

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

The NAIC solicits comments on this draft. Underlining and overstrikes show changes from the existing publication. Comments should be emailed to Jennifer Cook at [jcook@naic.org](mailto:jcook@naic.org) by **May 21, 2004**.

**Health and Welfare Plans  
Under the Employee Retirement  
Income Security Act:**

**Guidelines for State and Federal Regulation**

ERISA Working Group of the  
Health Insurance and Managed Care  
(B) Committee

**Deleted:** State and Federal Health  
Insurance  
Legislative Policy (B) Task Force

## Disclaimer

These materials are intended to provide a general overview of the concepts, principles, and procedures that the authors and editors believe may be of assistance to a state insurance regulator. These materials are not intended to serve as a definitive statement of the law or procedural requirements of any particular jurisdiction. They are not intended and should not be construed as being binding nor should a regulator act solely in reliance on the contents of this handbook. Materials in this handbook are not necessarily suitable or applicable for use in all situations.

While these materials have been prepared at the request of the National Association of Insurance Commissioners, they do not reflect the formal position of that organization or any individual or insurance regulatory authority in the states, districts, or territories of the United States.

Adoption of these materials are solely for the purpose of providing for its publication and distribution to parties who may have an interest in reviewing the material.

The users of these materials should consult the applicable statutory provisions, judicial and regulatory authority and experienced or professional personnel prior to utilizing the information contained in this handbook.

## **ACKNOWLEDGMENTS**

---

*Health and Welfare Plans Under the Employee Retirement Income Security Act (ERISA): Guidelines for State and Federal Regulation* has been prepared by the National Association of Insurance Commissioners (NAIC) ERISA Working Group of the Health Insurance and Managed Care (B) Committee.

**Deleted:** State and Federal Health Insurance Legislative Policy (B) Task Force

A special thanks goes to the state insurance regulators who reviewed and commented on and/or drafted various sections included in this edition. The ERISA Working Group also received comments from staff members of the United States Department of Labor during the drafting of the most recent edition. The working group appreciates the contribution all of these individuals have made in helping to enhance the usefulness of this handbook. The working group also appreciates the significant contribution by the NAIC staff member responsible for this revision.

Revised

2004

**Deleted:** Revised, Third Edition

**Deleted:**

# TABLE OF CONTENTS

I. Introduction

II. ERISA Preemption of State Regulation

A. The Scope of Preemption

- 1. The Preemption Clause
- 2. The Saving Clause
- 3. The Deemer Clause

B. Key Supreme Court Opinions on ERISA’s Preemption Provisions

- 1. Shaw v. Delta Air Lines
- 2. Metropolitan Life Ins. Co. v. Massachusetts
- 3. Pilot Life Ins. Co. v. Dedeaux
- 4. FMC Corp. v. Holliday
- 5. District of Columbia v. Greater Washington Board of Trade
- 6. New York Blue Cross Plans v. Travelers Ins. Co.
- 7. California Division of Labor Standards Enforcement v. Dillingham
- 8. De Buono v. NYSA-ILA Medical and Clinical Services Fund
- 9. Rush Prudential HMO, Inc. v. Moran
- 10. Kentucky Association of Health Plans v. Miller
- 11. Conclusion: revised in light of Miller.

- Formatted
- Formatted
- Formatted
- Formatted
- Deleted: District
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted

III. ERISA Plan Characteristics and Relationship to State Regulation

A. Non-Covered Benefit Arrangements

- 1. General Characteristics of an ERISA Plan<sup>2</sup>. Plan, Fund, or Program Established or Maintained Requirement
- 2. Employer or Employee Organization Requirement
- 3. Purpose Requirement
- 4. Participants Requirement
- 5. Conclusion

Deleted: 1

B. Single Employer Plans

- 1. Characteristics of a Single-Employer Plan
- 2. Single-Employer Plans and State Regulation
- 3. Conclusion

Deleted: C

C. Multiemployer Plans

- 1. Characteristics of a Multiemployer Plan
- 2. Multiemployer Plans and State Regulation
- 3. Conclusion

Deleted: D

D. Multiple Employer Welfare Arrangements

- 1. Characteristics of MEWAs
- 2. MEWAs and State Regulation
  - a. General Background: The Erlenborn Amendment

Deleted: E

- b. State Regulation of “Fully Insured” MEWAs
- c. State Regulation of Not “Fully Insured” MEWAs
- d. Conclusion

- IV. Typical Illegal Operations Claiming ERISA Status
  - A. Self-funded health plans purportedly covering enrollees as agents (TRG-type scams)
  - B. Purported “single employer” plans—out of state trusts and stop loss arrangements
  - C. Purported “fully insured” plans
  - D. Professional employee organizations (PEOs) Offering Self-funded Health Plans Illegally Under State Law
  - E. Purported Collectively Bargained Plans
  - F. Conclusion - Analytical Checklist for Determining State Jurisdiction Over Entities Offering Health Care Benefits

Deleted: F - Special Highlight: ERISA, collective bargaining agreements, and Taft-Hartley Trusts<sup>4</sup>

- V. Prevention
  - A. Consumer Education
  - B. Agent Education
  - C. Company Education

- VI. Questions & Answers about Insurance Department Jurisdiction
  - A. Can employers avoid state laws requiring workers’ compensation coverage by providing workers’ compensation through ERISA plans that also provide other benefits?
  - B. What is a Taft-Hartley Trust?
    - 1. Characteristics of a Taft-Hartley Trust
    - 2. Taft-Hartley Trusts and State Regulation
    - 3. Conclusion
  - C. What is a voluntary employees’ beneficiary association (VEBA)?
  - D. What is the difference between a Multiple Employer Trust (MET) and a Multiple Employer Welfare Arrangement (MEWA)?
  - E. What arrangements involving multiple employers that provide health benefits on a “self-funded” basis ease the administrative burden of providing those benefits?
  - F. If a not “fully insured” MEWA covers some employees in a state, but the employers are located in another state, does the state in which the MEWA covers some employees still have the authority to regulate the MEWA?
  - G. Is the term “fully insured” defined in ERISA?
  - H. May a state insurance department subpoena an ERISA plan’s books and records or conduct a charge for financial examination?
  - I. Can managed care organizations that are sponsored by providers and that accept insurance risk from ERISA plans be required to obtain an insurance license and be otherwise regulated under state insurance laws?

Deleted: III

Deleted: F

Deleted: Special Highlight: ERISA, collective bargaining agreements, and

Deleted: s

Deleted: B

Deleted: C

Deleted: D. Is a state law that is used to regulate a MEWA preempted by ERISA

Deleted: s

Deleted: E

Deleted: covers

Deleted: I. Are benefits sponsored by employee leasing companies exempt from state regulation because they are plans covered under ERISA of the employee leasing company claims that the arrangement is “self funded” for all leased employees?

Deleted: I

J. To what extent may states regulate third party administrators (TPAs) ~~that~~ provide administrative services to ERISA plans?

Deleted: K  
Deleted: which

VII. Glossary

Deleted: D

VIII. Appendix A

Deleted: IV

- A.
  - 1. Consumer Alert
  - 2. Agent Alert
  - 3. Regulatory Alert to Stop Loss Carriers and Third Party Administrators

B. NAIC Models

Deleted: A

- 2. Reporting Requirements for Licensees Seeking to do Business with Certain Unauthorized Multiple Employer Welfare Arrangements (MEWAs) Model Regulation (Model No. 220)

Deleted: 1. Jurisdiction to Determine Jurisdiction of Providers of Health Care Benefits Model Act (Model No. 95)

C. Department of Labor Advisory Opinions

Deleted: B

- 1. Opinion No. 84-17A
- 2. Opinion No. 90-18A
- 3. Opinion No. 91-05A
- 4. Opinion No. 91-06A
- 5. Opinion No. United Welfare Fund and Amalgamated Local Union 395
- 6. Opinion No. 93-11A
- 7. Opinion No. 94-07A
- 8. Opinion No. 95-29A

D. Key U.S. Supreme Court Cases

Deleted: C

- 1. *Shaw v. Delta Airlines*
- 2. *Metropolitan Life Ins. Co. v. Massachusetts*
- 3. *Pilot Life Ins. Co. v. Dedeaux*
- 4. *FMC Corp. v. Holliday*
- 5. *Nationwide Mutual Ins. Co. v. Darden*
- 6. *District of Columbia v. Greater Washington Board of Trade*
- 7. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*
- 8. *California Division of Labor Standards Enforcement v. Dillingham*
- 9. *De Buono v. NYSA-ILA Medical and Clinical Services Fund*
- 10. *Rush Prudential HMO, Inc. v. Moran*
- 11. *Kentucky Association of Health Plans v. Miller*

## INTRODUCTION

---

**DRAFT 3-11-04***ERISA: Guidelines for State and Federal Regulation*

The Employee Retirement Income Security Act of 1974 (ERISA)<sup>1</sup> is a complex and comprehensive statute ~~that~~ federalizes the law of employee benefits. ERISA establishes a comprehensive regulatory framework for employee pension benefit plans and also preempts most state laws relating to “employee welfare benefit plans,” a broad category that includes nearly all employer-sponsored and union-sponsored health plans.<sup>2</sup>

Deleted: which

However, ERISA does not preempt state insurance law. The result is a dual regulatory framework. To the extent that an ERISA plan pays directly out of plan assets (a “self-funded plan”), it is exempt from state regulation. To the extent that the plan purchases insurance to cover some or all of its benefit obligations (an “insured plan”), the state’s regulatory authority over the insurance contract results in indirect state regulation of aspects of the plan.<sup>3</sup>

The precise boundary of state jurisdiction has been the subject of numerous disputes involving complex preemption analysis. In contrast to the detailed and substantive standards ~~that~~ are imposed on employee pension benefit plans, there is no comparable federal regulatory program for employee welfare benefit plans.<sup>4</sup> The minimal federal standards for employee welfare benefit plans and the imprecision and complexity of the ERISA preemption analysis result in numerous disputes over the limits of state jurisdiction in areas related to employee welfare benefit plans.

