or any role in the transaction of the subject MEWA's business. This section sets forth standards and procedures for the Secretary to issue ex parte cease and desist and summary seizure orders and for administrative review of the issuance of such cease and desist orders.

(b) *Definitions.* When used in this section, the following terms shall have the meanings ascribed in this paragraph (b).

(1) *Multiple employer welfare arrangement (MEWA)* is an arrangement as defined in section 3(40) of ERISA that either is an employee welfare benefit plan subject to Title I of ERISA or offers benefits in connection with one or more employee welfare benefit plans subject to Title I of ERISA. For purposes of section 521 of ERISA, a MEWA does not include a health insurance issuer (including a health maintenance organization) that is licensed to offer or provide health insurance coverage to the public and employers at large in each State in which it offers or provides health insurance coverage, and that, in each such State, is subject to comprehensive licensure, solvency, and examination requirements that the State customarily requires for issuing health insurance policies to the public and employers at large. The term health insurance issuer does not include group health plans. For purposes of this section, the term "health insurance coverage" has the same meaning as in ERISA section 733(b)(1).

(2) *The conduct of a MEWA is fraudulent:*

(i) When the MEWA or any person acting as an agent or employee of the MEWA commits an act or omission knowingly and with an intent to deceive or defraud plan participants, plan beneficiaries, employers or employee organizations, or other members of the public, the Secretary, or a State regarding:

(A) The financial condition of the MEWA (including the MEWA's solvency and the management of plan assets);

(B) The benefits provided by or in connection with the MEWA;

(C) The management, control, or administration of the MEWA;

(D) The existing or lawful regulatory status of the MEWA under Federal or State law; or,

(E) Any other material fact, as determined by the Secretary, relating to the MEWA or its operation.

(ii) Fraudulent conduct includes any false statement regarding any of paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section that is made with knowledge of its falsity or that is made with reckless indifference to the statement's truth or falsity, and the knowing concealment of material information regarding any of paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section. Examples of fraudulent conduct include, but are not limited to, misrepresenting the terms of the benefits offered by or in connection with the MEWA or the financial condition of the MEWA or engaging in deceptive acts or omissions in connection with marketing or sales or fees charged to employers or employee organizations.

(3) *The conduct of a MEWA creates an immediate danger to the public safety or welfare* if the conduct of a MEWA or any person acting as an agent or employee of the MEWA impairs, or threatens to impair, a MEWA's ability to pay claims or otherwise unreasonably increases the risk of nonpayment of benefits. Intent to create an immediate danger is not required for this criterion. Examples of such conduct include, but are not limited to, a systematic failure to properly process or pay benefit claims, including failure to establish and maintain a claims procedure that complies with the Secretary's claims procedure regulations (29 CFR 2560.503-1 and 29 CFR 2590.715-2719), failure to establish or maintain a recordkeeping system that tracks the claims made, paid, or processed or the MEWA's financial condition, a substantial failure to meet applicable disclosure, reporting, and other filing requirements, including the annual reporting and registration requirements under sections 101(g) and 104 of ERISA, failure to establish and implement a policy or method to determine that the MEWA is actuarially sound with appropriate reserves and adequate underwriting, failure to comply with a cease and desist order issued by a government agency or court, and failure to hold plan assets in trust.

(4) *The conduct of a MEWA is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury:*

(i) If the conduct of a MEWA, or of a person acting as an agent or employee of the MEWA, is having, or is reasonably expected to have, a significant and imminent negative effect on one or more of the following:

(A) An employee welfare benefit plan that is, or offers benefits in connection with, a MEWA;

(B) The sponsor of such plan or the employer or employee organization that makes payments for benefits provided by or in connection with a MEWA; or

(C) Plan participants and plan beneficiaries; and

(ii) If it is not reasonable to expect that such effect will be fully repaired or rectified.

Intent to cause injury is not required for this criterion. Examples of such conduct include, but are not limited to, conversion or concealment of

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property of the MEWA; improper disposal, transfer, or removal of funds or other property of the MEWA, including unreasonable compensation or payments to MEWA operators and service providers (e.g. brokers, marketers, and third party administrators); employment by the MEWA of a person prohibited from such employment pursuant to section 411 of ERISA, and embezzlement from the MEWA. For purposes of section 521 of ERISA, compensation that would be excessive under 26 CFR 1.162-7 will be considered unreasonable compensation or payments for purposes of this regulation. Depending upon the facts and circumstances, compensation may be unreasonable under this regulation even if it is not excessive under 26 CFR 1.162-7.

(5) A MEWA is in a financially hazardous condition if:

(i) The Secretary has probable cause to believe that a MEWA:

(A) Is, or is in imminent danger of becoming, unable to pay benefit claims as they come due, or

(B) Has sustained, or is in imminent danger of sustaining, a significant loss of assets; or

(ii) A person responsible for management, control, or administration of the MEWA's assets is the subject of a cease and desist order issued by the Secretary.

(6) A person, for purposes of this section, is an individual, partnership, corporation, employee welfare benefit plan, association, or other entity or organization.

(c) *Temporary cease and desist order.* (1)(i) The Secretary may issue a temporary cease and desist order when the Secretary finds there is reasonable cause to believe that the conduct of a MEWA, or any person acting as an agent or employee of the MEWA, is -

(A) Fraudulent;

(B) Creates an immediate danger to the public safety or welfare; or

(C) Is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

(ii) A single act or omission may be the basis for a temporary cease and desist order.

(2) A temporary cease and desist order, as the Secretary determines is necessary and appropriate to stop the conduct on which the order is based, and to protect the interests of plan participants, plan beneficiaries, employers or employee organizations, or other members of the public, may--

(i) Prohibit specific conduct or prohibit the transaction of any business of the MEWA;

(ii) Prohibit any person from taking specified actions, or exercising authority or control, concerning funds or property of a MEWA or of any employee benefit plan, regardless of whether such funds or property have been commingled with other funds or property; and,

(iii) Bar any person either directly or indirectly, from providing management, administrative, or other services to any MEWA or to an employee benefit plan or trust.

(3) The Secretary may require documentation from the subject of the order verifying compliance.

(d) *Effect of order on other remedies.* The issuance of a temporary or final cease and desist order shall

not foreclose the Secretary from seeking additional remedies under ERISA.

(e) *Administrative hearing.* (1) A temporary cease and desist order shall become a final order as to any MEWA or other person named in the order 30 days after such person receives notice of the order unless, within this period, such person requests a hearing in accordance with the requirements of this paragraph (e).

(2) A person requesting a hearing must file a written request and an answer to the order showing cause why the order should be modified or set aside. The request and the answer must be filed in accordance with 29 CFR part 2571 and §18.4 of this title.

(3) A hearing shall be held expeditiously following the receipt of the request for a hearing by the Office of the Administrative Law Judges, unless the parties mutually consent, in writing, to a later date.

(4) The decision of the administrative law judge shall be issued expeditiously after the conclusion of the hearing.

(5) The Secretary must offer evidence supporting the findings made in issuing the order that there is reasonable cause to believe that the MEWA (or a person acting as an employee or agent of the MEWA) engaged in conduct specified in paragraph (c)(1) of this section.

(6) The person requesting the hearing has the burden to show that the order should be modified or set aside. To meet this burden such person must show by a preponderance of the evidence that the MEWA (or a person acting as an employee or agent of the MEWA) did not engage in conduct specified in paragraph (c) (1) of this section or must show that the requirements imposed by the order, are, in whole or part, arbitrary and capricious.

(7) Any temporary cease and desist order for which a hearing has been requested shall remain in effect and enforceable, pending completion of the administrative proceedings, unless stayed by the Secretary, an administrative law judge, or by a court.

(8) The Secretary may require that the hearing and all evidence be treated as confidential.

(f) *Summary seizure order.* (1) Subject to paragraphs (f)(2) and (3) of this section, the Secretary may issue a summary seizure order when the Secretary finds there is probable cause to believe that a MEWA is in a financially hazardous condition.

(2) Except as provided in paragraph (f)(3) of this section, the Secretary, before issuing a summary seizure order to remove assets and records from the control and management of the MEWA or any persons having custody or control of such assets or records, shall obtain judicial authorization from a federal court in the form of a warrant or other appropriate form of authorization and may at that time pursue other actions such as those set forth in paragraph (f)(5) of this section.

(3) If the Secretary reasonably believes that any delay in issuing the order is likely to result in the removal, dissipation, or concealment of plan assets or records, the Secretary may issue and serve a summary seizure order before seeking court authorization. Promptly following service of the order, the Secretary shall seek authorization from a federal court and may at

that time pursue other actions such as those set forth in paragraph (f)(5) of this section.

(4) A summary seizure order may authorize the Secretary to take possession or control of all or part of the books, records, accounts, and property of the MEWA (including the premises in which the MEWA transacts its business) to protect the benefits of plan participants, plan beneficiaries, employers or employee organizations, or other members of the public, and to safeguard the assets of employee welfare benefit plans. The order may also direct any person having control and custody of the assets that are the subject of the order not to allow any transfer or disposition of such assets except upon the written direction of the Secretary, or of a receiver or independent fiduciary appointed by a court.

(5) In connection with or following the execution of a summary seizure order, the Secretary may--

(i) Secure court appointment of a receiver or independent fiduciary to perform any necessary functions of the MEWA;

(ii) Obtain court authorization for the Secretary, the receiver or independent fiduciary to take any other action to seize, secure, maintain, or preserve the availability of the MEWA's assets; and

(iii) Obtain such other appropriate relief available under ERISA to protect the interest of employee welfare benefit plan participants, plan beneficiaries, employers or employee organizations or other members of the public. Other appropriate equitable relief may include the liquidation and winding up of the MEWA's affairs and, where applicable, the affairs of any person sponsoring the MEWA.

(g) *Effective date of orders.* Cease and desist and summary seizure orders are effective immediately upon issuance by the Secretary and shall remain effective, except to the extent and until any provision is modified or the order is set aside by the Secretary, an administrative law judge, or a court.

(h) *Service of orders.* (1) As soon as practicable after the issuance of a temporary or final cease and desist order and no later than five business days after issuance of a summary seizure order, the Secretary shall serve the order either:

(i) By delivering a copy to the person who is the subject of the order. If the person is a partnership, service may be made to any partner. If the person is a corporation, association, or other entity or organization, service may be made to any officer of such entity or any person designated for service of process under State law or the applicable plan document. If the person is an employee welfare benefit plan, service may be made to a trustee or administrator. A person's attorney may accept service on behalf of such person;

(ii) By leaving a copy at the principal office, place of business, or residence of such person or attorney; or

(iii) By mailing a copy to the last known address of such person or attorney.

(2) If service is accomplished by certified mail, service is complete upon mailing. If service is done by regular mail, service is complete upon receipt by the addressee.

(3) Service of a temporary or final cease and desist order and of a summary seizure order shall include a statement of the Secretary's findings giving rise to the order, and, where applicable, a copy of any warrant or other authorization by a court.

#### **§2560.521-2 Disclosure of order and proceedings.**

(a) Notwithstanding §2560.521-1(e)(8), the Secretary shall make available to the public final cease and desist and summary seizure orders or modifications and terminations of such final orders.

(b) Except as prohibited by applicable law, and at his or her discretion, the Secretary may disclose the issuance of a temporary cease and desist order or summary seizure order and information and evidence of any proceedings and hearings related to an order, to any Federal, State, or foreign authorities responsible for enforcing laws that apply to MEWAs and parties associated with, or providing services to, MEWAs.

(c) The sharing of such documents, material, or other information and evidence under this section does not constitute a waiver of any applicable privilege or claim of confidentiality.

#### **§2560.521-3 Effect on other enforcement authority.**

The Secretary's authority under section 521 shall not be construed to limit the Secretary's ability to exercise his or her enforcement or investigatory authority under any other provision of title I of ERISA. 29 U.S.C. 1001 *et seq.* The Secretary may, in his or her sole discretion, initiate court proceedings without using the procedures in this section.

#### **§2560.521-4 Cross-reference.**

See 29 CFR 2571.1 through 2571.13 for procedural rules relating to administrative hearings under section 521 of ERISA.

■ 3. Add part 2571 to read as follows:

### **PART 2571--PROCEDURAL REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT**

#### **Subpart A--Procedures for Administrative Hearings on the Issuance of Cease and Desist Orders Under ERISA Section 521--Multiple Employer Welfare Arrangements**

Sec.

2571.1 Scope of rules.

2571.2 Definitions.

2571.3 Service: copies of documents and pleadings.

2571.4 Parties.

2571.5 Consequences of default.

2571.6 Consent order or settlement.

2571.7 Scope of discovery.

2571.8 Summary decision.

2571.9 Decision of the administrative law judge.

2571.10 Review by the Secretary.

2571.11 Scope of review by the Secretary.

2571.12 Procedures for review by the Secretary.

2571.13 Effective date.

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**Subpart B--[Reserved]**

**Authority:** 29 U.S.C. 1002(40), 1132, 1135; and 1151, Secretary of Labor's Order 1-2011, 77 FR 1088 (January 9, 2012).

**Subpart A--Procedures for Administrative Hearings on the Issuance of Cease and Desist Orders Under ERISA Section 521--Multiple Employer Welfare Arrangements**

**§2571.1 Scope of rules.**

The rules of practice set forth in this part apply to ex parte cease and desist order proceedings under section 521 of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The rules of procedure for administrative hearings published by the Department's Office of Administrative Law Judges at Part 18 of this Title will apply to matters arising under ERISA section 521 except as modified by this section. These proceedings shall be conducted as expeditiously as possible, and the parties and the Office of the Administrative Law Judges shall make every effort to avoid delay at each stage of the proceedings.