Deleted: which

Deleted: 1

<sup>1</sup> Public Law 93-406, codified at 29 U.S.C. § 1001 et seq. (1985). Note that federal laws have their own internal numbering system and the numbering of many titles of the United States Code remains “unofficial.” For example, the preemption clause, 29 U.S.C § 1144, is the codification of P.L. 93-406, § 514, as amended is often cited as “Section 514.”

<sup>2</sup> The terms ‘employee welfare benefit plan’ and ‘welfare plan’ include any “program ... established or maintained by an employer or employee organization ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise” with any of a broad range of benefits, including among others “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.” 29 U.S.C. § 1002(1) (Supp. 1996).

<sup>3</sup> While ERISA governs both the insured and self-funded plan, the term “ERISA plan” is often used colloquially to refer to a self-funded plan. In this handbook, the term “ERISA plan” is used in the correct sense to include a reference to both the “self-funded” plan and the “insured” plan.

<sup>4</sup> ERISA was drafted specifically in response to concerns that working people were losing their pension benefits for a variety of reasons, including pension fraud, mismanagement and employer bankruptcy. With the growth in asset accumulation and the number of pension plans, Congress sought to ensure that appropriate safeguards were in place to protect pension plan funds. Congress also sought to encourage multistate employers who might be reluctant to form employee benefit plans in the face of fifty separate state regulatory schemes to provide employee benefits to their workers.

It is important to note that the impetus for ERISA was the security of pension plans and not concern for health care related benefits. Congress’ central concern for pension plan management is evident in the text of the Act as well as its legislative history. Under ERISA, pension plans are subject to uniform reporting, disclosure, fiduciary, participation, funding, and vesting requirements. Through these requirements, detailed and substantive standards are imposed on employers who furnish pension plans to their employees. On the other hand, employee welfare benefit plans are subject only to the reporting, disclosure, and fiduciary responsibility requirements. Consequently, the law does not require employee welfare benefit plans to meet requirements such as financial solvency standards. Through the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191, Congress did create standards for employee welfare benefit plans that offer health benefits that limited the use of preexisting condition exclusions and prohibited discrimination based on health status-related factors.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

The complexity of ERISA preemption is derived primarily from the multiple stages in the analysis of whether a state law is preempted by ERISA. When determining whether ERISA preemption applies, state regulators must consider the following questions:

1. Is the plan under consideration an ERISA plan and, if so, what type of ERISA plan?
2. Does the state law “relate to” the ERISA plan?<sup>5</sup>
3. Even if the law does “relate to” an ERISA plan, is it protected by the “saving clause” which saves “any law of any State which regulates insurance” from preemption?<sup>6</sup>
4. Is the “saving clause” protection limited by ERISA’s “deemer clause,” which prohibits states from “deeming” an employee benefit plan to be an insurer, bank, or investment company in order to assert their authority to regulate one of those entities?<sup>7</sup>

Deleted: s

Deleted: s

Determining whether a state law is preempted by ERISA is complex and confusing. Unfortunately, unscrupulous operators capitalize on this confusion and illegitimately claim that state laws do not apply to their health plans because they are preempted under ERISA. State regulators need to be aware of the common scams and understand ERISA in order not to fall victim to these spurious claims. See the Section on “Sham Plans and How to Stop Them” for a description of some of the more common scams claiming exemption from state law under ERISA.

The principal purpose of this handbook is to provide state insurance regulators with a resource guide to help them through the labyrinth of ERISA preemption analysis. While ERISA preemption applies to a broader range of contexts, this handbook focuses exclusively on health-related employee welfare benefit plans.<sup>10</sup> The first section discusses the scope of ERISA preemption. Specifically, it provides historical background information on ERISA preemption of state law and an overview of the statutory elements

**Deleted:** In addition, regulators must also be aware that the federal statute contains an exception to this preemption analysis for multiple employer welfare arrangements (MEWAs). The “MEWA clause,” allows states to regulate risk-bearing “multiple employer welfare arrangements” as insurers and also permits limited state regulation of those MEWAs that are fully insured.<sup>8</sup> However, regulators must further inquire whether an arrangement is pursuant to a collectively bargained agreement. Multiple employer plans established through agreements that the Secretary of the Department of Labor finds to be bona fide collective bargaining agreements are excluded from the definition of MEWA, and therefore can operate without being subject to state insurance regulation.<sup>9</sup>

<sup>5</sup>29 U.S.C. § 1144(a) (1985). It should be noted that ERISA does not apply to employee benefit plans maintained by governmental or church employers or to plans maintained only to comply with applicable state workers’ compensation, unemployment or disability laws. There are additional exemptions from ERISA for unfunded excess benefit plans and plans maintained outside the U.S. primarily for nonresident aliens. ERISA does provide an opt-in provision for church employers. 29 U.S.C. § 1003(b) (1985).

<sup>6</sup> 29 U.S.C. § 1144(b)(2)(A) (1985). State laws regulating banking and securities, generally applicable criminal laws, and most provisions of the Hawaii Prepaid Health Care Act are also saved from preemption. *Id.* § 1144(b)(2)-(5).

<sup>7</sup> 29 U.S.C. § 1144(b)(2)(B) (1985).

<sup>10</sup> This handbook does not provide an in depth analysis of ERISA preemption issues that have arisen specifically as a result of the enactment of HIPAA, P.L. 104-191.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

of the ERISA preemption analysis. The section ends with a summary of cases in which the Supreme Court has interpreted these statutory elements.

The second section of this handbook highlights the general characteristics of an ERISA plan and reviews the specific types of employee welfare benefit plans governed by ERISA: single-employer plans, multiemployer plans, and multiple employer welfare arrangements. The section describes how the preemption analysis applies to each individual plan type. The section also highlights some of the typical theories used by sham plan operators claiming ERISA preemption from state laws. The relationship between ERISA and Taft-Hartley trusts is also highlighted. The second section ends with an analytical checklist and chart regulators may find useful.

The third section of this handbook explores in a question and answer format a number of timely topics of interest to state insurance regulators. Some of the issues addressed in this section are basic settled questions that are commonly asked. Other questions reflect cutting edge issues that are still the subject of debate.

Finally, the fourth section of this handbook is an appendix that contains NAIC model laws, Department of Labor (DOL) advisory opinion letters,<sup>11</sup> key U.S. Supreme Court cases, and a glossary.

Deleted: appendices

---

<sup>11</sup> While DOL advisory opinion letters do not have the force of law, they represent the DOL's interpretation of Title I of ERISA and are binding on DOL. The advisory opinion letters are very influential in the judicial decision making process and provide useful guidance.

# ERISA PREEMPTION OF STATE REGULATION

## The Scope Of Preemption

The scope of ERISA preemption is sweeping. With the exception of state regulations applied to MEWAs, any state law that attempts to regulate ERISA-covered employee benefit plans is preempted due to federal occupation of the field.<sup>12</sup> However, ERISA exempts from federal preemption state laws that regulate the business of insurance. A “saving clause” in the Act empowers states to enforce all state laws that regulate insurance. The broad language of the saving clause is limited by a “deemer clause” in the statute, which has been judicially interpreted to mean that an employee benefit plan covered by ERISA cannot be deemed to be an insurance company or engaged in the business of insurance for the purposes of the application of state laws which regulate insurance.<sup>13</sup> Because little legislative history exists with respect to these clauses, the interpretation of their meaning has been developed through the judicial decision making process.

Deleted: s  
Deleted: s

The “saving clause” is also limited by case law holding that some provisions of state insurance codes regulating insurers go beyond regulating “the business of insurance” and therefore are preempted to the extent they apply to insurance issued to employee benefit plans.<sup>14</sup> The Supreme Court’s “interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts; if the plan is uninsured, the State may not regulate it.”<sup>15</sup>

Deleted: s

Deleted: Because little legislative history exists with respect to these clauses, the interpretation of their meaning has been developed through the judicial decisionmaking process.

This section provides a brief overview of those provisions of ERISA which:

- ◆ preempt state laws ‘relating to’ employee welfare benefit plans;
- ◆ save state laws ‘regulating the business of insurance’; and
- ◆ prohibit states from ‘deeming’ employee welfare benefit plans to be insurers or engaged in the business of insurance.

Summaries of a number of key Supreme Court cases interpreting these clauses are provided at the end of this section.

### The Preemption Clause

The preemption clause states that “Except as provided in subsection (b) of this section [referring to the saving clause] ... the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter

<sup>12</sup> 29 U.S.C. § 1144(a) (1985).

<sup>13</sup> *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

<sup>14</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50-51 (1987).

<sup>15</sup> *FMC*, 498 U.S. at 64.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.”<sup>16</sup>

Preemption applies only to a plan ~~that~~ was established or is maintained by an employer and/or an employee organization to provide any of the specified benefits to the employees of the employer or members of the employee organization.<sup>17</sup> Congress defined 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.”<sup>18</sup> An employee organization is defined as “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 any employee benefit plan, or other matters incidental to employment relationships; or an employees’ beneficiary association organized for the purpose in whole or in part, of establishing such a plan.”<sup>19</sup>

Deleted: which

The scope of ERISA preemption has been altered since the federal law’s original enactment. The vague phrase “any person acting directly ... or indirectly in the interest of an employer” in the definition of employer and the extremely broad scope of the language of the preemption clause created a troublesome loophole in ERISA. This loophole allowed unscrupulous promoters to peddle spurious health plans to all comers and to claim protection from state regulation as entities acting directly or indirectly in the interest of employers.

Congress reviewed the effect of preemption under ERISA in the Activity Report of the Committee on Education and Labor of the United States House of Representatives on January 3, 1977.<sup>20</sup> Although the Committee thought that the broad preemption provision of ERISA should be retained, it emphasized that entrepreneurial ventures masquerading as ERISA plans were “no more ERISA plans than is any other insurance policy sold to an employee benefit plan.”<sup>21</sup> Also, “[w]here a 'plan' is, in effect, an entrepreneurial venture, it is outside the policy of section 514 (the preemption clause of ERISA) ... In short, to be properly characterized as an ERISA benefit plan, a plan must satisfy the definition requirement ... in both form and substance.”<sup>22</sup> The committee concluded: “We most earnestly encourage private persons, in particular the membership of the National Association of State [*sic*] Insurance Commissioners, and urge the Department of Labor, to take appropriate action to prevent the continued wrongful avoidance of proper state

<sup>16</sup> 29 U.S.C. § 1144(a) (1985). ERISA defines state law to include “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State,” and also any “law of the United States applicable only to the District of Columbia.” 29 U.S.C. § 1144(c)(1) (1985).

<sup>17</sup> 29 U.S.C. § 1002(1) (Supp. 1996).

<sup>18</sup> 29 U.S.C. § 1002(5) (Supp. 1996).

<sup>19</sup> 29 U.S.C. § 1002(4) (Supp. 1996).

<sup>20</sup> ERISA OVERSIGHT REPORT OF THE PENSION TASK FORCE OF THE SUBCOMM. ON LABOR STANDARDS, HOUSE COMM. ON EDUCATION AND LABOR, H.R. Doc. No. 342-9, 94th CONG., 2d Sess. (Jan. 3, 1977) [“COMM. REPORT”].

<sup>21</sup> *Id.* at 10.

<sup>22</sup> *Id.* at 11.

regulation by the entities.”<sup>23</sup> Finally, in 1983, Congress enacted language to facilitate the efforts of the states and the DOL to establish a clear and effective regulatory framework for multiple employer plans. These provisions are discussed in more detail in the section on multiple employer welfare arrangements beginning at page 25.

Deleted: Department of Labor

Although the 1983 amendment to ERISA reduced the scope of ERISA preemption, for non-MEWA ERISA plans the potential for ERISA preemption of state laws remains significant. ERISA’s preemption provision has been interpreted broadly by the federal courts. When plaintiffs seek state law remedies in state courts for claims related to employee benefit plans, defendants invariably have the cases removed to the federal court where cases usually are dismissed on the grounds of preemption.

**The Saving Clause**

Deleted: s

Notwithstanding the preemption clause, ERISA does not substitute for or eliminate state insurance regulation. To preserve state laws regulating insurance and state authority to continue to do so, Congress included a “saving clause” in the Act. This provision reads: “Except as provided in subparagraph (B), [referring to the “deemer clause”], nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”<sup>24</sup> In other words, ERISA generally does not prohibit states from applying state insurance laws to entities engaged in the business of insurance.

Deleted: s

The “saving clause” is consistent with the McCarran-Ferguson Act,<sup>25</sup> which Congress passed in 1945 to reserve for the states the authority to regulate the business of insurance. Furthermore, ERISA explicitly states that “Nothing in this subchapter shall be construed

Deleted: s

<sup>23</sup> *Id.*

<sup>24</sup> 29 U.S.C. §1144(b)(2)(A) (1985).

<sup>25</sup> 15 U.S.C. §1011 *et seq.* (1985). The McCarran-Ferguson Act states in part:

§ 1011. Declaration of policy

The Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) State regulation. The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance; *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, [15 U.S.C. §§ 1 *et seq.*] and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, [15 U.S.C. §§ 41 *et seq.*], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Formatted

to alter, amend, modify, invalidate, impair, or supersede any law of the United States ... or any rule or regulation issued under any such law.”<sup>26</sup> Known as an “equal dignity” clause, this provision protects the McCarran-Ferguson Act from being superseded or modified by ERISA.

**The Deemer Clause**

While the “saving clause” seeks to protect state authority to regulate the business of insurance, state insurance laws cannot be applied to employee benefit plans. The “deemer clause” states, “Neither an employee benefit plan described in 29 U.S.C. §1003(a) of this title, which is not exempt under §1003(b) of this title (other than a plan established primarily for the purposes of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer ... or to be engaged in the business of insurance ... for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts...”<sup>27</sup>

Deleted: s

A state law that treats an employee welfare benefit plan as if it were an insurer negates the effect of the saving clause. The deemer clause does not negate the ability of states to apply insurance laws to those entities with which the employee welfare benefit plan has contracted to purchase insurance for its employees.

Deleted: which

Deleted: s

**Key United States Supreme Court Opinions On ERISA’s Preemption Provisions**

The interplay between ERISA’s preemption, saving, and deemer clauses and the impact of these clauses on state regulatory authority has been the subject of a multitude of cases presented before the judiciary. The Supreme Court established tests to be used when evaluating whether a state law is preempted because it “relates to” an employee benefit plan or because the state law “deems” an employee benefit plan to be an insurer or to be engaged in the business of insurance. The Court also established tests to be used when evaluating if a state law is “saved” because it regulates “the business of insurance.”

Deleted: s

Deleted: has

Deleted: has

Deleted: s

The guidance established in the Supreme Court cases is further augmented by lower court opinions. While the Supreme Court has provided the lower courts with direction not readily apparent in the statutory language, the complexity of the statute and the fact-specific nature of the cases that the courts must decide results in an uncertain judicial decision making process. Lower courts often reach conflicting decisions in interpreting similar state laws. As a consequence, legislators, regulators, employers, and insurers sometimes have difficulty predicting what the courts will consider a “preempted” or “saved” regulatory initiative.

The Supreme Court further complicated the issue in the April 2003 decision, *Kentucky Association of Health Plans v. Miller*<sup>28</sup>, when it announced a “clean break” from the tests

<sup>26</sup> 29 U.S.C. § 1144(d) (Supp. 1996).

<sup>27</sup> 29 U.S.C. § 1144(b)(2)(B) (1985).

<sup>28</sup> 538 U.S. \_\_\_\_\_, 71 U.S.L.W. 4259 (April 8, 2003)

the Supreme Court relied upon previously in interpreting the saving clause. There is uncertainty about the impact of the *Miller* case on future cases and on the precedential value of the Court's previous ERISA preemption cases. See the summaries of a number of the key Supreme Court cases provided below.

***SHAW v. DELTA AIR LINES,***  
***463 U.S. 85 , 103 S.Ct. 2890 (1983)***

In *Shaw v. Delta Air Lines*, the Supreme Court decided whether New York's Human Rights Law and Disability Benefits Law were preempted by ERISA. *Shaw* is particularly valuable because of its efforts to define what the phrase "relate to" means in the context of the ERISA preemption clause and to clarify the breadth of the states' reserved authority to regulate state-mandated disability, unemployment, and workers' compensation benefit plans.