**§2571.2 Definitions.**

For section 521 proceedings, this section shall apply in lieu of the definitions in §18.2 of this title:

(a) *Adjudicatory proceeding* means a judicial-type proceeding before an administrative law judge leading to an order;

(b) *Administrative law judge* means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) *Answer* means a written statement that is supported by reference to specific circumstances or facts surrounding the temporary order issued pursuant to 29 CFR 2560.521-1(c);

(d) *Commencement of proceeding* is the filing of an answer by the respondent;

(e) *Consent agreement* means a proposed written agreement and order containing a specified proposed remedy or other relief acceptable to the Secretary and consenting parties;

(f) *Final order* means a cease and desist order that is a final order of the Secretary of Labor under ERISA section 521. Such final order may result from a decision of an administrative law judge or of the Secretary on review of a decision of an administrative law judge, or from the failure of a party to invoke the procedures for a hearing under 29 CFR 2560.521-1 within the prescribed time limit. A final order shall constitute a final agency action within the meaning of 5 U.S.C. 704;

(g) *Hearing* means that part of a section 521 proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(h) *Order* means the whole or any part of a final procedural or substantive disposition of a section 521 proceeding;

(i) *Party* includes a person or agency named or admitted as a party to a section 521 proceeding;

(j) *Person* includes an individual, partnership, corporation, employee welfare benefit plan, association, or other entity or organization;

(k) *Petition* means a written request, made by a person or party, for some affirmative action;

(l) *Respondent* means the party against whom the Secretary is seeking to impose a cease and desist order under ERISA section 521;

(m) *Secretary* means the Secretary of Labor or his or her delegate;

(n) *Section 521 proceeding* means an adjudicatory proceeding relating to the issuance of a temporary order under 29 CFR 2560.521-1 and section 521 of ERISA;

(o) *Solicitor* means the Solicitor of Labor or his or her delegate; and

(p) *Temporary order* means the temporary cease and desist order issued by the Secretary under 29 CFR 2560.521-1(c) and section 521 of ERISA.

**§ 2571.3 Service: copies of documents and pleadings.**

For section 521 proceedings, this section shall apply in lieu of §18.3 of this title:

(a) *In general.* Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street NW., Suite 400, Washington, DC 20001-8002, or to the OALJ Regional Office to which the section 521 proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

(b) *By parties.* All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Secretary shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA Section 521 Proceeding, P.O. Box 1914, Washington, DC 20013 and any attorney named for service of process as set forth in the temporary order. The person serving the document shall certify to the manner of date and service.

(c) *By the Office of Administrative Law Judges.* Service of orders, decisions, and all other documents shall be made in such manner as the Office of Administrative Law Judges determines to the last known address.

(d) *Form of pleadings.*

(1) Every pleading or other paper filed in a section 521 proceeding shall designate the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to

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dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be printed when possible on standard size 8 1/2 x 11 inch paper.

(2) Illegible documents, whether handwritten, printed, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

#### **§2571.4 Parties.**

For section 521 proceedings, this section shall apply in lieu of §18.10 of this title:

(a) The term “party” wherever used in these rules shall include any person that is a subject of the temporary order and is challenging the temporary order under these section 521 proceedings, and the Secretary. A party challenging a temporary order shall be designated as the “respondent.” The Secretary shall be designated as the “complainant.”

(b) Other persons shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the section 521 proceeding and their interest is not adequately represented by the existing parties, and that in the discretion of the administrative law judge the participation of such persons would be appropriate.

(c) A person not named in a temporary order, but wishing to participate as a respondent under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person has knowledge of, or should have known about, the section 521 proceeding. The petition shall be filed with the administrative law judge and served on each person who has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner’s interest in the section 521 proceeding (including how the section 521 proceedings will directly and adversely affect them or the class they represent and why their interest is not adequately represented by the existing parties);

(2) How his or her participation as a party will contribute materially to the disposition of the section 521 proceeding;

(3) Who will appear for the petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioners have the requisite interest to be a party in the section 521 proceeding, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where persons with common interest file petitions to participate as parties in a section 521 proceeding, the administrative law judge may request all such petitioners to designate a single representative, or

the administrative law judge may designate one or more of the petitioners to represent the others. The administrative law judge shall give each such petitioner, as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and may consider whether to treat the petition as a request for participation as *amicus curiae*.

#### **§2571.5 Consequences of default.**

For section 521 proceedings, this section shall apply in lieu of §18.5(b) of this title. Failure of the respondent to file an answer to the temporary order within the 30-day period provided by 29 CFR 2560.521-1(e) shall constitute a waiver of the respondent’s right to appear and contest the temporary order. Such failure shall also be deemed to be an admission of the facts as alleged in the temporary order for purposes of any proceeding involving the order issued under section 521 of ERISA. The temporary order shall then become the final order of the Secretary, within the meaning of 29 CFR 2571.2(f), 30 days from the date of the service of the temporary order.

#### **§2571.6 Consent order or settlement.**

For section 521 proceedings, this section shall apply in lieu of §18.9 of this title:

(a) *In general.* At any time after the commencement of a section 521 proceeding, the parties jointly may move to defer the hearing for a reasonable time in order to negotiate a settlement or an agreement containing findings and a consent order disposing of the whole or any part of the section 521 proceeding. The administrative law judge shall have discretion to allow or deny such a postponement and to determine its duration. In exercising this discretion, the administrative law judge shall consider the nature of the section 521 proceeding, the requirements of the public interest, the representations of the parties and the probability of reaching an agreement that will result in a just disposition of the issues involved.

(b) *Content.* Any agreement containing consent findings and an order disposing of the section 521 proceeding or any part thereof shall also provide:

(1) That the consent order shall have the same force and effect as an order made after full hearing;

(2) That the entire record on which the consent order is based shall consist solely of the notice and the agreement;

(3) A waiver of any further procedural steps before the administrative law judge;

(4) A waiver of any right to challenge or contest the validity of the consent order and decision entered into in accordance with the agreement; and

(5) That the consent order and decision of the administrative law judge shall be final agency action within the meaning of 5 U.S.C. 704.

(c) *Submission.* On or before the expiration of the time granted for negotiations, the parties or their authorized representatives or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge;

(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or

(3) Inform the administrative law judge that agreement cannot be reached.

(d) *Disposition.* If a settlement agreement containing consent findings and an order, agreed to by all the parties to a section 521 proceeding, is submitted within the time allowed therefor, the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become a final agency action within the meaning of 5 U.S.C. 704.

(e) *Settlement without consent of all respondents.* In cases in which some, but not all, of the respondents to a section 521 proceeding submit an agreement and consent order to the administrative law judge, the following procedure shall apply:

(1) If all of the respondents have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice and a copy of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting respondent shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;

(3) If any respondent submits an objection to the proposed settlement, the administrative law judge shall decide within thirty (30) days after receipt of such objections whether to sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issue may be reasonably based;

(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section; and

(5) If the consent agreement is incorporated into a decision meeting the requirements of paragraph (d) of this section, the administrative law judge shall continue the section 521 proceeding with respect to any non-consenting respondents.

#### **§2571.7 Scope of discovery.**

For section 521 proceedings, this section shall apply in lieu of §18.14 of this title:

(a) A party may file a motion to conduct discovery with the administrative law judge. The administrative law judge may grant a motion for discovery only upon a showing of good cause. In order to establish “good

cause” for the purposes of this section, the moving party must show that the requested discovery relates to a genuine issue as to a fact that is material to the section 521 proceeding. The order of the administrative law judge shall expressly limit the scope and terms of the discovery to that for which “good cause” has been shown, as provided in this paragraph.

(b) Any evidentiary privileges apply as they would apply in a civil proceeding in federal district court. For example, legal advice provided by an attorney to a client is generally protected from disclosure. Mental impressions, conclusions, opinions, or legal theories of a party’s attorney or other representative developed in anticipation of litigation are also generally protected from disclosure. The administrative law judge may not, however, protect from discovery or use, relevant communications between an attorney and a plan administrator or other plan fiduciary, or work product, that fall under the fiduciary exception to the attorney-client or work product privileges. The fiduciary exception to these privileges exists when an attorney advises the plan administrator or other plan fiduciary on matters concerning plan administration or other fiduciary activities. Consequently, the administrative law judge may not protect such communications from discovery or from use by the Secretary in the proceedings. The administrative law judge also may also not protect attorney work product prepared to assist the fiduciary in its fiduciary capacity from discovery or from use by the Secretary in the proceedings. The fiduciary exception does not apply, however, to the extent that communications were made or documents were prepared exclusively to aid the fiduciary personally or for non-fiduciary matters (e.g. settlor acts), provided that the plan did not pay for the legal services. The Secretary need not make a special showing, such as good cause, merely to obtain information or documents covered by the fiduciary exception. Other relevant exceptions to the attorney-client or work product privileges shall also apply.

#### **§2571.8 Summary decision.**

For section 521 proceedings, this section shall apply in lieu of §18.41 of this title:

(a) *No genuine issue of material fact.* Where the administrative law judge finds that no issue of a material fact has been raised, he or she may issue a decision which, in the absence of an appeal, pursuant to §§2571.10 through 2571.12, shall become a final agency action within the meaning of 5 U.S.C. 704.

(b) A decision made under this section, shall include a statement of:

(1) Findings of fact and conclusions of law, and the reasons thereof, on all issues presented; and  
(2) Any terms and conditions of the ruling.

(c) A copy of any decision under this section shall be served on each party.

#### **§2571.9 Decision of the administrative law judge.**

For section 521 proceedings, this section shall apply in lieu of §18.57 of this title:

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

(b) *Decision of the administrative law judge.* The administrative law judge shall make his or her decision expeditiously after the conclusion of the section 521 proceeding. The decision of the administrative law judge shall include findings of fact and conclusions of law with reasons therefore upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record and shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§2571.10 through 2571.12.

**§2571.10 Review by the Secretary.**

(a) The Secretary may review the decision of an administrative law judge. Such review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such a decision. In all other cases, the decision of the administrative law judge shall become the final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of an appeal, the Secretary shall request the Chief Administrative Law Judge to submit to the Secretary a copy of the entire record before the administrative law judge.

**§2571.11 Scope of review by the Secretary.**

The review of the Secretary shall be based on the record established before the administrative law judge. There shall be no opportunity for oral argument.

**§2571.12 Procedures for review by the Secretary.**

(a) Upon receipt of a notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken.

Such decision by the Secretary shall be the final agency action with the meaning of 5 U.S.C. 704.

**§2571.13 Effective date.**

This regulation is effective with respect to all cease and desist orders issued by the Secretary under section 521 of ERISA at any time after April 1, 2013.

**Subpart B--[Reserved]**

Signed at Washington, DC, this 26th day of February, 2013.

Phyllis C. Borzi,

*Assistant Secretary, Employee Benefits Security Administration, Department of Labor.*

[FR Doc. 2013-04862 Filed 2-28-13; 8:45 am]

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DEPARTMENT OF LABOR  
Employee Benefits Security Administration

**29 CFR Part 2520**

**RIN 1210-AB51**

**Filings Required of Multiple Employer Welfare Arrangements and Certain Other Related Entities**

**AGENCY:** Employee Benefits Security Administration, Department of Labor.

**ACTION:** Final rules.

**SUMMARY:** This document contains final rules under Title I of the Employee Retirement Income Security Act (ERISA) that implement reporting requirements for multiple employer welfare arrangements (MEWAs) and certain other entities that offer or provide benefits that consist of medical care (within the meaning of section 733(a)(2) of ERISA and 29 CFR 2590.701-2) for employees of two or more employers. These final rules amend the existing Form M-1 reporting rules by incorporating new provisions enacted as part of the Patient Protection and Affordable Care Act (the “Affordable Care Act”). They also amend existing Form 5500 annual reporting rules for ERISA-covered plans subject to Form M-1 reporting rules. Elsewhere in this edition of the **Federal Register**, the Employee Benefits Security Administration is publishing final rules related to the Secretary of Labor’s new enforcement authority with respect to MEWAs, a notice adopting final revisions to the Form 5500 Annual Return/Report and its instructions to add new Form M-1 compliance questions, as well as an additional notice announcing the finalized revisions to the Form M-1 and its instructions. These improvements in reporting, together with stronger enforcement tools authorized by the Affordable Care Act, are designed to reduce MEWA fraud and abuse, protecting consumers from unpaid medical bills.

**DATES:** *Effective date.* These final rules are effective on April 1, 2013.

*Applicability dates:* These final rules pertaining to Form M-1 filings generally apply for all filing events beginning on or after July 1, 2013, except that in the case of the 2012 Form M-1 annual report, the deadline is now May 1, 2013 with an extension until July 1, 2013 available. The rules pertaining to Form 5500 annual reporting will be applicable for all Form 5500 Annual Return/Report filings beginning with the 2013 Form 5500.

**FOR FURTHER INFORMATION CONTACT:**

Allison Goodman or Suzanne Bach, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335. This is not a toll-free number.

**SUPPLEMENTARY INFORMATION:**

*Customer Service Information:* Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor’s Web site (<http://www.dol.gov/ebsa>). Information on health reform can be found at <http://www.healthcare.gov>.

**I. Executive Summary**

*A. Purpose of the Regulatory Action*

1. Need for Regulatory Action

ERISA section 101(g), 29 U.S.C. 1021(g), as amended by the Affordable Care Act, directs the Department of Labor (the Department) to promulgate rules requiring MEWAs that are not group health plans (non-plan MEWAs) to register with the Secretary of Labor (the Secretary) prior to operating in a State. The statute also allows the Department to promulgate rules requiring non-plan MEWAs to report annually for the purpose of determining the extent to which the requirements of ERISA part 7 are being carried out in connection with such benefits. While the statutory authority is directed at non-plan MEWAs, the Department asserts its authority under ERISA sections 505, 29 U.S.C. 1135, 104, 29 U.S.C. 1024(b), and 734, 29 U.S.C. 1191c, consistent with the MEWA annual reporting rule promulgated in 2003 (the 2003 rule or 2003 regulation), to apply these filing requirements to MEWAs which are group health plans (plan MEWAs) as well.

The Form M-1 and the MEWA reporting requirements were originally developed under the 2003 rule and used as a mechanism to help States identify MEWAs in order to combat a history of MEWA fraud and abuse. Despite these reporting rules, MEWA abuses persist and often lead to insolvency.<sup>1</sup> As a result, affected employees and their dependents become financially responsible for medical claims even though they previously paid premiums to MEWAs for their medical coverage.<sup>2</sup> These regulations amend the 2003 rule and establish new registration and reporting requirements under the amended section 101(g) of ERISA. Specifically, these final rules establish filing requirements and deadlines that apply to MEWAs annually and upon specified events.