New York's Human Rights Law contained a number of employment discrimination provisions, including one prohibiting employers from discriminating against their employees on the basis of sex, and defining sex discrimination to include discrimination on the basis of pregnancy. New York's Disability Benefits Law required employers to provide employees the same benefits for pregnancy as were provided for other disabilities.<sup>29</sup>

In its analysis, the Court held that both of these state laws "related to" employee benefit plans. The Court's interpretation of "relate to" was according to "the normal sense of the phrase, if it has a connection with or reference to such a plan."<sup>30</sup> The Human Rights statute prevented employers from structuring their employee benefit plans in a discriminatory fashion on the basis of pregnancy. The Disability Benefits statute required employers to include certain benefits in their employee welfare benefit plan.<sup>31</sup>

The Court noted that ERISA does not merely preempt state laws that deal with requirements covered by ERISA, such as reporting, disclosure, and fiduciary responsibility. Nor does the Act merely preempt state laws specifically directed to employee benefit plans.<sup>32</sup> State laws that indirectly "relate to" employee benefit plans may also be preempted by ERISA. The Court did note that some state laws "may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan."<sup>33</sup>

**Deleted:** The summaries of a number of key cases involving employee welfare benefit plans are included below to provide regulators with a general overview of the Court's interpretation of the preemption, savings, and deemer clauses. The cases below do not represent an exhaustive list of judicial authority on these clauses, nor do these cases reflect the array of lower court opinions interpreting these clauses. To obtain a full picture of the potential status of a particular state's law, regulators will need to be familiar with the specific facts of the case, the provisions of the relevant state statute(s), and the judicial holding of relevant cases decided in the applicable circuit.

**Deleted:** which

<sup>29</sup> *Shaw v. Delta Air Lines*, 463 U.S. 85, 88-9 (1983).

<sup>30</sup> *Id.* at 96-97.

<sup>31</sup> *Id.* at 97.

<sup>32</sup> *Id.* at 98.

<sup>33</sup> *Id.* n. 21, at 100.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

Following its conclusion that both state laws “related to” employee benefit plans, the Court proceeded to inquire whether either of the laws was nevertheless exempt from ERISA preemption. The state argued that the Human Rights Law was exempt from ERISA preemption because ERISA’s “equal dignity” clause prohibited interpretations that impaired other federal laws and state fair employment laws were integral to the federal enforcement scheme under Title VII. The Court rejected this claim, noting that ERISA preemption of the Human Rights Law as it related to employee benefit plans did not impair Title VII because Title VII did not prohibit the practices under consideration in this case.<sup>34</sup>

Deleted: which

With respect to the Disability Benefits Law, the Court noted that ERISA specifically exempts from coverage those plans which are “maintained solely for the purpose of complying with applicable ... disability insurance laws.”<sup>35</sup> Consequently, the Court held that states cannot apply their laws to multi-benefit ERISA plans which may include disability benefits, but can require the employer to administer a separate disability plan which does comply with state law.<sup>36</sup>

***METROPOLITAN LIFE INS. CO. v. MASSACHUSETTS,***  
***471 U.S. 724, 105 S. Ct. 2380 (1985)***

In *Metropolitan Life v. Massachusetts*, the Court reviewed whether a state statute mandating coverage of mental health benefits was preempted by ERISA as applied to insurance policies purchased by employee welfare benefit plans. All insurance policies within the scope of the statute, including policies purchased by ERISA health plans, were required to include the mandated mental health benefit. Because the statute had the effect of requiring insured employee benefit plans to provide a particular benefit, the Commonwealth of Massachusetts did not dispute that the statute “related to” ERISA plans.<sup>37</sup> The Commonwealth did claim, however, that the law regulated the business of insurance, and thus, was saved from ERISA preemption.<sup>38</sup>

In its analysis, the Court highlighted that ERISA does not distinguish between “traditional and innovative insurance laws.”<sup>39</sup> Further, the Court noted that “[t]he presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope.”<sup>40</sup> The Court also noted that Congress did not intend to preempt areas of traditional state regulation.<sup>41</sup>

---

<sup>34</sup> *Id.* at 103-04.  
<sup>35</sup> *Id.* at 106; See 29 U.S.C. § 1003(b)(3) (1985).  
<sup>36</sup> *Id.* at 107-08.  
<sup>37</sup> *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724, 739 (1985).  
<sup>38</sup> *Id.* at 733.  
<sup>39</sup> *Id.* at 741.  
<sup>40</sup> *Id.* at 741.  
<sup>41</sup> *Id.* at 740.

The opinion adopted a “common-sense view” of the saving clause, observing that it would seem to “state the obvious” that a law which “regulates the terms of certain insurance contracts” is “a law ‘which regulates insurance’” within the meaning of the saving clause.<sup>42</sup> The Court explained further that the case law interpreting the phrase “the business of insurance” under the McCarran-Ferguson Act “also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws ‘which regulate insurance.’”<sup>43</sup> Under the McCarran-Ferguson Act, “Statutes aimed at protecting or regulating [the insurer-policyholder] relationship, directly or indirectly, are laws regulating the ‘business of insurance.’”<sup>44</sup> The Court reviewed the McCarran-Ferguson “reverse preemption” cases as an aid to determine if a practice is the “business of insurance”.<sup>45</sup>

Deleted: relies heavily upon

Deleted: Act.

Deleted: criteria used

Deleted: business of insurance and therefore saved from the preemption clause.

- (1) Does the practice have the effect of “spreading a policyholder’s risk”?
- (2) Is the practice an “integral part of the policy relationship between the insurer and the insured”?
- (3) Is the practice “limited to entities within the insurance industry”?

Deleted:

The Supreme Court opinion which established this three-pronged test, *Union Labor Life v. Pireno*<sup>46</sup>, specifically noted that not all of these prongs are necessary and noted, in particular, that the third prong of the test was not dispositive to a determination that an entity was engaged in the business of insurance.<sup>47</sup>

Deleted: In *Metropolitan*, the Court does not say that a law must meet all three of these criteria to classify as a state law which “regulates the business of insurance.”

Deleted: may be

The Court held that the Massachusetts law met all three of the *Pireno* criteria derived from the McCarran-Ferguson Act. It found that:

- (1) The law regulated the spreading of risk since the state legislature’s intent was that the risk associated with mental health services should be shared;
- (2) The law directly regulated an integral part of the relationship between the insurer and the policyholder
- (3) The law met the third prong because it only imposed requirements on insurers.<sup>48</sup>

Deleted: the

Deleted: the

Deleted: the

<sup>42</sup> *Id.* at 740.

<sup>43</sup> *Id.* at 742–43.

<sup>44</sup> *Id.* at 744, quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

<sup>45</sup> *Id.* at 742, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). Although some courts, including on occasion the Supreme Court itself, have cited *Metropolitan Life* and/or *Pireno* as supporting the proposition that courts should evaluate whether the law itself “has the effect of spreading a policyholder’s risk,” that is not how the standard was originally formulated by the Court.

<sup>46</sup> *Union Labor Life v. Pireno*, 458 U.S. 119 (1982).

<sup>47</sup> *Id.* at 133.

<sup>48</sup> *Metropolitan*, 471 U.S. at 743.

The Court acknowledged, “we are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction created by Congress in the “deemer clause,” a distinction Congress is aware of and one it has chosen not to alter.”<sup>49</sup>

It is important for regulators to keep in mind that this distinction between indirectly regulated insured plans and unregulated self-funded plans is the result, not the source, of states’ reserved authority to regulate insurance. Thus, the applicability of state insurance law to an insurance policy purchased by an employee benefit plan is not conditional on some prior determination that the plan is an “insured” plan.

***PILOT LIFE INS. CO. v. DEDEAUX,***  
***481 U.S. 41, 107 S.Ct. 1549 (1987)***

*Pilot Life Ins. Co. v. Dedeaux* involved state common law tort and contract claims as applied to the processing of claim benefits under an employee welfare benefit plan. In *Pilot Life*, a unanimous Court held that the plaintiff’s common law causes of action for the insurer’s alleged bad faith handling of the plaintiff’s disability claim “related to” an employee benefit plan and were preempted by ERISA because they involved the processing of claims under an employee benefit plan.<sup>50</sup>

The Court found that the state law bad-faith common law tort claims were not protected by the “saving clause.” The Court stated that “in order to regulate insurance, a law must not just have an impact on the insurance industry, but be *specifically directed* toward that industry.”<sup>51</sup> Applying the criteria used to determine whether a practice constitutes the business of insurance for purposes of the McCarran-Ferguson Act, the Court determined that: (1) the common law tort of bad faith did not effect a spreading of the risk; (2) the tort was not integral to the insurer-insured relationship; and (3) because common law tort claims were not limited to entities within the insurance industry, the McCarran-Ferguson “business of insurance” test did not save the state law claims.<sup>52</sup> Further, the Court stated that “the deliberate care with which ERISA’s civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive.”<sup>53</sup>

**Deleted:** Finding  
**Deleted:** claims procedures were outside of the “saving clause,” the

**Deleted:** concluded  
**Deleted:** The Court noted in *Pilot Life* that Mississippi’s common law of bad faith, even if associated with the insurance industry, “developed from principles of tort and contract law available in any Mississippi breach of contract case” and was not limited to entities within the insurance industry. Broadly interpreted, this holding means that the mere inclusion of a statute in a state insurance code is not sufficient to “save” a state consumer statute from ERISA preemption if that statute is rooted in the substantive common law. The common law duty of good faith to handle and settle claims fairly, the basis of most state “deceptive trade practices” acts, meets none of the three parts of the McCarran-Ferguson test for the “business of insurance.” At any rate, as the Supreme Court pointed out in *Pilot Life*, the exclusivity of ERISA’s civil enforcement scheme is a more important determinant of preemption than whether state laws arguably “regulate insurance.”<sup>54</sup>

The Court went beyond considering the exclusive remedy as an additional factor in support of its conclusion that the bad faith tort does not “regulate insurance” within the meaning of the saving clause – the Court concluded that even if Mississippi’s law did

<sup>49</sup> *Id.* at 747  
<sup>50</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987).  
<sup>51</sup> *Id.* at 50. Emphasis supplied.  
<sup>52</sup> *Id.* at 57.  
<sup>53</sup> *Id.* at 54.  
<sup>55</sup> 481 U.S. at 56–57.

regulate insurance, it would still be preempted. The Court distinguished *Metropolitan Life* on the ground that it “did not involve a state law that conflicted with a substantive provision of ERISA.”<sup>55</sup> The Court concluded that all state laws that “supplemented or supplanted” the causes of action and remedies available under ERISA were preempted,<sup>56</sup> whether or not they “regulated insurance” within the meaning of the saving clause.

ERISA preemption also controls the forum in which the complaint is to be heard. The Federal Rules of Civil Procedure provide that “any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.”<sup>57</sup> In a companion case to *Pilot Life, Metropolitan Life Ins. Co. v. Taylor*,<sup>58</sup> the Supreme Court held that state court cases can be removed to federal court if the common-law cause of action is preempted by ERISA, even though no federal law issues appear in the complaint. The Court held that this doctrine, originally developed in the context of labor law preemption,<sup>59</sup> was equally applicable to ERISA preemption.<sup>60</sup>

Deleted: 1

The deference that the Court afforded to the civil enforcement scheme of ERISA stressed the need for exclusivity and uniformity of ERISA plan remedies.<sup>61</sup> As a result, it is important to distinguish state insurance regulation and enforcement relating to claims handling, utilization review, grievance handling and coverage or claim appeals from civil remedies. The *Pilot Life* “conflict” exception to the saving clause should not be invoked by a court reviewing an insurance regulatory provision relating to these topics because they are not a “civil remedy” for the participant, even if they have the effect of providing restitution to consumers.

Deleted: which

Deleted: Thus, if a statutorily-created remedy conflicts with this Congressional policy, preemption may result regardless of the outcome of the *Pilot Life* analysis of the statute.<sup>62</sup> State regulators are now faced with the anomalous situation that individual policyholders have some statutory and common law remedies available to them that are not available to those covered under a group policy extending similar benefits.

***FMC CORP. v. HOLLIDAY,***  
***498 U.S. 52 (1990)***

<sup>56</sup> *Id.* at 56. The Court based its analysis on legislative history, submitted by the Solicitor General as *amicus curie*, indicating that the preemption provisions in ERISA were based on the broad exclusive remedy provisions in the Taft-Hartley Act (LMRA), 29 U.S.C. § 185. The Taft-Hartley Act does not contain an insurance saving clause, a difference from ERISA that was not addressed by the *Pilot Life* Court. See *UNUM Life Ins. Co. v. Ward*, 526 U.S. at 376 n.7.

<sup>57</sup> 28 U.S.C. § 1441(a) (1994).

<sup>58</sup> *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

<sup>59</sup> See *Avco Corp. v. Machinists*, 390 U.S. 557 (1968). In *Avco*, the Court permitted the removal of cases purporting to be based only on state law causes of action in labor cases preempted by § 301 of the Labor Management Relations Act.

<sup>60</sup> *Taylor* at 66-67. However, as noted by the U.S. Supreme Court in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), for non-diversity of citizenship cases, a defendant may not remove a case to federal court unless the plaintiff’s complaint establishes that the case arises under federal law. Federal law as a defense is generally not sufficient to remove an action to federal court. The cause of action must come within the scope of ERISA’s civil enforcement provisions (29 U.S.C. §502).

<sup>61</sup> William A. Chittenden, III, *ERISA Preemption: The Demise of Bad Faith Actions in Group Insurance Cases*, 12 S. Ill. U.L. J., 517 (1988).

<sup>63</sup> *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990).

At issue in *FMC Corp. v. Holliday* was a Pennsylvania state statute that prevented employee welfare benefit plans from subrogating a plan beneficiary’s tort recovery involving motor vehicle-related incidents. The plan at issue was a self-funded employee welfare benefit plan.<sup>63</sup>

Deleted: which

The Court concluded that the statute “related to” the employee benefit plan because it referenced such plans and was connected to such plans by subjecting multi-state self-funded plans to conflicting state regulations.<sup>64</sup> The Court also concluded that the statute fell within the “saving” clause as an insurance regulation.<sup>65</sup>

Deleted: s

Nevertheless, after concluding that the statute “related to” the employee benefit plan and regulated insurance, the Court ultimately held that the statute was not “saved” to the extent that it regulated ERISA-covered self-funded employee welfare benefit plans. Since the “deemer” clause exempts ERISA plans from state laws that regulate insurance, the state could not apply laws directed at the business of insurance to self-funded employee welfare benefit plans or to the terms of the plans.<sup>66</sup> The Court reaffirmed that the “saving” clause “retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee welfare benefit plans.”<sup>67</sup> Specifically, the Court stated that “if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts; if the plan is uninsured, the State may not regulate it.”<sup>68</sup>

Deleted: because it improperly “deemed”

Deleted: to be insurance companies

Deleted: s

***DISTRICT OF COLUMBIA v. GREATER WASHINGTON BOARD OF TRADE,***  
***506 U.S. 125, 113 S. Ct. 580 (1992)***

In *District of Columbia v. Greater Washington Board of Trade*, the Supreme Court held that ERISA preempted a statute that required an employer to provide employees who were eligible for workers’ compensation benefits with the same coverage the employer provided through its health insurance program if one was offered.<sup>69</sup>

Deleted: which

The Court noted that the statute clearly “related to” employee welfare benefit plans because it specifically mentioned them.<sup>70</sup> The Court rejected the District of Columbia’s reliance on *Shaw* because *Shaw* had specifically held that a state cannot apply a statute directly to an employee welfare benefit plan. Although *Shaw* does allow a state to require an employer to set up a separate plan to comply with laws directed at benefits not covered by ERISA, such as disability, unemployment, and workers’ compensation benefits, the

<sup>64</sup> *Id.* at 58-60.

<sup>65</sup> *Id.* at 60-61.

<sup>66</sup> *Id.* at 65.

<sup>67</sup> *Id.* at 64.

<sup>68</sup> *Id.*

<sup>69</sup> *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 126-27 (1992).

<sup>70</sup> *Id.* at 130.

District of Columbia law did not do so.<sup>71</sup> The benefit it mandated was tied directly to the terms of the employer's ERISA plan.<sup>72</sup>

***NEW YORK BLUE CROSS PLANS v. TRAVELERS INS. CO.***  
***514 U.S. 645, 115 S. Ct. 1671 (1995)***

In *New York Blue Cross Plans v. Travelers Ins. Co.*, the Court upheld a statute which required that hospitals impose one level of surcharge on patients insured by commercial insurers, another level of surcharge on patients insured by HMOs, and no surcharge on patients insured by Blue Cross and Blue Shield plans. Commercial insurers challenged the state law, claiming that the statute was preempted by ERISA because the state law "related to" the bills of patients whose insurance was purchased by employee welfare benefit plans.

The District Court held that the surcharges "related to" ERISA plans and were thus preempted because they had the effect of increasing the costs to commercial insurers and HMOs and therefore, indirectly increasing the costs to employee welfare benefit plans. Consequently, the District Court enjoined the enforcement of the surcharges. The Court of Appeals affirmed the District Court's decision, reasoning that the "purpose[ful] interfer[ence] with the choices that the ERISA plans make for health care coverage ... is sufficient to constitute [a] "connection with" ERISA plans."<sup>73</sup>

In a unanimous decision, the Supreme Court reversed the holding of the Court of Appeals. The Court noted that the statute did not make "reference to" an employee welfare benefit plan because the surcharge was imposed irrespective of whether the insurance was purchased by an ERISA plan, private individual, or other purchaser.<sup>74</sup>

After reviewing the purposes and objectives of Congress in enacting the ERISA statute, the Court also concluded that the statute did not have a "connection with" employee welfare benefit plans. The Court held that an indirect economic influence is not a sufficient connection to trigger preemption if it does not bind plan administrators to any particular choice or preclude uniform administrative practices. While a surcharge may increase plan costs and affect its shopping decisions, it does not preclude the plan from seeking the best deal that it can obtain. The Court noted that the state laws which have an indirect economic effect on the relative costs of health insurance packages leaves "plan administrators where they would be in any case, with the responsibility to choose the best overall coverage for the money."<sup>75</sup>

---

<sup>71</sup> *Id.* at 132.

<sup>72</sup> *Id.* at 132.

<sup>73</sup> *New York Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 1675-7 (1995).

<sup>74</sup> *Id.* at 1677.