<sup>1</sup> See, e.g., *Chao v. Graf*, 2002 WL 1611122 (D. Nev. 2002), *In re Raymond Palombo, et al.*, 2011 WL 1871438 (Bankr. C.D. CA 2011) and *Solis v. Palombo*, No. 1:08-CV-2017 (N.D. Ga 2009); *Chao v. Crouse*, 346 F.Supp.2d 975 (S.D. Ind. 2004).

<sup>2</sup> See Kofman, Mila, Bangit, Eliza, and Lucia, Kevin, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (The Commonwealth Fund March 2004), and *Employee Benefits: States Need Labor’s Help Regulating Multiple Employer Welfare Arrangements*, March 1992, GAO/HRD-92-40.

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The statute is detailed but not self-implementing, contains ambiguities, and specifically requires the Department to develop regulations. Therefore, these consumer protections cannot be established without these regulations.

## 2. Legal Authority

The substantive authority for these regulations is generally ERISA section 101(g), which explicitly requires the Department to issue regulations requiring MEWAs to register with the Secretary prior to operating in a State. It further provides the Secretary with authority to issue regulations requiring MEWAs to report annually on their compliance with part 7 of ERISA. Section 505 of ERISA also gives the Secretary authority to prescribe such regulations as necessary or appropriate to carry out the provisions of Title I of ERISA, which includes the amended ERISA section 101(g). Further, ERISA section 734 authorizes the Secretary to promulgate regulations necessary or appropriate to carry out the provisions of ERISA part 7.

In addition, section 104(a)(3) authorizes the Secretary to exempt any welfare plan from all or part of the reporting and disclosure requirements of Title I or provide for simplified reporting and disclosure if she finds that such requirements are inappropriate as applied to welfare plans.

### *B. Summary of the Major Provisions of This Regulatory Action*

Paragraph (a) of §2520.101-2 in these final rules implements the general registration and reporting requirements and explains which entities are required to file. The regulations explain that while the language in section 101(g) of ERISA only applies to non-plan MEWAs, the regulations preserve the structure promulgated as part of the 2003 rule, which required both plan MEWAs and non-plan MEWAs to file the Form M-1 based on authority found in sections 505 and 734 of ERISA.

Paragraph (b) defines the terms used in the final regulations, with some additions and modifications from the 2003 rule. Paragraph (c) sets forth the requirement that, with certain exceptions, the administrators of MEWAs and certain entities that claim not to be a MEWA solely due to the exception in section 3(40)(A)(i) of ERISA (referred to as Entities Claiming Exception or ECEs) file reports with the Department.

Paragraph (d) describes how MEWAs and ECEs will comply with the final rules by filing the Form M-1, and the conditions under which the Secretary may reject a filing.

Paragraphs (e) and (f) set forth the timeframes when MEWAs and ECEs must file the Form M-1. Paragraph (g) directs that the Form M-1 be filed electronically. The information provided through Form M-1 filings will then be accessible by the public and other interested parties such as State regulators.

Paragraph (h) explains the civil penalties that may result from a failure to comply with these final rules. Civil penalties for failure to file a report required by ERISA section 101(g) or §2520.101-2 have been applicable for non-plan MEWAs under ERISA section 502(c)(5) since May 1, 2000.

These final rules also amend regulations under ERISA sections 103 and 104 to further enhance the Department's ability to enforce §2520.101-2 by making the filing of the Form M-1 an integral part of compliance with ERISA's annual reporting requirements for plans subject to the Form M-1 filing requirements under §2520.101-2. As a result, failure to provide information on the Form 5500 about compliance with the requirement to file a Form M-1 may result in the rejection of the Form 5500 as incomplete and the assessment of civil penalties under ERISA section 502(c)(2).

Finally, new criminal penalties were added by the Affordable Care Act under ERISA section 519 for any person who knowingly submits false statements or false representations of fact in connection with a MEWA's financial condition, the benefits it provides, or its regulatory status as a MEWA. The Affordable Care Act also amended ERISA section 501(b) to impose criminal penalties on any person who is convicted of violating the prohibition in ERISA section 519. The final rules retain the cross-reference to sections 501(b) and 519 for the purpose of implementing these new rules as these provisions relate to filing a Form M-1.

Final rules published elsewhere in today's **Federal Register** provide further guidance with respect to ex parte cease and desist and summary seizure orders for MEWAs.

### *C. Costs and Benefits*

These final regulations are designed to impose a minimal amount of burden on legally compliant MEWAs and ECEs while implementing the Secretary's authority under the Affordable Care Act to take enforcement action against fraudulent or abusive MEWAs and working to protect health benefits for businesses and their employees. This rule implements the new provisions while preserving the filing structure and provisions of the 2003 rule, which directed plan MEWAs and non-plan MEWAs to file the Form M-1.

The additional filing requirements will enhance the State and Federal governments' joint mission to take enforcement action against fraudulent and abusive MEWAs, thus limiting the losses suffered by American workers, their families, and businesses when abusive MEWAs become insolvent and fail to reimburse medical claims.

Under the final regulations, MEWAs and ECEs will incur costs to fill out and electronically file the Form M-1 and Form 5500. The Department estimates that the annualized cost may be approximately \$0.1 million. As is common with regulations implementing new policies, there is considerable uncertainty arising from general data limitations and the degree to which economies of scale exist for disclosing this

information. Nonetheless, the Department believes that these final regulations lower overall administrative costs from the 2003 rule because of the move to an electronic only filing system.

In accordance with Executive Orders 12866 and 13563, the Department believes that the benefits of this regulatory action justify the costs.

## II. Background

The term “multiple employer welfare arrangement” (MEWA) is defined in section 3(40) of ERISA, 29 U.S.C. 1002(40), 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 welfare benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association. For purposes of this definition, two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group. The term “control group” means a group of trades or businesses under common control. The determination of whether a trade or business is under “common control” with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b) of ERISA, 29 U.S.C. 1301(b), except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent.<sup>3</sup>

The Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936) (1996) (HIPAA) amended ERISA to provide for, among other things, improved portability and continuity of health insurance coverage. HIPAA also added section 101(g) to ERISA, providing the Secretary with the authority to require, by regulation, annual reporting by non-plan MEWAs. The Secretary exercised the authority under the HIPAA provision by creating the Form M-1 under a 2000 interim final rule and 2003 rule.<sup>4</sup> Those rules generally required the administrator of both non-plan and plan MEWAs and ECEs to file the Form M-1 annually with the Secretary. The purpose of this form

was to allow the Department to determine whether the requirements of part 7 were being met. Part 7 of ERISA includes statutory amendments made by HIPAA and other statutes for which MEWAs must annually report compliance.

The original MEWA reporting requirement created under HIPAA was also enacted in response to a 1992 General Accounting Office (GAO) report<sup>5</sup> that detailed a history of MEWA fraud and abuse.<sup>6</sup> To combat fraudulent MEWAs, the GAO recommended that the Department develop a mechanism to help States identify MEWAs. Although the annual MEWA reporting rules enabled the Department to develop a registry of MEWAs that filed the Form M-1, the requirement alone has not stopped the abuses discussed in the GAO report. MEWAs are frequently marketed by unlicensed entities that do not comply with State insurance reserve, contribution, and consumer protection requirements. As a result, such entities often offer health coverage at rates substantially lower than licensed insurers, making them particularly attractive to some small employers that find it difficult to obtain affordable health insurance for their employees. Unfortunately, due to insufficient funding and inadequate reserves, and in some situations, excessive administrative fees and fraud, some MEWAs have become insolvent and unable to pay medical benefit claims. This results in affected employees and their dependents becoming financially responsible for paying medical claims even after they paid premiums for their medical coverage. The unfortunate reality is that currently, the Department often does not find out about insolvent or fraudulent MEWAs until significant harm has occurred to employers and participants. Furthermore, while the Department--often working with State insurance departments--has had some success with both civil and criminal cases against MEWA operators, the monetary judgments are often uncollectible, leaving the employers and/or individual participants without coverage for claims that can be considerable.<sup>7</sup>

The Patient Protection and Affordable Care Act (Pub. L. 111-148, 124 Stat. 119) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, 124 Stat. 1029) (these are collectively known as the “Affordable Care Act”), have established a multipronged approach to MEWA abuses. The principal provisions include sections 6601, 6605, and 6606 of the Affordable Care Act. Section 6601 prohibits false statements and representations in connection with the marketing or sale of a MEWA. Section 6605 enables the Secretary to issue administrative cease and desist orders when MEWAs engage in certain conduct and

<sup>3</sup>This provision was added to ERISA by section 302(b) of the Multiple Employer Welfare Arrangement Act of 1983, Public Law 97-473, 96 Stat. 2611, 2612 which also amended section 514(b) of ERISA, 29 U.S.C. 1144(a). Section 514(a) of ERISA provides that State laws that relate to employee benefit plans are generally preempted by ERISA. Section 514(b) sets forth several exceptions to the general rule of section 514(a) and subjects employee benefit plans that are MEWAs to various levels of State regulation depending on whether the MEWA is fully insured. Sec. 302(b), Public Law 97-473, 96 Stat. 2611, 2613 (29 U.S.C. 1144(b)(6)).

<sup>4</sup>65 FR 7152 (02/11/2000) and 68 FR 17494 (04/09/2003). The Form M-1 is reissued each year in December by the Department and has been

modified to address changes to the statutory provisions in part 7 of ERISA.

<sup>5</sup>See, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, March 1992, GAO/HRD-92-40.

<sup>6</sup>For example, the 1992 GAO report indicated that between 1988 and 1991, MEWAs left at least 398,000 participants and beneficiaries with over \$123 million in unpaid claims. Meanwhile more than 600 MEWAs failed to comply with State insurance laws. See supra note 3.

<sup>7</sup>See *United States v. Gerald Rising, Jr.*, plea agreement, 11-cr-00117-WYD-01 (U.S.D.Ct.CO) (In 2012, the owner of a MEWA that sold stop-loss insurance pled guilty for understating the claim amounts that would trigger stop-loss payments in order to charge excessive fees; the

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summary seizure orders against MEWAs in a financially hazardous condition. In addition, section 6606 amended section 101(g) of ERISA. Under this last amendment, MEWAs providing benefits consisting of medical care (within the meaning of section 733(a)(2) of ERISA, 29 U.S.C. 1191b(a)(2)), which are not group health plans must now register with the Secretary prior to operating in a State. Congress left untouched the Secretary's authority to issue regulations directing such MEWAs to report, not more frequently than annually, in such form and such manner as the Secretary specifies for the purpose of determining the extent to which the requirements of part 7 of ERISA are being met. These final regulations implement the ERISA section 101(g) MEWA annual reporting provision by directing all MEWAs, including those that are plan MEWAs, to report compliance with the part 7 rules, including the Public Health Service Act (PHS Act) market reforms (PHS Act sections 2701 through 2728) incorporated by reference in ERISA section 715 by the Affordable Care Act. These final regulations also require MEWAs to register with the Department before operating in a State. The additional information provided on the Form M-1 as a result of these final rules will enhance the State and Federal governments' joint mission to prevent harm and take enforcement action against fraudulent and abusive MEWAs, thus limiting the losses suffered by American workers, their families, and businesses when abusive MEWAs become insolvent and fail to reimburse medical claims. These final rules implement the statutory requirements in a way that limits the burden on legitimate MEWAs but gives the Secretary, States, employers, and the participants and beneficiaries of the plans additional information about these entities and a stronger enforcement scheme.

On December 6, 2011, the Department published in the **Federal Register** proposed regulations (76 FR 76222) implementing the new reporting requirements for MEWAs and ECEs. The Department received six comments on the proposed rules. After consideration of the comments received, the Department is publishing these final regulations. While these final rules reflect a few changes and add some clarifications in response to questions posed by commenters, they do not

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owner also commingled clients' premiums, overcharged fees, and issued fraudulent invoices, to a cost of over \$3.6 million to his victims, which included over 250 individuals, businesses and government agencies.) See also *United States v. Edwards*, plea agreement, 1:05CR 265 (M.D.N.C. 2006) (In 2005, a MEWA operator, whom the Department showed collected over 36 million dollars in healthcare insurance premiums and failed to obtain health insurance coverage for its employer clients which resulted in thousands of uncovered employees and approximately \$8 million in unpaid claims), and *Solis v. W.I.N. Ass'n, L.L.C., et. al.*, slip op. 4:11-cv-00616 (S.D. Tex. 2011) (The Department investigated a MEWA which failed to make payments on health care claims, charged excessive fees, engaged in self-dealing, and failed to disclose fees to the client employers in the plan. The Department obtained a Consent Judgment and Order against the MEWA operators for leaving hundreds of participants without coverage and permanently enjoining them from acting as fiduciaries in the future. Also, the court authorized the Secretary to bring a collection action for the plan losses against one of the MEWA operators relative to his ability to restore those plan losses.) For additional information about MEWAs, see <http://www.dol.gov/ebsa/newsroom/fsMEWAenforcement.html>.

significantly modify the requirements set forth in the proposed rules.

### III. Overview of the Final Regulations

#### A. Amendment of 29 CFR 2520.101-2 Under ERISA Section 101(g).

To implement the changes made to ERISA section 101(g) by the Affordable Care Act, these final rules amend the 2003 rule. In the 2003 rule, ECEs and MEWAs were largely subject to the same filing requirements. ECEs, however, were only required to submit an annual M-1 filing for the first three years following an origination event. In keeping with this structure, these final rules extend the new filing events prescribed by the Affordable Care Act to MEWAs and ECEs alike. They also preserve the three-year limitation included in the 2003 regulation for ECEs. Based on comments on the proposed rules from the multiemployer plan community, the final rules limit the events that will constitute an origination to those defined as such in the 2003 rule.

Paragraph (a) of §2520.101-2 in these final regulations describes the provisions of section 101(g) of ERISA that direct MEWAs that provide benefits consisting of medical care (within the meaning of section 733(a)(2) of ERISA) to register with the Secretary prior to operating in a State, and to report annually regarding compliance with part 7 of ERISA.

Paragraph (b) defines the terms used in the final regulations, with some additions and modifications from the 2003 rule. Paragraph (c) sets forth the requirement that, with certain exceptions, the administrators of MEWAs or ECEs file reports with the Department.