<sup>75</sup> *Id.* at 1680.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

The *Travelers* Court clarified that state statutes which “produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers ... might indeed be preempted.”<sup>76</sup> Because the hospital surcharge statute only indirectly affects the cost of insurance policies, it does not fall into this category of indirect regulation preempted by ERISA.

**CALIFORNIA DIVISION OF LABOR STANDARDS ENFORCEMENT**  
**v. DILLINGHAM**  
**117 S.Ct. 832 (1997)**

At issue in *California Division of Labor Standards Enforcement v. Dillingham* was whether ERISA preempted California’s minimum wage law to the extent that it allowed payment of a lesser wage to workers that participate in a state-approved apprenticeship program. The Supreme Court considered whether the state law “related to” an ERISA plan and was therefore preempted under ERISA § 502(a). The Court utilized a two-part inquiry to determine whether California’s minimum wage law “related to” an ERISA plan. The Court considered whether the state law had either a “reference to” or a “connection with” an ERISA plan.<sup>77</sup>

The Court noted common characteristics among the cases where it had held that certain state laws made “reference to” an ERISA plan. The Supreme Court highlighted cases “[w]here a State’s law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law’s operation, as in *Greater Washington Board of Trade* and *Ingersoll-Rand*, that “reference” will result in preemption.”<sup>78</sup> The Court determined that California’s minimum wage law, as it applied to apprentice wages, applied to more than just ERISA plans and, as a result, did not make “reference to” ERISA plans.

In order to determine whether a state law has a “connection with” an ERISA plan, the Court acknowledged that “an ‘uncritical literalism’ in applying the ‘connection with’ standard offers scant utility in determining Congress’ intent to the extent of the reach of the preemption clause.”<sup>79</sup> In applying the “connection with” standard, the Court looked to the “objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive [ERISA preemption] as well as to the nature of the effect of state law on ERISA plans.”<sup>80</sup>

---

<sup>76</sup> *Id.* at 1683.

<sup>77</sup> 519 U.S. 316, 324, quoting the test used in *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 (1992) (quoting *Shaw v. Delta Airlines, Inc.* 463 U.S. 85, 96-97 (1983)).

<sup>78</sup> *Id.* at 325.

<sup>79</sup> *Id.* citing *Travelers*, 514 U.S. at 656.

<sup>80</sup> *Id.* citing *Travelers*, 514 U.S. at 658-659.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

With respect to the issue of Congressional intent, the Supreme Court’s analysis starts with a presumption against preemption—Congress did not intend to preempt areas of traditional state regulation absent evidence that it was the clear and manifest purpose of Congress.<sup>81</sup> In *Travelers*, the Court stated that “the preemption of areas of traditional state regulation where ERISA has nothing to say would be “unsettling.”<sup>82</sup> California’s minimum wage laws, like the hospital surcharge law at issue in the *Travelers* case, involved issues traditionally regulated by the states. In addition, the Court observed that the areas covered by the state laws at issue in both cases were “quite remote from the areas with which ERISA is expressly concerned—reporting, disclosure, fiduciary responsibility, and the like.”<sup>83</sup> Therefore, the Supreme Court was not persuaded that it was the intent of Congress to have ERISA preempt state laws addressing apprentice wages and wages to be paid on public works contracts.

In past ERISA preemption cases decided by the Supreme Court, a “connection with” an ERISA plan was observed when the state law at issue had either “mandated employee benefit structures or their administration.”<sup>84</sup> The Court compared the effect of the New York law on ERISA plans in the *Travelers* case to the effect of the California law on ERISA plans in the instant case. The indirect economic influence that resulted from the state law at issue in *Travelers* did not force ERISA plans to make a particular choice, nor did it regulate the ERISA plan itself. Similarly, California’s prevailing wage statute did not bind ERISA plans to any particular decision.<sup>85</sup> The Court stated that “[t]he [California] law only alters the incentives, but does not dictate the choices facing ERISA plans.”<sup>86</sup> The Court reasoned that the California minimum wage law was no different “from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.”<sup>87</sup>

The Court concluded that California’s prevailing wage law had neither a “connection with” nor did it make “reference to” an ERISA plan. Therefore, it did not “relate to” an ERISA plan so as to be preempted under Section 514(a) of ERISA.

**DeBUONO v. NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND**  
**520 U.S. 806 (1997)**

At issue in this case was the application of a New York hospital tax to medical centers operated by an ERISA plan. The Court of Appeals for the Second Circuit held that the New York tax was preempted because it “related to” an ERISA plan within the meaning of ERISA §514(a). The case was appealed to the United States Supreme Court. The

---

<sup>81</sup> *Id.* citing *Travelers*, 514 U.S. at 655, quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)(citation omitted).

<sup>82</sup> *Id.* at 330, citing *Travelers* at 665 n 7.

<sup>83</sup> *Id.* at 330, citing *Travelers*, 514 U.S. at 661 (quoting *Shaw*, 463 U.S. at 98)

<sup>84</sup> *Id.* at 328. citations omitted.

<sup>85</sup> *Id.* at 332.

<sup>86</sup> *Id.* at 334.

<sup>87</sup> *Id.* at 334. citing *Travelers*, 514 U.S. at 668.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

Supreme Court remanded the case for reconsideration in light of its opinion in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,<sup>88</sup>

The Second Circuit reconsidered its opinion and, distinguishing the tax at issue in *Travelers* from the tax at issue in this case, again held the law preempted as it applied to hospitals owned by ERISA plans. The Second Circuit reasoned that in *Travelers*, the surcharge only impacted ERISA plans indirectly by influencing a plan administrator's decision. However, in this case, the impact of the tax on ERISA plans was direct, by depleting the funds assets.<sup>89</sup>

On petition before the Supreme Court for the second time, the Court reversed the Second Circuit and held that the New York tax did not "relate to" an ERISA plan, and therefore, was not preempted as it applied to hospitals owned by ERISA plans. The Court explained that the holding in *Travelers* required re-evaluation of its previous interpretations of the "relates to" phrase. Prior to its decision in *Travelers*, cases requiring the Court to interpret the "relates to" language in ERISA had obvious connections to or made obvious references to ERISA plans.<sup>90</sup> The Court's decision in *Travelers* rejected a strict and literal interpretation of "relates to".<sup>91</sup>

The Court explained that the "relates to" language in §514(a) does not modify the starting presumption that Congress does not intend to preempt state law.<sup>92</sup> In order to overcome this presumption against preemption, one "must go beyond the unhelpful text . . . and instead look to the objectives of the ERISA Statute as a guide to the scope of the law that Congress understood would survive."<sup>93</sup>

The Court reiterated that the scope of ERISA's preemptive reach was not intended to extend to the historic police powers of the states, which includes matters of health and safety.<sup>94</sup> The Court observed that the tax at issue in this case, while a revenue raising measure and not a hospital regulation per se, clearly occupied a realm that was historically a state concern.<sup>95</sup> Consequently, the Fund had the "considerable burden" of overcoming the presumption against preemption of state law.<sup>96</sup>

The Court explained that the New York hospital tax was a law of general applicability. All hospitals were required to pay the tax regardless of their relationship to an ERISA plan. Laws of general applicability may impose burdens on the administration of ERISA plans and still not "relate to" an ERISA plan.<sup>97</sup> The Court observed that "any state tax or

---

<sup>88</sup> 514 U.S. 645.

<sup>89</sup> Id. at 812 citing *NYSA-ILA Medical Center and Clinical Services Fund v. Axelrod*.

<sup>90</sup> Id. at 813 citing *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85.

<sup>91</sup> Id at 812.

<sup>92</sup> Id. at 813 citing *Travelers* at 655 citing *Rice v. Sante Fe Elevator Corp.*, 331 U.S. 218, 230.

<sup>93</sup> Id. at 813, 814 citing *Travelers* 514 US at 656.

<sup>94</sup> Id at 814.

<sup>95</sup> Id.

<sup>96</sup> Id.

<sup>97</sup> Id. at 815 citing *Travelers* 514 U.S. at 668.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute.”<sup>98</sup> In a footnote the Court re-iterated a statement from *Travelers* conceding that there may be a situation where the economic impact of the state law is so great that an ERISA plan would be forced to buy certain coverage or not use certain insurers, in which case there may be preemption.<sup>99</sup> However, the tax at issue in this case was not such a law. The tax was held not to “relate to” an ERISA plan and was not preempted by ERISA.<sup>100</sup>

---

<sup>98</sup> Id. at 816.

<sup>99</sup> Id. at n.16 citing 514 U.S. at 668.

<sup>100</sup> Id. at 816-817.