Paragraph (d) describes how MEWAs and ECEs will comply with the final rules by filing the Form M-1, and the conditions under which the Secretary may reject a filing.

Paragraphs (e) and (f) set forth the timeframes when MEWAs and ECEs must file the Form M-1. Paragraph (g) directs that the Form M-1 be filed electronically. In addition to minimizing errors and providing faster access to reported data, electronic filing will also be less burdensome on the filer. Once information about the MEWA or ECE is entered into the system, filers will have the option of allowing the system to copy information provided on a past filing into a new filing. This transfer of past information provides filers an easy way to update or verify information. The information provided through Form M-1 filings will then be accessible by the public and other interested parties such as State regulators.

Paragraph (h) explains the civil penalties that may result from a failure to comply with the rule. Civil penalties for failure to file a report required by ERISA section 101(g) or §2520.101-2 have been applicable for non-plan MEWAs under ERISA section 502(c)(5) since May 1, 2000.<sup>8</sup>

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Finally, new criminal penalties were added by the Affordable Care Act under ERISA section 519 for any person who knowingly submits false statements or false representations of fact in filing reports required under the rule.

#### 1. Basis and Scope

These final regulations set forth rules implementing section 101(g) of ERISA, as amended by section 6606 of the Affordable Care Act, which directs MEWAs that are not group health plans to register with the Secretary prior to operating in a State. These regulations also update the existing requirement in section 101(g) of ERISA, that MEWAs, which are group health plans, and certain other entities claiming an exception, file the Form M-1 annually and upon the occurrence of specified events. While the language in section 101(g) of ERISA only applies to non-plan MEWAs, these final rules preserve the structure promulgated as part of the 2003 regulation, which required both plan and non-plan MEWAs to file the Form M-1, based on authority found in sections 505 and 734 of ERISA. Section 505 of ERISA states that the Secretary may prescribe such regulations as she finds necessary or appropriate to carry out the provisions of Title I of ERISA. Section 734 of ERISA allows the Secretary to promulgate such regulations as may be necessary or appropriate to carry out the provisions of part 7 of ERISA.

One commenter questioned the Department's authority to require ECEs to file a Form M-1 prior to operating in a State. As explained in the preamble to the 2003 rule, the Department has set forth procedures for administrative hearings to obtain a determination by the Secretary that a collectively bargained plan is exempted from ERISA's definition of a MEWA. 29 CFR 2510.3-40. An entity that has a determination from an Administrative Law Judge (ALJ) that it is such a collectively-bargained plan is not required to file a Form M-1 while the opinion remains in effect unless the circumstances underlying the determination change. Entities may, however, claim the exemption on their own accord and sometimes do so incorrectly, including as part of an insurance fraud scheme using sham unions and collective bargaining agreements to market health coverage to small employers. The Secretary remains concerned about MEWA operators who avoid State insurance regulation by making false assertions that the arrangement is pursuant to a collective bargaining agreement. The requirement that ECEs file the Form M-1 for only three years after an origination event continues to provide an important enforcement tool while imposing little burden on bona fide collectively bargained plans. Bona fide collectively bargained plans also benefit from the early identification of MEWA operators using sham unions and collective bargaining

<sup>8</sup>Under these final regulations, similar civil penalties under ERISA section 502(c)(2) may apply to plan MEWAs and ECEs required to file the Form M-1 that fail to answer questions on the Form 5500 about compliance with the requirement to file a Form M-1. See section B of this preamble for the changes that are being made to §§2520.103-1, 104-20, and 104-41 to further enhance the Department's ability to enforce these provisions with regard to MEWAs and ECEs that are group health plans.

agreements. Consequently, based on the Department's authority under ERISA sections 505 and 734, the final rules preserve the three-year limitation included in the 2003 regulation for ECEs.

#### 2. Definitions

a. *Operating.* Paragraph (b)(8) of §2520.101-2 of the proposed and these final rules adds a definition of "operating" and defines it as any activity including but not limited to marketing, soliciting, providing, or offering to provide benefits consisting of medical care. This definition, which includes marketing and administrative activities, governs when Form M-1 filings must be made. Some commenters raised concerns that the definition in the proposed rules could be interpreted broadly to include participants receiving medical care in a State in which the MEWA or ECE has not been providing medical benefits and for which it is not otherwise required to make any filings. These commenters noted that MEWAs or ECEs would be unable to comply with the requirement to file the Form M-1 30 days before operating in an additional State because they would not know when a participant planned, for instance, to move or travel to a new State. The Department never intended for the definition of operating to apply to the receipt of medical care without any action by, or on behalf of, the MEWA or ECE to market, solicit, provide, or offer to provide medical benefits to a participating employer in that State.

Commenters also noted that, in general, they would not be aware in advance if an employer or union, on its own accord, distributes information about medical care in a State in which the MEWA or ECE has not been operating and is not registered. ECEs, in particular, may not be aware of a contract awarded for work in a new State to a company that is part of a collective bargaining agreement. The Department agrees that there are circumstances in which it would be difficult, if not impossible, for a MEWA or ECE to file the Form M-1 30 days before operating in an additional State. Consequently, while the Department has not revised the definition of operating, as discussed later in this preamble, provisions in paragraph (e) in these final rules on when a MEWA or ECE must file when it begins operating in an additional State have been revised to address this concern.

b. *Origination and Special Filing Events.* The 2003 rule used the term "origination" to determine if additional filings were necessary for both MEWAs and ECEs. As in the proposed rules, the Department only uses the term "origination" when it refers to events that trigger an additional filing by ECEs in the final rules. The term "registration" also continues to be used to refer to filings by MEWAs.

The definition of origination, however, has been modified in the final rules. This change responds to a commenter who found the provisions in the proposed rules relating to the application of the three-year limitation to ECEs that begin operating in additional States to be confusing. These final rules have been adjusted to clarify that an ECE is not required to file a Form M-1 solely because it begins operating in

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an additional State or experiences a material change after the three-year period following any of the three origination events: (i) The ECE first begins operating with regard to the employees of two or more employers (including one or more self-employed individuals); (ii) the ECE begins operating following a merger with another ECE (unless all of the ECEs that participate in the merger previously were last originated at least three years prior to the merger); or (iii) the number of employees receiving coverage for medical care under the ECE is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless the increase is due to a merger with another ECE under which all ECEs that participate in the merger were last originated at least three years prior to the merger).

In paragraph (b)(9)(ii) and (v) of §2520.101-2 of the proposed rules, the definition of origination also included an ECE that begins operating in an additional State or experiences a material change. To clarify that the three-year rule does not restart or extend when those two events occur, they were moved to a new paragraph (b)(11) in the final rules on special filing events. Additionally, the reference to the three-year period during which filings are required was removed from the definition of origination. In the final rules, the paragraph (b)(9) origination events and the corresponding filing rules in paragraph (c)(1)(ii) now clarify that only the events in paragraph (b)(9) restart or extend the three-year period for ECEs.

c. *Reporting.* As in the proposed rules, the final rules add a definition of “reporting.” “Reporting” or “to report” means to file the Form M-1 as required pursuant to section 101(g) of ERISA; §2520.101-2; or the instructions to the Form M-1. The term “reporting” is used in order to correspond to the terminology of §2560.502c-5, which uses the generic term “report” to describe the Form M-1 filing process, including the annual report as well as registration, origination, and all other required M-1 filings.

d. *State.* The final rules also, like the proposed rules, add a definition of “State” and define the term by reference to §2590.701-2. This definition was added because MEWAs must register, and ECEs must make an origination filing, prior to operating in a State.

### 3. Persons Required to Report

Paragraph (c) of §2520.101-2 of the final rules set forth the persons required to report. As under the 2003 rule and the proposed rules, the final rules direct the administrator of a MEWA that provides benefits consisting of medical care, whether or not the MEWA is a group health plan, to file the Form M-1. It also requires filing by the administrator of an ECE that offers or provides coverage consisting of medical care. Several commenters suggested changes to this section. One commenter sought to have third party administrators carved out of the definition of administrator. Another sought to have affiliated service groups exempted from the filing requirements. The Department considered these comments but declines

to modify these longstanding provisions promulgated as part of the 2003 rule. However, as noted above, to clarify the timing requirements for filings required of ECEs, this paragraph references the requirement that such filings be made only during the three years after the ECE is originated.

### 4. Information To Be Reported

Paragraph (d) of the final rules is unchanged from the proposed rules. It clarifies that the reporting requirements of §2520.101-2 will only be satisfied by filing a completed copy of the Form M-1, including any additional statements required pursuant to the Form M-1 instructions. One commenter wanted even more detailed financial information collected on the Form M-1. As noted earlier, after consideration of the comments made, the Department has reviewed the Form M-1 but made only minor changes to the content of the Form M-1 that was proposed to correspond to these final rules. A notice announcing the availability of the finalized revisions to the Form M-1 and its instructions are published elsewhere in this edition of the **Federal Register**.

### 5. Reporting Requirements and Timing

The final rules retain from the 2003 rule and the proposed rules that both MEWAs and ECEs must file the Form M-1 annually, with ECEs only having to file annually for the first three years following an origination. However, to clarify the application of the new registration requirements, the annual filing requirements were moved from paragraph (e) to paragraph (f) (and paragraphs (f) and (g) were redesignated paragraphs (g) and (h)).

As mentioned previously, MEWAs and ECEs are also subject to additional (non-annual) filings in certain circumstances. Several non-annual filing events were included in the 2003 regulation, but, as previously explained, these filings were relabeled and expanded in the proposed rules and these final rules to implement changes to the statutory language. The 2003 regulation and the proposed rules generally required an additional filing when a MEWA or ECE: (1) First began offering or providing coverage for medical care to employees of two or more employers; (2) began offering or providing coverage for medical care to employees of two or more employers after a merger with another MEWA or ECE; or (3) increased the number of employees receiving medical care under the MEWA or ECE by at least 50 percent over the number of employees on the last day of the previous calendar year. In the proposed rules, the first event was modified to conform to the statutory language under ERISA section 101(g) directing MEWAs to register with the Secretary by filing a Form M-1 prior to operating in any State. Additionally, the proposed rules directed that a filing be made in the event a MEWA (and in some cases an ECE) expands its operations into additional States or experiences a material change as defined in the Form M-1 instructions. These filing events are preserved in these final rules.

Several commenters sought to limit filings due to a material change. This filing event was added to direct an entity to update its Form M-1 filing in the event that it experienced changes in certain financial or custodial information. The Department intends to follow the same basic structure for these filings as it has indicated it will for filings related to operating in a State. So, for example, if a MEWA or ECE takes action to add or remove an individual who is a marketer or promoter, the MEWA or ECE would have experienced a material change and would need to report. However, if the MEWA or ECE employs a third party (and appropriately identifies that entity in its filings) and the third party takes action to add or remove an individual who is a marketer or promoter, the MEWA or ECE will not have experienced a material change and no additional filing will be required. In the event an entity experiences a material change, the online filing system will allow them to log on, import data from the most recently completed filing, and make the necessary changes. The regulatory provision is retained as proposed, but in response to these comments, the Department will continue to ensure the electronic filing system minimizes the additional burden on entities that experience a material change. Consistent with the 2003 rule and the proposed rules, these final rules direct MEWAs to submit filings for the duration of their existence and ECEs to file only during the three-year period following an origination. As noted above, ECEs that begin operating in a new State or experience a material change during their three-year filing period report those events. ECEs that are not required to file because they are outside their three-year period do not need to report those events.

The final rules also apply new timing standards on MEWAs and ECEs for these additional filings. Under the 2003 regulation, MEWAs and ECEs filed the Form M-1 within 90 days of the occurrence of certain events. The proposed and these final rules direct entities to file 30 days prior to or within 30 days of the event, depending on the type of event which prompts the filing. The timing requirements in paragraph (e) implement section 6606 of the Affordable Care Act, which provides that the filing must happen “prior to operating in a State” and will also facilitate the Department’s timely receipt of information related to the other filing events described above. One commenter suggested that ECEs not be required to file 30 days prior to operating in an additional State because it might be difficult for the entity to determine when the event occurs. The Department considered this comment and, as previously stated, has revised the provision to address this concern. In these final rules, a MEWA or ECE will need to make a registration or special filing within 30 days of knowingly operating in any additional State or States. The Department does, however, expect MEWAs and ECEs to periodically monitor the activities of participating employers so that they become aware of any unilateral actions by participating employers that have caused them to begin operating in an additional State. Knowledge by a MEWA or ECE includes knowledge by an employee or agent of the MEWA or ECE.

The provision included in the proposed rules to discourage “blanket filings,” (i.e., registration, origination, or special filings that cover multiple States, unless the filer expects to begin operating in all the named States in the near future), was retained in these final rules. Blanket filings that list States where the filer has no immediate intent to operate could frustrate the law’s goal of gathering and maintaining timely and accurate information on MEWAs. Under this provision, a filing is considered lapsed with respect to a State if benefits consisting of medical care are not offered or provided in the State during the calendar year immediately following the filing. A new filing would be required if the filer intends to resume operating in that State.

To minimize the burden of compliance, the final rules continue to permit MEWAs and ECEs to make a single filing to satisfy multiple filing events so long as the filing is timely for each event.

As in the 2003 rule and the proposed rules, filing extensions are available. Any filing deadline that is a Saturday, Sunday, or federal holiday is automatically extended to the next business day. The proposed rules provided a more substantial extension for annual filings if MEWAs and ECEs requested such an extension following the procedure outlined in the instructions to the Form M-1. A question was raised regarding whether extensions were limited to annual filings. The Department considered this option and believes that any filing should be eligible for an extension so long as the request is made in a timely manner and in accordance with the Form M-1 instructions. A modification to this effect was made to the operative language in paragraph (e) of §2520.101-2 of the final rules.

#### 6. Electronic Filing

As in the proposed rules, paragraph (g) of §2520.101-2 of the final rules eliminates the option to file a paper copy of the completed Form M-1. As is now the case for Form 5500 Annual Return/Report filings required under Title I of ERISA and consistent with the goals of E-government, as recognized by the Government Paperwork Elimination Act<sup>9</sup> and the E-Government Act of 2002,<sup>10</sup> these final rules require that the Form M-1 be filed electronically. Electronic filing of benefit plan information, among other program strategies, facilitates EBSA’s achievement of its Strategic Goal to “assure the security of the retirement, health and other workplace related benefits of American workers and their families.” EBSA’s strategic goal directly supports the Secretary of Labor’s Strategic Goal to “secure health benefits.”<sup>11</sup> A cornerstone of the Department’s enforcement program is the collection, analysis, and disclosure of benefit plan information. Electronic filing minimizes errors and provides faster access to reported data, assisting EBSA in its enforcement, oversight, and disclosure roles and ultimately enhancing the security of plan benefits.

<sup>9</sup>Title XVII, Public Law 105-277, 112 Stat. 2681 (Oct. 21, 1998).

<sup>10</sup>Public Law 107-347, 116 Stat. 2899 (Dec. 17, 2002).

<sup>11</sup>For further information on the Department of Labor’s Strategic Plan and EBSA’s relationship to it, see [http://www.dol.gov/\\_sec/stratplan/](http://www.dol.gov/_sec/stratplan/).

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Electronic filing of the Form M-1 also reduces the paperwork burden and costs related to printing and mailing forms and, with the use of secure account access, allows updating of previously reported information to facilitate simplified future reporting. Finally, consistent with current practice, the information will be available for reference by participants, beneficiaries, participating employers, and other interested parties such as State regulators. A notice announcing the availability of the updated Form M-1 filing system will be published elsewhere in this edition of the **Federal Register**.

#### 7. Penalties

a. *Civil penalties and procedures.* The final rules retain the references to section 502(c)(5) of ERISA, 29 U.S.C. 1132(c)(5) and §2560.502c-5 regarding civil penalties and procedures.

b. *Criminal penalties and procedures.* Affordable Care Act section 6601 added ERISA section 519, which prohibits a person from making false statements or representations of fact in connection with a MEWA's financial condition, the benefits it provides, or its regulatory status as a MEWA. The Affordable Care Act also amended ERISA section 501(b) to impose criminal penalties on any person who is convicted of violating the prohibition in ERISA section 519. The final rules retain the cross-reference to sections 501(b) and 519 of ERISA, 29 U.S.C. 1131 and 1149, for the purpose of implementing these new rules as they relate to filing a Form M-1 prior to operating in a State or other registration, origination, and special filings.

c. *Cease and desist and summary seizure and procedures.* Section 6605 of the Affordable Care Act added section 521 to ERISA, which authorizes the Secretary to issue cease and desist orders, without prior notice or a hearing, when it appears to the Secretary that the alleged conduct of a MEWA is "fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury." This section also allows the Secretary to issue an order to seize the assets of a MEWA that the Secretary determines to be in a financially hazardous condition. The regulation providing guidance on the cease and desist orders and summary seizure rules published elsewhere in this **Federal Register** also includes regulatory guidance on the procedural rules for this process. A cease and desist order containing a prohibition against transacting business with any MEWA or plan would prevent the MEWA or a person from avoiding the cease and desist order by shutting the MEWA down and re-establishing it in a new location or under a new identity.

As such, the final rules retain the cross-reference to section 521 of ERISA and §2560.521 regarding the Secretary's authority to issue cease and desist and summary seizure orders.

#### B. Amendment to Regulations Under ERISA Sections 103 and 104

Pursuant to authority in ERISA section 104(a)(3) to establish reporting exemptions and simplified reporting for welfare benefit plans, this rulemaking also makes filing the Form M-1 an integral part of compliance with ERISA's simplified reporting requirements by requiring all plans subject to the Form M-1 filing requirements under §2520.101-2 to file a Form 5500 Annual Return/Report, and include specific Form M-1 compliance information. The revisions to the Form 5500 and instructions reflecting these final rules are being published simultaneously as a Notice of Adoption of Revisions to the Form 5500 Annual Return/Report in today's **Federal Register**. That document includes a discussion of the changes to the Form 5500 and instructions as well as the Department's findings required under sections 104(a)(3) and 110 of ERISA with regard to the use of the revised Form 5500 as a simplified report, alternative method of compliance, and/or limited exemption pursuant to §2520.103-1(b).

We requested but received no comments on these changes to the annual reporting requirements; therefore, these final rules retain the changes proposed to further enhance the Department's ability to enforce the Form M-1 filing requirements under §2520.101-2, except for technical changes and a clarification that all plans required to file the Form M-1 (plan MEWAs and ECEs) are required to file a Form 5500 and to answer the Form M-1 compliance questions on the Form 5500.<sup>12</sup>

The primary change to §2520.103-1 being adopted in this rule is the addition of a new paragraph (f) regarding the content of the annual report. Existing paragraph (f) of §2520.103-1 is redesignated paragraph (g), but is otherwise unchanged. New §2520.103-1(f) applies to all plans that are subject to the Form M-1 filing requirements of §2520.101-2 during the plan year. This change provides that all such plans must demonstrate compliance with §2520.101-2 (filing the Form M-1) in order to satisfy the annual reporting requirements of §2520.103-1. Pursuant to ERISA section 502(c)(2), 29 U.S.C. 1132(c)(2), a plan administrator who fails to file a Form 5500 Annual Return/Report with a proof of compliance with §2520.101-2 may be subject to a civil penalty of up to \$1,100 a day (or higher amount if adjusted pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended) for each day a plan administrator fails or refuses to file a complete report. Although ERISA sections 505 and 734 give the Secretary the authority to require MEWAs and ECEs that are employee benefit plans to comply with the requirements of §2520.101-2, unlike MEWAs that are not employee benefit plans, there is no specific ERISA civil penalty applicable to plan MEWAs and

<sup>12</sup>Unlike plan MEWAs that are under a permanent requirement to file the Form M-1, 29 CFR 2520.101-2 requires an ECE to file the Form M-1 only during the three years following each origination event (an ECE may experience more than one origination event). Therefore, the final Form 5500 rules for plans required to file the Form M-1 apply to ECEs only during the periods in which ECEs are required to file the Form M-1.

ECEs for a failure to comply with those requirements. These changes to the Form 5500 annual reporting requirements for plan MEWAs and ECEs will enhance the Department's ability to enforce the Form M-1 filing requirements.

The final rules include conforming changes adding references to the new §2520.103-1(f) and other conforming changes in §§2520.103-1(a), (b), (c) and §2520.104-41. A corresponding change is also made to §2520.104-20 to expressly provide that the limited filing exemption under §2520.104-20 is no longer available to plan MEWAs and ECEs with fewer than 100 participants required to file the Form M-1 (small plans). In addition, a new paragraph (E) has been added to §2520.103-1(c)(2)(ii) to provide that small plans subject to the Form M-1 filing requirements are not eligible to file the Form 5500-SF (Short Form 5500 Annual Return/Report of Small Employee Benefit Plan) under §2520.103-1(c)(2)(ii) and §2520.104-41.<sup>13</sup>

Although small plans subject to the Form M-1 filing requirements are not eligible to file the Form 5500-SF, these plans are still eligible for the simplified Form 5500 annual reporting for small welfare plans, and these plans that meet all of the requirements for the relief under §2520.104-44 are exempt from certain financial reporting and audit requirements. Small plan MEWAs and ECEs that qualify for the relief provided by 29 CFR 2520.104-44 would only need to file the Form 5500 Annual Return/Report and, if applicable, Schedule A (Insurance Information) and Schedule G, Part III (nonexempt transactions).<sup>14</sup> Such plans are no longer eligible to use the Form 5500-SF because that form does not include Schedule A insurance information. The Department believes that plans subject to these final rules that claim to provide insured benefits should be required to complete the Schedule A so that enforcement officials and the public have information about the insurance policy and insurance company through which the plan is providing insurance coverage. Thus, these changes give the Secretary an important enforcement tool while imposing minimal burden on small plan MEWAs and ECEs.

#### IV. Regulatory Impact Analysis

##### A. Executive Order 12866 and 13563

Under Executive Order 12866, a “significant” regulatory action is subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f) of the Executive Order, a “significant regulatory action” is 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. OMB has determined that this action is not economically significant within the meaning of section 3(f)(1) of the Executive Order but is significant under section 3(f)(4) of the Executive Order because it raises novel legal or policy issues arising from the President's priorities. Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

The Department estimates that the total cost of this rule would be approximately \$137,400 in the first year, or an average of approximately \$284 for each of the 484 entities expected to file the Form M-1. These costs are all associated with the information collection request contained in these rules and, therefore, are discussed in the Paperwork Reduction Act Section, below.

##### 1. Summary and Need for Regulatory Action

As discussed earlier in this preamble, section 6606 of the Affordable Care Act amended section 101(g) of ERISA to require the Secretary of Labor to promulgate regulations requiring MEWAs providing medical care benefits (within the meaning of section 733(a)(2) of ERISA) that are not ERISA-covered group health plans (non-plan MEWAs) to register with the Secretary before operating in a State.

The original MEWA reporting requirement in ERISA section 101(g) was enacted by Congress as part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 in response to a 1992 General Accounting Office (GAO) recommendation.<sup>15</sup> The GAO recommended that the Department develop a mechanism to help States identify fraudulent and abusive MEWAs. The HIPAA provision led to the Department creating the Form M-1 under a 2000 interim final rule and 2003 final rule.<sup>16</sup>

ERISA section 101(g), as amended by the Affordable Care Act, directs the Department of Labor (the Department) to promulgate rules requiring MEWAs that are not group health plans (non-plan MEWAs) to

<sup>13</sup>In addition, an unrelated technical correction to 29 CFR 2520.104-41 is being included in this rulemaking to add an express reference to the Form 5500-SF.

<sup>14</sup>Neither these final regulations nor the companion revisions to the Form 5500 change the eligibility requirements for the limited exemption under 29 CFR 2520.104-44. The Department expects that many plan MEWAs and ECEs will not satisfy the unfunded and insured eligibility requirements in the limited exemption and will continue to be ineligible for the reporting relief under 29 CFR 2520.104-44.

<sup>15</sup>See, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, March 1992, GAO/HRD-92-40.

<sup>16</sup>65 FR 715 (02/11/2000) and 68 FR 17494 (04/09/2003). The Form M-1 has been updated and is reissued each year in December by the Department and modified periodically to address changes to the statutory provisions in part 7 of ERISA.

register with the Secretary of Labor (the Secretary) prior to operating in a State. ERISA sections 505 and 734 provide the Secretary with the authority to require plan MEWAs and ECEs to comply with the Form M-1 reporting requirements,<sup>17</sup> but because ERISA section 101(g) only applies to non-plan MEWAs, only non-plan MEWAs are subject to civil penalties under ERISA section 502(c)(5) for failure to comply with the Form M-1 requirements.<sup>18</sup> In order to enhance the Department's ability to enforce the Form M-1 requirements and ensure that MEWAs are subject to the same rules under the law, this final rule will require all plan MEWAs to prove compliance with the Form M-1 filing requirements in order to satisfy the ERISA annual reporting requirements.<sup>19</sup> In amending the Department's MEWA reporting regulation to require MEWAs to register with the Secretary before operating in a State, these final rules direct Form M-1 filers to provide additional information regarding the MEWA or ECE and apply new timing standards for the filings that are made when a MEWA's or ECE's status changes. These amendments will aid the Department in its oversight of MEWAs consistent with its expanded authority provided by the Affordable Care Act<sup>20</sup> and allow the Department to provide critical information to State insurance departments that coordinate their investigations and enforcement actions against fraudulent and abusive MEWAs with the Department.

Over the last several years, the Department has observed a downward trend in the number of MEWAs that file the Form M-1, raising concerns that some existing MEWAs are not filing the form. Under the 2003 regulation, the Department has the ability to assess penalties against MEWAs that fail to file the Form M-1 only in limited circumstances and if a determination regarding plan status was made by the Secretary. To address this issue and encourage compliance with the Form M-1 filing requirement, the Department also is amending, as part of this regulatory action, the Form 5500 annual reporting requirements. The amendment

will require all plans subject to the Form M-1 filing requirements, regardless of plan size or type of funding,<sup>21</sup> to file the Form 5500 Annual Return/Report and demonstrate on the form compliance with Form M-1 filing requirements. Failure to do so may result in an assessment of penalties under ERISA section 502(c)(2).<sup>22</sup>

These amendments to the Department's MEWA reporting standards would provide a cost effective means to implement the expanded MEWA reporting as enacted in the Affordable Care Act. As stated above, the Department estimates that the average cost for each entity that the Department expects to file the revised Form M-1 would average approximately \$284 during the first year and \$181 during each subsequent year.

## 2. Benefits of Rule

As discussed earlier in this preamble, section 6606 of the Affordable Care Act amended section 101(g) of ERISA directing the Secretary to promulgate regulations requiring non-plan MEWAs providing medical care benefits (within the meaning of section 733(a)(2) of ERISA) to register with the Secretary before operating in a State. By implementing this statutory amendment, the Department would receive prior notice of a MEWA's intention to commence operations in a State. Such notification would help the Department and State insurance commissioners to ensure that MEWAs are being lawfully operated and that sufficient insurance has been purchased or adequate reserves established to pay benefit claims before the MEWAs begin operating<sup>23</sup> in a State. These final rules would improve MEWA compliance and deter fraudulent and abusive MEWA practices, thereby protecting and securing the benefits of participants and beneficiaries by ensuring that MEWA assets are preserved and benefits timely paid. These potential benefits have not been quantified, but the Department expects that they will justify the costs.

## 3. Costs of Rule

The costs of the rule are associated with the amendments to the Form M-1 and Form 5500 reporting requirements and are therefore discussed in the Paperwork Reduction Act section, below.

### *B. Paperwork Reduction Act*

In accordance with the requirements of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)), the Department submitted an information collection request (ICR) to OMB in accordance with 44 U.S.C. 3507(d), contemporaneously

<sup>17</sup>In the preamble to the 2000 interim final rule, the Department explained "[a]n important reason for requiring these groups to file is that the administrator of a MEWA may incorrectly determine that it is a group health plan or that it is established or maintained pursuant to a collective bargaining agreement. A reporting requirement limited only to MEWAs that are not group health plans may not result in reporting by many such MEWAs, thus greatly reducing the value of the data collected." See 65 FR 7152, 7153 (Feb. 11, 2000).