**UNUM LIFE INSURANCE COMPANY V. JOHN E. WARD**  
**526 U.S. 358 (1999)**

This case involved John Ward's claim for disability benefits pursuant to a policy provided by his employer. Mr. Ward filed his claim with UNUM Life Insurance Company after the expiration of the deadline provided for in his insurance policy. Consequently, UNUM denied his claim. Mr. Ward filed suit under ERISA §502(a) for benefits due under the terms of the plan, claiming that under California law, *Elfstrom v. New York Life Ins.Co.*, 432 P.2d 731, UNUM had received timely notice of Ward's disability. Under *Elfstrom*, an employer that administers a group health plan is the agent of the insurer. Therefore, the notice that Ward provided to his employer, which was within the timeframe set forth the insurance policy, served as notice to UNUM. The district court, however, disagreed and granted summary judgment in favor of UNUM. The district court reasoned that the *Elfstrom* rule did not apply to Mr. Ward's situation because the rule "related to" an ERISA plan and was therefore preempted.

Ward appealed to the Court of Appeals for the Ninth Circuit, which reversed the district court's decision and remanded. First, the Ninth Circuit held that a doctrine of California law, known as the notice-prejudice rule, operated to prevent UNUM from denying Ward's claim as untimely unless UNUM could show that it had been prejudiced by the delay. Alternatively, the Ninth Circuit held that, if UNUM could show that it was prejudiced by the delay, the *Elfstrom* rule would prevent UNUM from denying Ward's claim for benefits. According to the Ninth Circuit, the notice-prejudice rule was saved from preemption because, although it "relates to" an ERISA plan, it was nevertheless "saved" from preemption as a law that "regulates insurance," within the meaning of ERISA § 514(b)(2)(a). The *Elfstrom* rule also was not preempted, according to the Ninth Circuit, because as a law of general application, it did not "relate to" an ERISA plan.

The decision of the Ninth Circuit was affirmed in part and reversed in part by the Supreme Court. The Supreme Court conducted a two-part analysis into whether the notice-prejudice rule was a law that "regulates insurance" within the meaning of ERISA's saving clause. First, the Court considered whether the law regulates insurance from a "common-sense" perspective. Second, the Court considered three factors used to determine whether a state law is the "business of insurance" within the meaning of the McCarran-Ferguson Act, 526 U.S. at 367. Under the first factor, the Court considers whether the law "has the effect of transferring or spreading a policyholder's risk." Under the second factor, the Court considers "whether the law is an integral part of the policy relationship between the insurer and the insured." Under the third factor, the Court considers "whether the law is limited to entities within the insurance industry." The three factors assist the Court in "verify[ing] the common sense view"<sup>101</sup> of whether a law regulates insurance. The Court clarified that the three McCarran-Ferguson factors are not mandatory requirements.<sup>102</sup> Each factor does not need to be met individually, but instead

---

<sup>101</sup> 526 U.S. at 374.

<sup>102</sup> Id. at 372.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

serve as “guideposts”<sup>103</sup> or “considerations to be weighed”<sup>104</sup> when determining whether a law “regulates insurance” within the meaning of ERISA’s saving clause.

The Court applied this two-part analysis to the notice-prejudice rule. The Court first considered whether the law regulated insurance from a common sense perspective. Observing that the notice-prejudice rule “controls the terms of the insurance relationship,” is “directed specifically at the insurance industry” and is “grounded in policy concerns specific to the insurance industry,” the Court found that the notice-prejudice rule clearly regulated insurance.

The Court considered the second part of the “regulates insurance” analysis—the three factors used to determine whether a state law regulates the business of insurance within the meaning of the McCarran-Ferguson Act. The Court declined to decide the first factor, the risk spreading factor, because the remaining two factors were clearly satisfied. However, with respect to the “risk spreading” factor, the Court acknowledged, but did not adopt, the argument forwarded by the United States as *amicus curiae*.<sup>105</sup> In its brief, the United States noted that the notice-prejudice rule “shifts risk” to the extent that the risk of late notice and stale evidence is shifted from the insured to the insurer and may result in higher premiums and spreading risk among policyholders.<sup>106</sup> The second factor is satisfied because the notice prejudice rule dictates the terms of the insurance contract by requiring that the insurer prove prejudice before enforcing a timeliness of claim provision in the contract.<sup>107</sup> The third factor is also satisfied because the notice prejudice rule has more than a passing impact on the insurance industry—it is aimed at it.<sup>108</sup>

The Court specifically rejected UNUM’s arguments that the notice-prejudice rule conflicted with ERISA. UNUM asserted that the notice-prejudice rule conflicted with ERISA’s requirement in §504 (a)(1)(D) that requires fiduciaries to act in accordance with plan documents. The Court points out that, under this argument, ERISA §504 preempts any state law contrary to a written plan term, an outcome that “makes scant sense”<sup>109</sup> and would “virtually read the saving clause out of ERISA.”<sup>110</sup> The Court, citing *Metropolitan Life*, 471 U.S. at 758, and *FMC Corp*, 498 U.S. at 64, points out that the Court has repeatedly held that state laws mandating insurance contract terms are saved from preemption under §514(b)(2)(A).<sup>111</sup>

UNUM also attempted to convince the Court that ERISA’s civil remedies preempt any action for plan benefits brought under state rules. The Court summarily disposed of this argument by pointing out that the cause of action in this case was brought pursuant to

---

<sup>103</sup> Id. at 374.

<sup>104</sup> Id. at 373.

<sup>105</sup> Id. at 374.

<sup>106</sup> Id. citing United States as *Amicus Curiae* 14.

<sup>107</sup> Id. at 374 – 375.

<sup>108</sup> Id. at 375 (citations omitted).

<sup>109</sup> Id.

<sup>110</sup> Id. at 376.

<sup>111</sup> Id. at 375 - 376.

ERISA § 502(a)(1)(B). However, the Court specifically acknowledged in a footnote the United States' argument as *amicus curiae* that, notwithstanding *Pilot Life*, a state law that "regulates insurance" within the meaning of the saving clause is saved from preemption even if it provides a state law cause of action or remedy.<sup>112</sup>

The Court rejected the Ninth Circuit's conclusion that the *Elfstrom* rule does not "relate to" an ERISA plan and, therefore, was not preempted. The Court pointed out that the *Elfstrom* rule, by "deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration."<sup>113</sup> Therefore, the *Elfstrom* rule "relates to" an ERISA plan and is preempted.

***RUSH PRUDENTIAL HMO, INC. v. MORAN***  
**536 U.S. 355 (2002)**

Deleted: f

In *Rush Prudential HMO, Inc. v. Moran*, the Court held that Illinois's independent review law was not preempted as a law that "relates to" an ERISA plan because it "regulates insurance" within the meaning of ERISA's saving clause.

The Court explained that there is a presumption against preemption that informs the saving clause analysis. According to the Court, the "unhelpful drafting" of ERISA's preemption and saving clauses require that the ordinary meaning of these "antiphonal phrases" be qualified by the assumption that "the historic police powers of the states were not meant to be superceded unless it was the clear and manifest purpose of Congress."<sup>114</sup>

The Court stated that the Illinois independent review law "related to" an ERISA plan because it "bears indirectly but substantially on all insured benefit plans (citation omitted) by requiring them to submit to an extra layer of review for certain benefit denials"<sup>115</sup> and would be preempted unless it "regulates insurance" within the meaning of the saving clause.

The Court held that an HMO is both a health care provider and an insurer.<sup>116</sup> By underwriting and spreading the risk of treatment costs among the HMO participants, the HMO performs a traditional insurance function. The fact that an HMO may also provide medical services or that it may transfer some of its risk to the providers does not take the HMO out of the insurance business.<sup>117</sup> The Court also recognized that Congress intended for state insurance laws to apply to HMOs and that most state insurance departments are primarily responsible for the regulation of HMOs.<sup>118</sup> The Court stated that the application

---

<sup>112</sup> *Id.* at n.7.

<sup>113</sup> *Id.* at 379.

<sup>114</sup> 122 S.Ct. 2151, 2158-2159 (citations omitted).

<sup>115</sup> *Id.* at 2159.

<sup>116</sup> *Id.* at 2160.

<sup>117</sup> *Id.*

<sup>118</sup> *Id.* at 2160-2161.

of the law to HMOs acting solely as administrators did not lead to preemption of its application to HMOs acting as insurers.<sup>119</sup>

The Court applied the three McCarran-Ferguson factors.<sup>120</sup> All three factors are not required in order for a law to regulate insurance within the meaning of the saving clause.<sup>121</sup> The Court confirmed its “common sense” conclusion by observing that the statute met two of the three factors: (i) it regulated an integral part of the policy relationship between the insured and insurer by providing “a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMOs medical obligations”<sup>122</sup> and (ii) the statute was aimed at a practice limited to entities within the insurance industry for the same reasons it satisfied common sense test.<sup>123</sup>

Deleted: Second.