<sup>18</sup>Pursuant to ERISA section 502(c)(5), a civil penalty of up to \$1,100 (or higher amount if adjusted pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended) a day may be assessed for each day a non-plan MEWA fails to file a complete Form M-1.

<sup>19</sup>Pursuant to ERISA section 502(c)(2), a plan administrator who fails to file a Form 5500 Annual Return/Report with a proof of compliance with the M-1 filing requirements may be subject to a civil penalty of up to \$1,100 a day (or higher amount if adjusted pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended) for each day a plan administrator fails or refuses to file a complete report.

<sup>20</sup>As part of the Affordable Care Act, Congress also enacted ERISA section 521, which authorized the Secretary to issue cease and desist orders, without prior notice or a hearing, when it appears to the Secretary that a MEWA's alleged conduct is fraudulent, creates an immediate danger to the public safety or welfare, or causes or can reasonably be expected to cause significant, imminent, and irreparable public injury. Section 521 also authorizes the Secretary to issue a summary order to seize the assets of a MEWA that the Secretary determines to be in financially hazardous condition. The Department also is finalizing rules for these provisions, which are published elsewhere in today's **Federal Register**.

<sup>21</sup>The final rules expressly provide that the limited exemption for certain unfunded and insured small welfare plans under §2520.104-20 is not available for any plans subject to the Form M-1 filing requirements. In addition, these plans also are not eligible to use the Form 5500-SF.

<sup>22</sup>A plan administrator who fails to file a Form 5500 with a proof of Form M-1 compliance could be subject to a civil penalty of up to \$1,100 a day for each day the plan administrator fails or refuses to file a complete report.

<sup>23</sup>Section 2520.101-2(b)(8) of the proposed rule provides that the term "operating" means any activity including but not limited to marketing, soliciting, providing, or offering to provide medical care benefits.

with the publication of the proposed regulation, for OMB's review.

Although no additional public comments were received that specifically addressed the paperwork burden analysis of the information collections at the proposed rules stage, the comments that were submitted and described earlier in this preamble, contained information relevant to the costs and administrative burdens attendant to the proposals. The Department took into account such public comments in connection with making changes to the final rules and in developing the revised paperwork burden analysis summarized below.

In connection with publication of these final rules, the Department submitted a revision to the ICR under OMB Control Number 1210-0116. OMB approved the revised ICR, which is scheduled to expire on February 29, 2016. A copy of the revised ICR may be obtained by contacting the PRA addressee shown below or at <http://www.RegInfo.gov>.

PRA ADDRESSEE: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW., Room N-5718, Washington, DC 20210. Telephone: (202) 693-8410; Fax: (202) 219-4745. These are not toll-free numbers.

Between 2006 and 2010, an average of 484 entities (MEWAs and ECEs) filed the Form M-1 with the Department (a high of 533 in 2006 and a low of 436 in 2010). Of the total filings, on average, 217 were submitted via mail and 267 were submitted electronically through the Form M-1 electronic filing system provided by the Department via the Internet. The fraction filing electronic returns has been increasing and reached nearly 63 percent in 2010. This rule will require all filings to be submitted electronically.

As discussed above and pursuant to section 6606 of the Affordable Care Act, these rules amend the information required to be disclosed on the Form M-1 by adding new data elements. Therefore, the Department assumes that all administrators of MEWAs

and ECEs that file the Form M-1 in-house (an estimated 10 percent of filers) would spend two hours familiarizing themselves with the changes to the form that would be made by the final regulations. This would result in a total hour burden of 97 hours (48 entities \* 2 hours). The Department estimates that Part I of the Form (the identifying information) would require five minutes to complete. The time required to complete Part II would vary based on the number of States in which the entity provides coverage, and the Department estimates that this would require 60 minutes for single-State filers and 120 minutes for multi-State filers. The Department expects the time required to complete Part III would be 15 minutes for fully-insured filers and 30 minutes for not fully-insured filers. Table 1 below summarizes the estimates of time required to complete each part of the form. Based on the foregoing, the Department estimates that the total hour burden for entities to file the Form M-1 using in-house resources would be 188 hours in the first year with an equivalent cost of \$17,900 assuming all work will be performed by an employee benefits professional at \$94.91 per hour.<sup>24</sup> The cost to submit electronic filings would be negligible.

The Department estimates that the annual hour burden for Form M-1 filings prepared in-house in subsequent years would be approximately 100 hours as summarized in Table 2.<sup>25</sup> The Department's estimate is based on the assumption that approximately 44 new entities<sup>26</sup> will file the Form M-1 each year, and thus, approximately four new entities will prepare the Form M-1 in-house. The Department estimates that it would take two hours for these administrators, resulting in an hour burden of eight hours. The Department estimates that entities preparing the form in-house would spend four hours completing Part I, 68 hours completing Part II, and 15 hours completing Part III. The equivalent cost of this annual hour burden is estimated to be \$8,600, assuming a \$94.91 hourly labor rate for an employee benefits professional.

Table 1--Time To Fill Out Form  
[Minutes]

	Fully-insured		Not fully-insured	
	One State	Multi States	One State	Multi States
New Filing.....	120	120	120	120
Part I.....	5	5	5	5
Part II.....	60	120	60	120
Part III.....	15	30	30	30

<sup>24</sup>The Department estimates 2012 hourly labor rates include wages, other benefits, and overhead based on data from the National Occupational Employment Survey (June 2011, Bureau of Labor Statistics) and the Employment Cost Index (September 2011, Bureau of Labor Statistics); the 2010 estimated labor rates are then inflated to 2012 labor rates.

<sup>25</sup>These are rounded values. The totals may differ slightly as a result.

<sup>26</sup>An average of 9 percent of entities originate each year according to Form M-1 data.

Table 2--Hour Burden to Prepare Form M-1, In-House Preparation

	Fully-insured		Not fully-insured		Total
	One State	Multi States	One State	Multi States	
# of MEWAs and ECEs.....	16	18	9	5	48
Review: Year 1.....	32	36	18	11	97
New Filing: Subsequent Years.....	3	3	2	1	9
Part I.....	1	2	1	0	4
Part II.....	16	36	9	11	72
Part III.....	4	5	4	3	16
Total Time: Year 1.....	54	78	31	25	188
Total Time: Subsequent Years.....	24	45	15	15	100

1. Cost Burden

The Department assumes that 90 percent of the 484 entities (435 entities) that will file the Form M-1 will use third-party service providers to complete and submit the Form M-1.<sup>27</sup> Because the Department is adding additional data elements to the form, the Department assumes that in the year of implementation, all service providers would spend additional time familiarizing themselves with the changes. The Department estimates that entities that use third party service providers would incur the cost of one hour for service providers to review the new rule as service providers likely will provide this service for multiple entities and therefore spread this burden across multiple entities. This results in a one-time cost burden of \$41,300 (435 entities \* 1 hour \* \$94.91).

The total estimated cost burden for preparing the form is arrived at by multiplying the number of filers (found in Table 3) by the amount of time required to prepare the documents (Table 1) and multiplying this result by the hourly cost of an employee benefits professional (\$94.91 dollars an hour). Based on the foregoing, the total cost burden for entities that use purchased third-party resources to file the Form M-1 is \$119,500 in the first year and \$78,200 in later years. Table 3 summarizes the estimates of the cost burden.

These regulations direct a plan that is subject to Form M-1 filing requirements to include proof of Form M-1 compliance as part of the Form 5500. Accordingly, the Department is adding a new Part III to the Form 5500, that asks for information regarding whether the employee welfare benefit plan is subject to the Form

Table 3--Cost Burden to Prepare Form M-1, Third-Party Preparation

	Fully-insured		Not fully-insured		Total
	One State	Multi States	One State	Multi States	
# of MEWAs and ECEs.....	145	163	79	49	435
Review: Year 1.....	\$13,700	\$15,400	\$7,500	\$4,700	\$41,300
New Filing: Subsequent Years.....	\$0	\$0	\$0	\$0	\$0
Part I.....	\$1,100	\$1,300	\$600	\$400	\$3,400
Part II.....	\$13,700	\$30,900	\$7,500	\$9,400	\$61,400
Part III.....	\$3,400	\$3,900	\$3,700	\$2,300	\$13,400
Total Time: Year 1.....	\$32,000	\$51,400	\$19,300	\$16,800	\$119,500
Total Time: Subsequent Years.....	\$18,300	\$36,000	\$11,800	\$12,100	\$78,200

**Note:** The displayed numbers are rounded to the nearest hundred and therefore may not add up to the totals.

M-1 filing requirements, and if so, whether the plan is currently in compliance with the Form M-1 filing requirements under §2520.101-2. Plan administrators that indicate the plan is subject to the Form M-1 filing requirements also would be required to enter the Receipt Confirmation Code for the Form M-1 annual report or the most recent Form M-1 required to be filed with the Department. Failure to answer the Form M-1 compliance questions will result in

rejection of the Form 5500 Annual Return/Report as incomplete and civil penalties may be assessed pursuant to ERISA section 502(c)(2). The Department believes that the burden associated with this revision would be de minimis because plan administrators would know whether the plan is subject to and in compliance with the Form M-1 filing requirements, and they would have the Receipt Confirmation Code for the Form M-1 filing readily available.

<sup>27</sup>This assumption is made in connection with EBSA's principal reporting form, the Form 5500, and was validated through a filer survey.

The regulations also amend §2520.104-20 to expressly provide that the exemption from filing the Form 5500 is not available for small plans required to file the Form M-1. Following the methodology used to calculate the burden in the Form 5500 regulations, the Department estimates that for small plans that meet the requirements of §2520.104-44, filing a Form 5500 and completing Schedule A and Part III of Schedule G would cause them to incur an annual cost of \$450 to engage a third-party service provider to prepare the form and schedules for submission. The Department does not have sufficient data to determine the number of small plan MEWAs and ECEs that would be required to file the Form 5500 under the final rules, but believes that the number of such plans would be small, because 90 percent of the entities that file Form M-1 with the Department cover more than 100 participants.

**2. Cost to the Government**

The Department estimates that the cost to the Federal government to process Form M-1s is approximately \$7,200. This includes the cost to process online submissions and maintain the processing system, and was estimated by the offices within EBSA that are

**Table 4--Cost of Federal Government of Form M-1**

<b>Processing of M1 Forms</b>	
Online.....	\$2,200
Maintenance of System.....	5,000
<b>Total.....</b>	<b>7,200</b>

responsible for overseeing these activities.

These paperwork burden estimates are summarized as follows:

*Type of Review:* Revised collection.

*Agency:* Employee Benefits Security Administration, Department of Labor.

*Title:* MEWA Form M-1

*OMB Control Number:* 1210-0116

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

*Estimated Number of Respondents:* 484 (first year); 484 (three-year average).

*Estimated Number of Responses:* 484 (first year); 484 (three-year average).

*Frequency of Response:* Annually.

*Estimated Annual Burden Hours:* 188 (first year); 130 (three-year average).

*Estimated Annual Burden Cost:* \$119,500 (first year); \$92,000 (three-year average).

**C. Regulatory Flexibility Act**

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and 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 603 of the RFA requires the agency to present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations and governmental jurisdictions. In accordance with the RFA, the Department prepared an initial regulatory flexibility analysis at the proposed rule stage and requested comments on the analysis. No comments were received. Below is the Department’s final regulatory flexibility analysis and its certification that these final regulations do not have a significant economic impact on a substantial number of small entities.

The Department does not have data regarding the total number of MEWAs and ECEs that currently exist. The best information the Department has to estimate the number of MEWAs and ECEs is based on filings of the Form M-1, which MEWAs and certain collectively bargained arrangements have filed annually with the Department. Just over 436 entities filed the Form M-1 with the Department in 2010, the latest year for which data is available.

The Small Business Administration uses a size standard of less than \$7 million in average annual receipts as the cut off for small business in the finance and insurance sector.<sup>28</sup> While the Department does not collect revenue information on the Form M-1, it does collect data regarding the number of participants covered by MEWAs and ECEs that file Form M-1 and can use participant data and average premium data to determine the number of MEWAs and ECEs that are small entities, because their revenues do not exceed the \$7 million threshold. For 2009, the average single coverage annual premium was \$4,717 and the average annual family coverage premium was \$12,696.<sup>29</sup> Combining these premium estimates with estimates of the ratio of policies to the covered population from the Current Population Survey at employers with less than 500 workers (0.309 for single coverage and 0.217 for family coverage), the Department estimates that 62 percent of entities filing Form M-1 (258 entities) are small entities.

While this number is a relatively large fraction of all entities, it is about 7 percent when expressed as a fraction of all participants covered by MEWAs and ECEs. In addition, the Department notes that the reporting burden that would be imposed on all MEWAs and ECEs by the rule is estimated as an average cost of \$284 for each entity filing Form M-1. For all but the smallest MEWAs or ECEs (less than 15 participants), this represents less than one-half of one percent of revenues.

The regulations also amend §2520.104-20 to expressly provide that the limited exemption from filing

<sup>28</sup>U.S. Small Business Administration, “Table of Small Business Size Standards Matched to North American Industry Classification System Codes.” [http://www.sba.gov/sites/default/files/Size\\_Standards\\_Table.pdf](http://www.sba.gov/sites/default/files/Size_Standards_Table.pdf)

<sup>29</sup>Kaiser Family Foundation and Health Research Educational Trust, “Employer Health Benefits, 2009 Annual Survey.” The reported numbers are from Exhibit 1.2 and are for the category Annual, all Small Firms (3-199 workers).

the Form 5500 for certain unfunded and insured small welfare plans is not available for plans required to file the Form M-1. As discussed in the PRA section above, the Department estimates that these small plan MEWAs and ECEs would incur an annual cost of \$450 to engage a third-party service provider to prepare the form and schedules for submission. Any burden for small ECEs is even less because these plans are subject to the Form M-1 filing requirements only for limited periods. The Department does not have sufficient data to determine the number of small plan MEWAs and ECEs that would be required to file the Form 5500 under the final rules. About 10 percent (48) of MEWAs and ECEs filing the Form M-1 in 2010 had less than 100 participants. However, the 2010 Form M-1 lacks information on the source of funding to determine which of these small MEWAs and ECEs would be ERISA-covered plans affected by the Final Rules.

Accordingly, the Department hereby certifies that this regulation does not have a significant economic impact on a substantial number of small entities.

#### *D. 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.

#### *E. 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 the States and the Federal government share dual jurisdiction over MEWAs that are employee benefit plans or hold plan assets. Generally, States are primarily responsible for overseeing the financial soundness and licensing of MEWAs under State insurance laws. The Department enforces ERISA's fiduciary responsibility provisions against MEWAs that are ERISA plans or hold plan assets.

Over the years, the Department and State insurance departments have worked closely and coordinated their investigations and other actions against fraudulent and abusive MEWAs. For example, EBSA regional offices have met with State officials in their regions and supported their enforcement efforts to shut down fraudulent and abusive MEWAs. States have often lobbied for stronger Federal enforcement tools to help combat fraudulent and insolvent MEWAs. By requiring MEWAs to register with the Department before

operating in a State by filing the Form M-1 and to provide additional information, these final rules respond to the States' concern and enhance the State and Federal governments' joint mission to take enforcement action against fraudulent and abusive MEWAs and limit the losses suffered by American workers, their families, and businesses when abusive MEWAs become insolvent and fail to reimburse medical claims.

#### **List of Subjects in 29 CFR Part 2520**

Accounting, Employee benefit plans, Pensions, Reporting and recordkeeping requirements.

For the reasons set out in the preamble, part 2520 of Chapter XXV of Title 29 of the Code of Federal Regulations is amended as follows:

#### **PART 2520--[AMENDED]**

■ 1. The authority citation for part 2520 is revised to read as follows:

**Authority:** 29 U.S.C. 1021-1024, 1027, 1029-31, 1059, 1134 and 1135; Secretary of Labor's Order 1-2011, 77 FR 1088 (January 9, 2012). Sec. 2520.101-2 also issued under 29 U.S.C. 1181-1183, 1181 note, 1185, 1185a-d, and 1191-1191c. Sec. 2520.103-1 also issued under 26 U.S.C. 6058 note. Sec. 2520.101-6 also issued under 29 U.S.C. 1021(k); Secs. 2520.102-3, 2520.104b-1 and 2520.104b-3 also issued under 29 U.S.C. 1003, 1181-1183, 1181 note, 1185, 1185a-d, 1191, and 1191a-c. Secs. 2520.104b-1 and 2520.107 also issued under 26 U.S.C. 401 note, 111 Stat. 788;

■ 2. Section 2520.101-2 is revised to read as follows:

#### **§2520.101-2 Filing by multiple employer welfare arrangements and certain other related entities.**

(a) *Basis and scope.* Section 101(g) of the Employee Retirement Income Security Act (ERISA), as amended by the Patient Protection and Affordable Care Act, requires the Secretary of Labor (the Secretary) to establish, by regulation, a requirement that multiple employer welfare arrangements (MEWAs) providing benefits that consist of medical care (as described in paragraph (b)(6) of this section), which are not group health plans, to register with the Secretary prior to operating in a State. Section 101(g) also permits the Secretary to require, by regulation, such MEWAs to report, not more frequently than annually, in such form and manner as the Secretary may require, for the purpose of determining the extent to which the requirements of part 7 of subtitle B of title I of ERISA (part 7) are being carried out in connection with such benefits. Section 734 of ERISA provides that the Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of part 7. This section sets out requirements for reporting by MEWAs that provide benefits that consist of medical care and by certain entities that claim not

to be a MEWA solely due to the exception in section 3(40)(A)(i) of ERISA (referred to in this section as Entities Claiming Exception or ECEs). The reporting requirements apply regardless of whether the MEWA or ECE is a group health plan.

(b) *Definitions.* As used in this section, the following definitions apply:

(1) *Administrator* means--(i) The person specifically so designated by the terms of the instrument under which the MEWA or ECE is operated;

(ii) If the MEWA or ECE is a group health plan and the administrator is not so designated, the plan sponsor (as defined in section 3(16)(B) of ERISA); or

(iii) In the case of a MEWA or ECE for which an administrator is not designated and a plan sponsor cannot be identified, jointly and severally, the person or persons actually responsible (whether or not so designated under the terms of the instrument under which the MEWA or ECE is operated) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent, custodian, or trustee designated by such person or persons.

(2) *Entity Claiming Exception (ECE)* means an entity that claims it is not a MEWA on the basis that the entity is established or maintained pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements within the meaning of section 3(40)(A)(i) of ERISA and §2510.3-40.

(3) *Excepted benefits* means *excepted benefits* within the meaning of section 733(c) of ERISA and §2590.701-2 of this chapter.

(4) *Group health plan* means a *group health plan* within the meaning of section 733(a) of ERISA and §2590.701-2 of this chapter.

(5) *Health insurance issuer* means a *health insurance issuer* within the meaning of section 733(b) (2) of ERISA and §2590.701-2 of this chapter.

(6) *Medical care* means *medical care* within the meaning of section 733(a)(2) of ERISA and §2590.701-2 of this chapter.

(7) *Multiple employer welfare arrangement (MEWA)* means a *multiple employer welfare arrangement* within the meaning of section 3(40) of ERISA.

(8) *Operating* means any activity including but not limited to marketing, soliciting, providing, or offering to provide benefits consisting of *medical care*.

(9) *Origination* means, with regard to an ECE, the occurrence of any of the following events (an ECE is considered to have been *originated* only when an event described below occurs)--

(i) The ECE begins operating with regard to the employees of two or more employers (including one or more self-employed individuals);

(ii) The ECE begins operating following a merger with another ECE (unless all of the ECEs that participate in the merger previously were last originated at least three years prior to the merger); or

(iii) The number of employees receiving coverage for medical care under the ECE is at least 50 percent greater than the number of such employees on the last

day of the previous calendar year (unless the increase is due to a merger with another ECE under which all ECEs that participate in the merger were last originated at least three years prior to the merger).

(10) *Reporting or to report* means to file the Form M-1 as required pursuant to sections 101(g) of ERISA; §2520.101-2; or the instructions to the Form M-1.

(11) *Special filing event* means, with regard to an ECE--

(i) The ECE begins knowingly operating in any additional State or States that were not indicated on a previous report filed pursuant to paragraph (e)(1)(i) or (f)(2)(i) of this section; or

(ii) The ECE experiences a material change as defined in the Form M-1 instructions.

(12) *State* means *State* within the meaning of §2590.701-2 of this chapter.

(c) *Persons required to report--*(1) General rule. Except as provided in paragraph (c)(2) of this section, the following persons are required to report under this section:

(i) The administrator of a MEWA regardless of whether the entity is a group health plan; and

(ii) The administrator of an ECE during the three-year period following an event described in paragraph (b)(9) of this section.

(2) *Exceptions--*(i) Nothing in this paragraph (c) shall be construed to require reporting under this section by the administrator of a MEWA or ECE described under this paragraph (c)(2)(i).

(A) A MEWA or ECE licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees;

(B) A MEWA or ECE that provides coverage that consists solely of excepted benefits, which are not subject to ERISA part 7. If the MEWA or ECE provides coverage that consists of both excepted benefits and other benefits for medical care that are not excepted benefits, the administrator of the MEWA or ECE is required to report under this section;

(C) A MEWA or ECE that is a group health plan not subject to ERISA, including a governmental plan, church plan, or a plan maintained solely for the purpose of complying with workmen's compensation laws, within the meaning of sections 4(b)(1), 4(b)(2), or 4(b)(3) of ERISA, respectively; or

(D) A MEWA or ECE that provides coverage only through group health plans that are not covered by ERISA, including governmental plans, church plans, or plans maintained solely for the purpose of complying with workmen's compensation laws within the meaning of sections 4(b)(1), 4(b)(2), or 4(b)(3) of ERISA, respectively (or other arrangements not covered by ERISA, such as health insurance coverage offered to individuals other than in connection with a group health plan, known as individual market coverage).

(ii) Nothing in this paragraph (c) shall be construed to require reporting under this section by the administrator of an entity that would not constitute a MEWA or ECE *but for* the following circumstances under this paragraph (c)(2)(ii).

(A) The entity provides coverage to the employees of two or more trades or businesses that share a common control interest of at least 25 percent at any time during the plan year, applying principles similar to the principles of section 414(c) of the Internal Revenue Code;

(B) The entity provides coverage to the employees of two or more employers due to a change in control of businesses (such as a merger or acquisition) that occurs for a purpose other than avoiding Form M-1 filing and is temporary in nature. For purposes of this paragraph, “temporary” means the MEWA or ECE does not extend beyond the end of the plan year following the plan year in which the change in control occurs; or

(C) The entity provides coverage to persons (excluding spouses and dependents) who are not employees or former employees of the plan sponsor, such as non-employee members of the board of directors or independent contractors, and the number of such persons who are not employees or former employees does not exceed one percent of the total number of employees or former employees covered under the arrangement, determined as of the last day of the year to be reported or, determined as of the 60th day following the date the MEWA or ECE began operating in a manner such that a filing is required pursuant to paragraph (e)(1)(i), (2), or (3) of this section.

(3) *Examples.* The rules of this paragraph (c) are illustrated by the following examples:

*Example 1.* (i) *Facts.* MEWA A begins operating by offering coverage to the employees of two or more employers on August 1, 2013. MEWA A is licensed or authorized to operate as a health insurance issuer in every State in which it offers coverage for medical care to employees.

(ii) *Conclusion.* In this *Example 1*, the administrator of MEWA A is not required to report via Form M-1. MEWA A meets the exception to the filing requirement in paragraph (c)(2)(i)(A) of this section because it is licensed or authorized to operate as a health insurance issuer in every State in which it offers coverage for medical care to employees.

*Example 2.* (i) *Facts.* Company B maintains a group health plan that provides benefits for medical care for its employees (and their dependents). Company B establishes a joint venture in which it has a 25 percent stock ownership interest, determined by applying the principles similar to the principles under section 414(c) of the Internal Revenue Code, and transfers some of its employees to the joint venture. Company B continues to cover these transferred employees under its group health plan.

(ii) *Conclusion.* In this *Example 2*, the administrator is not required to file the Form M-1 because Company B’s group health plan meets the exception to the filing requirement in paragraph (c)(2)(ii)(A) of this section. This is because Company B’s group health plan would not constitute a MEWA but for the fact that it provides coverage to two or more trades or businesses that share a common control interest of at least 25 percent.

*Example 3.* (i) *Facts.* Company C maintains a group health plan that provides benefits for medical care for its employees. The plan year of Company C’s group

health plan is the fiscal year for Company C, which is October 1st—September 30th. Therefore, October 1, 2012—September 30, 2013 is the 2013 plan year. Company C decides to sell a portion of its business, Division Z, to Company D. Company C signs an agreement with Company D under which Division Z will be transferred to Company D, effective September 30, 2013. The change in control of Division Z therefore occurs on September 30, 2013.

Under the terms of the agreement, Company C agrees to continue covering all of the employees that formerly worked for Division Z under its group health plan until Company D has established a new group health plan to cover these employees. Under the terms of the agreement, it is anticipated that Company C will not be required to cover the employees of Division Z under its group health plan beyond the end of the 2014 plan year, which is the plan year following the plan year in which the change in control of Division Z occurred.

(ii) *Conclusion.* In this *Example 3*, the administrator of Company C’s group health plan is not required to report via the Form M-1 on March 1, 2014 for fiscal year 2013 because it is subject to the exception to the filing requirement in paragraph (c)(2)(ii)(B) of this section for an entity that would not constitute a MEWA but for the fact that it is created by a change in control of businesses that occurs for a purpose other than to avoid filing the Form M-1 and is temporary in nature. Under the exception, “temporary” means the MEWA does not extend beyond the end of the plan year following the plan year in which the change in control occurs. The administrator is not required to file the 2013 Form M-1 annual report because it is anticipated that Company C will not be required to cover the employees of Division Z under its group health plan beyond the end of the 2014 plan year, which is the plan year following the plan year in which the change in control of businesses occurred.

*Example 4.* (i) *Facts.* Company E maintains a group health plan that provides benefits for medical care for its employees (and their dependents) as well as certain independent contractors who are self-employed individuals. The plan is therefore a MEWA. The administrator of Company E’s group health plan uses calendar year data to report for purposes of the Form M-1. The administrator of Company E’s group health plan determines that the number of independent contractors covered under the group health plan as of the last day of calendar year 2013 is less than one percent of the total number of employees and former employees covered under the plan determined as of the last day of calendar year 2013.

(ii) *Conclusion.* In this *Example 4*, the administrator of Company E’s group health plan is not required to report via the Form M-1 for calendar year 2013 (a filing that is otherwise due by March 1, 2014) because it is subject to the exception to the filing requirement provided in paragraph (c)(2)(ii)(C) of this section for entities that cover a very small number of persons who are not employees or former employees of the plan sponsor.

(d) *Information to be reported--(1)* Any reporting required by this section shall consist of a completed

copy of the Form M-1 Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs) (Form M-1) and any additional statements required pursuant to the instructions for the Form M-1.

(2) *Rejected filings.*--The Secretary may reject any filing under this section if the Secretary determines that the filing is incomplete, in accordance with §2560.502c-5 of this chapter.

(3) If the Secretary rejects a filing under paragraph (d)(2) of this section, and if a revised filing satisfactory to the Secretary is not submitted within 45 days after the notice of rejection, the Secretary may bring a civil action for such relief as may be appropriate (including penalties under section 502(c)(5) of ERISA and §2560.502c-5 of this chapter).

(e) *Origination, registration, and other non-annual reporting requirements and timing--*(1) *General rule for ECEs--*(i) Except as provided in paragraph (e)(1)(ii) of this section, and subject to the limitations established by paragraph (c)(1)(ii) of this section, when an ECE experiences an event described in paragraphs (b)(9) or (b)(11) of this section, the administrator of the ECE shall file Form M-1 by the 30th day following the date of the event.

(ii) *Exception.* Paragraph (e)(1)(i) of this section does not apply to ECEs that experience an origination as described in paragraph (b)(9)(i) of this section. Such entities are required, subject to the limitations established by paragraph (c)(1)(ii) of this section, to file the Form M-1 30 days prior to the date of the event.

(2) *General rule for MEWAs--*(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, the administrator of the MEWA is required to register with the Secretary by filing the Form M-1 30 days prior to operating in any State.

(ii) *Exception.* Paragraph (e)(2)(i) of this section does not apply to MEWAs that, prior to the effective date of this section, were already in operation in a State (or States). Such entities are required to submit an annual filing pursuant to annual reporting rules described in paragraph (f)(2)(i) of this section for that State (or those States).

(3) *Special rule requiring MEWAs to make additional filings.* Subsequent to registering with the Secretary pursuant to paragraph (e)(2)(i) of this section, the administrator of a MEWA shall file the Form M-1:

(i) Within 30 days of knowingly operating in any additional State or States that were not indicated on a previous report filed pursuant to paragraph (e)(2)(i) or (f)(2)(i) of this section;

(ii) Within 30 days of the MEWA operating with regard to the employees of an additional employer (or employers, including one or more self-employed individuals) after a merger with another MEWA;

(iii) Within 30 days of the date the number of employees receiving coverage for medical care under the MEWA is at least 50 percent greater than the number of such employees on the last day of the previous calendar year; or

(iv) Within 30 days of experiencing a material change as defined in the Form M-1 instructions.

(4) *Anti-abuse rule.* If a MEWA or ECE neither offers nor provides benefits consisting of medical care within a State during the calendar year immediately following the year in which a filing is made by the ECE pursuant to paragraph (e)(1) of this section (due to an event described in paragraph (b)(9)(i) or (b)(11)(i) of this section) or a filing is made by the MEWA pursuant to paragraph (e)(2) or (3) of this section, with respect to operating in such State, such filing will be considered to have lapsed.

(5) *Multiple filings not required in certain circumstances.* If multiple filings are required under this paragraph (e), a single filing will satisfy this section so long as the filing is timely for each required filing.

(6) *Extensions.* (i) An extension may be granted for filing a report required by paragraph (e)(1), (2), or (3) of this section if the administrator complies with the extension procedure prescribed in the instructions to the Form M-1.

(ii) If the filing deadline set forth in this paragraph (e) is a Saturday, Sunday, or federal holiday, the form must be filed no later than the next business day.

(f) *Annual reporting requirements and timing--*(1) *Period for which reporting is required.* A completed copy of the Form M-1 is required to be filed for each calendar year during all or part of which the MEWA is operating and for each of the three calendar years following an origination during all or part of which the ECE is operating.

(2) *Filing deadline--*(i) *General March 1 filing due date for annual filings.* Except as provided in paragraph (f)(2)(ii) of this section, a completed copy of the Form M-1 is required to be filed on or before each March 1 that follows a period for which reporting is required (as described in paragraph (f)(1) of this section).

(ii) *Exception.* Paragraph (f)(2)(i) of this section does not apply to ECEs and MEWAs if, between October 1 and December 31, the entity is required to make a filing pursuant to paragraph (e)(1), (2), or (3) of this section and makes that filing timely.

(3) *Extensions.* (i) An extension may be granted for filing a report required by paragraph (f)(2)(i) of this section if the administrator complies with the extension procedure prescribed in the instructions to the Form M-1.

(ii) If the filing deadline set forth in this paragraph (f) is a Saturday, Sunday, or federal holiday, the form must be filed no later than the next business day.

(4) *Examples.* The rules of paragraphs (e) and (f) of this section are illustrated by the following examples:

*Example 1.* (i) *Facts.* MEWA A began offering coverage for medical care to the employees of two or more employers on July 1, 2003 (and continues to offer such coverage). MEWA A has satisfied all filing requirements to date.

(ii) *Conclusion.* In this *Example 1*, the administrator of MEWA A must continue to file a timely completed Form M-1 annual report each year, but the administrator is not required to register with the Secretary because MEWA A meets the exception to the registration requirement in paragraph (e)(2)(ii) of this section and

has not experienced any event described in paragraph (e)(3) that would require registering with the Secretary.

*Example 2.* (i) *Facts.* On August 25, 2013, MEWA *B* is operating in State *P* and has made all appropriate filings related to those operations. On December 22, 2013 one of the employers that participates in MEWA *B* is awarded a new contract in State *Q*. The employer adds an office in State *Q* and the employees there are eligible to access its group health plan.

(ii) *Conclusion.* In this *Example 2*, the administrator of MEWA *B* must report the addition of State *Q* by filing the Form M-1 within 30 days of knowing that it is operating in State *Q*.

*Example 3.* (i) *Facts.* As of July 1, 2013, MEWA *C* is preparing to operate in States *Y* and *Z*. MEWA *C* is not licensed or authorized to operate as a health insurance issuer in any State and does not meet any of the other exceptions set forth in paragraph (c)(2) of this section.

(ii) *Conclusion.* In this *Example 3*, the administrator of MEWA *C* is required to register with the Secretary by filing a completed Form M-1 30 days prior to operating in States *Y* or *Z*. The administrator of MEWA *C* must also report by filing the Form M-1 annually by every March 1 thereafter.

*Example 4.* (i) *Facts.* As of July 28, 2013, MEWA *D* is operating in States *V* and *W*. MEWA *D* has satisfied the requirements of (e)(2) and, if applicable, (e)(3) with respect to those States. MEWA *D* is not licensed or authorized to operate as a health insurance issuer in any State and does not meet any of the other exceptions set forth in (c)(2) of this section. On August 5, 2013 MEWA *D* knowingly begins operating in State *X*.

(ii) *Conclusion.* In this *Example 4*, the administrator of MEWA *D* is required to make an additional registration filing with the Secretary by September 4, 2013 (within 30 days of knowingly operating in State *X*). Additionally, the administrator of MEWA *D* must continue to file the Form M-1 annually by every March 1 thereafter.

*Example 5.* (i) *Facts.* ECE *A* began offering coverage for medical care to the employees of two or more employers on January 1, 2007 and ECE *A* has not been involved in any mergers or experienced any other origination as described in paragraph (b)(9) of this section.

(ii) *Conclusion.* In this *Example 5*, ECE *A* was originated on January 1, 2007 and has not been originated since then. Therefore, the administrator of ECE *A* is not required to file a 2012 Form M-1 because the last time the ECE *A* was originated was January 1, 2007 which is more than three years prior. Further, the ECE has satisfied its reporting requirements by making three timely annual filings after its origination.

*Example 6.* (i) *Facts.* ECE *B* wants to begin offering coverage for medical care to the employees of two or more employers on July 1, 2013.

(ii) *Conclusion.* In this *Example 6*, the administrator of ECE *B* must file a completed Form M-1 on or before June 1, 2013 (which is 30 days prior to the origination date). In addition, the administrator of ECE *B* must file an updated copy of the Form M-1 by March 1, 2014 because the last date ECE *B* was originated was July 1, 2013 (which is less than three years prior to the March 1, 2014 due date). Furthermore, the administrator of

ECE *B* must file the Form M-1 by March 1, 2015 and again by March 1, 2016 (because July 1, 2013 is less than three years prior to March 1, 2015 and March 1, 2016, respectively). However, if ECE *B* is not involved in any mergers and does not experience any other origination as described in paragraph (b)(9) of this section, there would not be a new origination date and no Form M-1 is required to be filed after March 1, 2016.

*Example 7.* (i) *Facts.* ECE *D*, which currently operates in State *A* and is still within the three-year window following its origination and the timely filing related thereto, is making preparations to operate in State *B* beginning on November 1, 2013.

(ii) *Conclusion.* In this *Example 7*, by operating in State *B*, ECE *D* experiences a special event within the three-year window following its origination and must make a filing by December 2, 2013.

*Example 8.* (i) *Facts.* Same facts as *Example 7*. ECE *D* satisfied its special filing requirement but is unsure about its annual filing requirements.

(ii) *Conclusion.* ECE *D* is exempt from the next annual filing due March 1, 2014 pursuant to the filing deadline exception under (f)(2)(ii) of this section. However, ECE *D* must continue making annual filings for the remainder of the three years following its origination.

*Example 9.* (i) *Facts.* MEWA *E* begins distributing marketing materials on August 31, 2013.

(ii) *Conclusion.* In this *Example 8*, because MEWA *E* began operating on August 31, 2013, the administrator of MEWA *E* must register with the Secretary by filing a completed Form M-1 on or before August 1, 2013 (30 days prior to operating in any State). In addition, the administrator of MEWA *E* must file the Form M-1 annually by every March 1 thereafter.

*Example 10.* (i) *Facts.* Same facts as *Example 9*, but MEWA *E* registers on or before August 1, 2013 by filing a Form M-1 indicating it will begin operating in every State. However, in the calendar year immediately following the filing, MEWA *E* only offered or provided benefits consisting of medical care to participants in State *Z*.

(ii) *Conclusion.* In this *Example 10*, the registration for all States (other than State *Z*) have lapsed under (e)(4) because MEWA *E* only offered or provided benefits consisting of medical care to participants in State *Z* in the calendar year immediately following the filing. If subsequently, MEWA *E* begins offering or providing benefits consisting of medical care to participants in any additional State (or States), it must make a new registration filing pursuant to (e)(3) of this section.

(g) *Electronic filing.* A completed Form M-1 is filed with the Secretary by submitting it electronically as prescribed in the instructions to the Form M-1.

(h) *Penalties--(1) Civil penalties and procedures.* For information on civil penalties under section 502(c)(5) of ERISA for persons who fail to file the information required under this section, see §2560.502c-5 of this chapter. For information relating to administrative hearings and appeals in connection with the assessment of civil penalties under section 502(c)(5) of ERISA, see §§2570.90 through 2570.101 of this chapter.

(2) *Criminal penalties and procedures.* For information on criminal penalties under section 519 of ERISA for persons who knowingly make false statements or false representation of fact with regards to the information required under this section, see section 501(b) of ERISA.

(3) *Cease and desist and summary seizure orders.* For information on the Secretary's authority to issue a cease and desist or summary seizure order under section 521 of ERISA, see §2560.521.

■ 3. Section 2520.103-1 is amended by:

■ a. Revising paragraphs (a) introductory text, (b) introductory text and (c)(1),

■ b. Amending paragraph (c)(2)(ii)(C) by removing the reference "and" at the end of the paragraph,

■ c. Removing the period at the end of paragraph (c)(2)(ii)(D) and adding the reference "; and" at the end of the paragraph,

■ d. Adding a new paragraph (c)(2)(ii)(E),

■ e. Redesignating paragraph (f) as paragraph (g) and adding a new paragraph (f).

The revisions and additions read as follows:

#### §2520.103-1 Contents of the annual report.

(a) *In general.* The administrator of a plan required to file an annual report in accordance with section 104(a)(1) of the Act shall include with the annual report the information prescribed in paragraph (a)(1) of this section or in the simplified report, limited exemption or alternative method of compliance described in paragraph (a)(2) of this section.

\* \* \* \* \*

(b) *Contents of the annual report for plans with 100 or more participants electing the limited exemption or alternative method of compliance.* Except as provided in paragraph (d) and paragraph (f) of this section and in §§2520.103-2 and 2520.104-44, the annual report of an employee benefit plan covering 100 or more participants at the beginning of the plan year which elects the limited exemption or alternative method of compliance described in paragraph (a)(2) of this section shall include:

\* \* \* \* \*

(c) \* \* \*

(1) Except as provided in paragraph (c)(2), paragraph (d) and paragraph (f) of this section, and in §§2520.104-43, 2520.104a-6, and 2520.104-44, the annual report of an employee benefit plan that covers fewer than 100 participants at the beginning of the plan year shall include a Form 5500 "Annual Return/Report of Employee Benefit Plan" and any statements or schedules required to be attached to the form, completed in accordance with the instructions for the form, including Schedule A (Insurance Information), Schedule SB (Single Employer Defined Benefit Plan Actuarial Information), Schedule MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information), Schedule D (DFE/Participating Plan Information), Schedule I (Financial Information-

-Small Plan), and Schedule R (Retirement Plan Information). See the instructions for this form.

(2) \* \* \*

(ii) \* \* \*

(E) Is not a plan subject to the Form M-1 requirements under §2520.101-2 (Filing by Multiple Employer Welfare Arrangements and Certain Other Related Entities).

\* \* \* \* \*

(f) *Plans subject to the Form M-1 filing requirements under §2520.101-2.* The annual report of an employee welfare benefit plan that is subject to the Form M-1 requirements under §2520.101-2 (Filing by Multiple Employer Welfare Arrangements and Certain Other Related Entities) during the plan year shall also include any statements or information required by the instructions to the Form 5500 relating to compliance with the Form M-1 filing requirements under §2520.101-2.

\* \* \* \* \*

■ 4. Section 2520.104-20 is amended by removing the reference "and" in paragraph (b)(2)(iii), removing the period at the end of paragraph (b)(3)(ii) and adding the reference "; and" in its place, and adding a new paragraph (b)(4) to read as follows:

#### §2520.104-20 Limited exemption for certain small welfare plans.

\* \* \* \* \*

(b) \* \* \*

(4) Which are not subject to the Form M-1 requirements under §2520.101-2 (Filing by Multiple Employer Welfare Arrangements and Certain Other Related Entities).

\* \* \* \* \*

■ 5. In §2520.104-41, revise paragraph (c) to read as follows:

#### §2520.104-41 Simplified annual reporting requirements for plans with fewer than 100 participants.

\* \* \* \* \*

(c) *Contents.* The administrator of an employee pension or welfare benefit plan described in paragraph (b) of this section shall file, in the manner described in §2520.104a-5, a completed Form 5500 "Annual Return/Report of Employee Benefit Plan" including, if applicable, the information described in §2520.103-1(f) or, to the extent eligible, a completed Form 5500-SF "Short Form Annual Return/Report of Small Employee Benefit Plan," and any required schedules or statements prescribed by the instructions to the applicable form, and, unless waived by §2520.104-44 or §2520.104-46, a report of an independent qualified public accountant meeting the requirements of §2520.103-1(b).

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Signed this 26th day of February, 2013.  
**Phyllis C. Borzi**,  
*Assistant Secretary, Employee Benefits Security  
Administration, Department of Labor:*  
[FR Doc. 2013-04863 Filed 2-28-13; 8:45 am]  
**BILLING CODE 4510-29-P**