The Court explained that the Illinois law does not “supplemen[t] or supplan[t] the federal scheme by allowing beneficiaries to obtain remedies under state law that Congress rejected in ERISA”<sup>124</sup> because the Illinois law “provides no new cause of action under state law and authorizes no new form of ultimate relief.”<sup>125</sup>

The Court made clear that ERISA does not require that a plan’s benefit determinations be discretionary or receive deferential review.<sup>126</sup> The Court stated that the Illinois law effectively “prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract’s terms” and in this way, “is no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption.”<sup>127</sup>

The Moran Court ruled that the Illinois independent review law is not preempted. However the Court left open the possibility that a state independent review scheme might conflict sufficiently with ERISA to be preempted. Moran involved a state review process that resolves only disputes concerning application of medical judgment. Also the Court mentioned that a state law would be preempted if it imposed “procedures so elaborate, and burdens so onerous that they might undermine [ERISA’s civil enforcement provisions].”<sup>128</sup> However, this concession is made only after the Court stated its view that state independent review laws, while entailing different procedures, would not impose unacceptable administrative burdens so as to be preempted.<sup>129</sup> The Court explained that disuniformities are the inevitable result of the congressional decision to

---

<sup>119</sup> *Id.* at 2163.

<sup>120</sup> See discussion of *Metropolitan Life v. Massachusetts* on p. \_\_\_\_.

<sup>121</sup> *Id.* at 2163.

<sup>122</sup> *Id.* at 2164.

<sup>123</sup> *Id.* at 2163-2164.

<sup>124</sup> *Id.* at 2166.

<sup>125</sup> *Id.* at 2167.

<sup>126</sup> *Id.* at 2169-2171.

<sup>127</sup> *Id.* at 2170.

<sup>128</sup> *Id.* at 381 n.11.

<sup>129</sup> *Id.*

save state insurance laws and that HMOs have to establish procedures for conforming with local laws in any event.<sup>130</sup>

**KENTUCKY ASSOCIATION OF HEALTH PLANS v. MILLER**  
**123 S.Ct. 1471 (April 2, 2003)**

In *Kentucky Association of Health Plans v. Miller* the Court held that Kentucky’s “any willing provider (AWP)” laws were not preempted under ERISA because they “regulated insurance” within the meaning of ERISA’s saving clause, §514(b)(2)(A). In reaching this conclusion, the Court announced a new test for determining whether a state law regulates insurance, and in so doing, **announced a clean break** from over 15 years of saving clause precedent.

At issue were two Kentucky AWP laws: one requiring that health insurers include in their networks all providers willing to agree to the terms of the contract; and another requiring that insurers offering chiropractic benefits include in their networks all chiropractors willing to accept the terms of the contract.

In determining that Kentucky’s AWP laws regulated insurance, the Court announced a new two-part test for determining whether a state law regulates insurance.<sup>131</sup> The first part of the new test requires that the state law be “specifically directed towards entities engaged in insurance.”<sup>132</sup> To explain this test, the Court refers to its previous opinions in *Pilot Life, Rush Prudential* and *FMC Corp.*<sup>133</sup> In order for a state law to be “specifically directed toward” the insurance industry, the state law must be more than a law of general application with some bearing on insurers.<sup>134</sup> But even a law specifically directed at the insurance industry must regulate an insurer with respect to the insurer’s insurance practices.<sup>135</sup>

Further, the Court makes clear that a state law’s impact on non-insurers is not inconsistent with the requirement that a law be “specifically directed toward” the insurance industry and does not take the law the outside the scope of ERISA’s saving clause.<sup>136</sup> The Kentucky Association of Health Plans argued that Kentucky’s AWP laws were not specifically directed at the insurance industry because of: (1) their impact on providers;<sup>137</sup> and (2) their application to “self-insurer or multiple employer arrangements

---

<sup>130</sup> *Id.*

<sup>131</sup> 123 S.Ct. 1471, 1479

<sup>132</sup> *Id.*

<sup>133</sup> *Id.* at 1475

<sup>134</sup> *Id.* citing *Pilot Life v. Dedeaux*, 481 U.S. 41, 50; *Rush Prudential v. Moran*, 536 U.S.355, 366; *FMC Corp v. Holliday*, 498 U.S. 52, 61.

<sup>135</sup> 123 S. Ct. at 1474 citing *Rush Prudential v. Moran*, 536 U.S. 366.

<sup>136</sup> 123 S.Ct. at 1476

<sup>137</sup> *Id.* at 1475-1476

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

not exempt from state regulation by ERISA”<sup>138</sup> and HMOs that provide administrative services only to self-insured plans.<sup>139</sup> The Court rejected these arguments.

The Court observed that all laws that regulate insurers will have some impact on entities that have relationships with those insurers, including laws the Court held regulated insurance in *FMC Corp.* and *Rush Prudential*.<sup>140</sup> With respect to the scope of the Kentucky AWP laws, the court pointed out that ERISA’s saving clause requires that a state law “regulate insurance”, not “insurance companies” or the “business of insurance.”<sup>141</sup> Therefore, the fact that Kentucky’s AWP laws apply to self-insurers and multiple employer welfare arrangements, which are entities engaged in the same kind of risk-spreading activities as are insurance companies, does not forfeit the laws’ status as laws regulating insurance within the meaning of the saving clause.<sup>142</sup> ERISA’s deemer clause<sup>143</sup> prevents states from regulating self-funded ERISA plans that they could otherwise regulate.<sup>144</sup>

The Court employs this same analysis to explain that Kentucky’s AWP laws are “specifically directed towards” the insurance industry, even though they apply to HMOs administering self-insured plans. The Court expresses the opinion that the activity of administering a self-insured plan, which the Court already explained engages in risk-spreading functions identical to insurers, is sufficient to bring the HMO within the activity of insurance for the purposes of ERISA’s saving clause, even though the deemer clause would prevent a state from applying the law to a self-funded plan.<sup>145</sup> Further, the Court in *Rush Prudential* explained that Congress did not intend for overbreadth in the application of a state law to remove a state law entirely from the category of state regulation saved from preemption.<sup>146</sup>

The second part of the new saving clause analysis requires that the state law “substantially affect the risk pooling arrangement between the insurer and the insured.” This new test is a “clean break from the McCarran-Ferguson factors”<sup>147</sup> and does not require that the state law actually “spread risk,”<sup>148</sup> or “alter or control the actual terms of insurance policies” in order to regulate insurance within the meaning of the saving clause.<sup>149</sup> The Court explained that Kentucky’s AWP laws meet the second part of the new test by “alter[ing] the scope of permissible bargains between insurers and insureds in a manner similar to the mandated benefit laws [] upheld in *Metropolitan Life*, the notice

---

<sup>138</sup> *Id.* at 1476 note 1

<sup>139</sup> *Id.*

<sup>140</sup> *Id.* at 1475.

<sup>141</sup> *Id.* at 1476 n.1

<sup>142</sup> *Id.*

<sup>143</sup> ERISA §514(b)(2)(B)

<sup>144</sup> 123 S.Ct. at 1476 n.1

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> *Id.* at 1479

<sup>148</sup> *Id.* at 1478 n.3

<sup>149</sup> *Id.* at 1477

prejudice rule [] sustained in *UNUM*, and the independent review provisions [] approved in *Rush Prudential*.<sup>150</sup>

The practical effect of the Court’s new two-part test on state laws remains to be seen. Perhaps the fact that the McCarran-Ferguson factors are no longer a part of the preemption analysis will result in more laws being considered laws which regulate insurance within the meaning of the saving clause. On the other hand, the McCarran-Ferguson factors were only guideposts used to reinforce the common-sense understanding of whether a law regulated insurance and the risk-spreading factor in particular was set aside by the Court in *UNUM* and *Rush Prudential*. No one can know the true impact of this new preemption test until a new round of cases work their way through the federal courts and ultimately is applied by the Supreme Court.

**Conclusion**

ERISA establishes a comprehensive federal regulatory scheme for employee benefit plans. Because it was drafted primarily in response to concerns about pension mismanagement, the statutory language does not provide substantial guidance on how preemption may actually affect various forms of state laws.

Deleted: s  
Formatted

Supreme Court jurisprudence has provided guidance on the relationship between the ERISA preemption, saving, and deemer clauses and state regulatory initiatives. The recent *Kentucky Association of Health Plans* case is likely to expand the courts’ view of what is encompassed by the saving clause.

Deleted: Through case law, the  
Deleted: has attempted to provide instruction  
Deleted: s  
Formatted  
Formatted

Subject to some uncertainty as to how the *Kentucky Association of Health Plans* precedent will be applied, the following is guidance regarding whether state laws “relate to” ERISA plans and the application of the deemer clause.

Deleted: It has sought to clarify the breadth and the depth of ERISA preemption and has provided the

- ◆ Subject to the saving clause, state laws which “relate to” employee welfare benefit plans are preempted by ERISA.
- ◆ “Relate to” means having a reference or a connection to an employee welfare benefit plan.
- ◆ -----
- ◆ A state law of general applicability, which has an indirect economic influence on ERISA plans, does not “relate to” an ERISA plan and therefore is not preempted by ERISA. State laws that impose such high indirect costs on ERISA plans that the laws force ERISA plans to adopt a certain scheme of substantive coverage or effectively restrict a plan’s administration may be preempted by ERISA.

Deleted: s

Deleted: ERISA does not only preempt state laws which deal with the substantive requirements of ERISA or which are specifically directed to ERISA plans.

Deleted: choice of insurer laws

<sup>150</sup> *Id.* at 1477-1478

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

- ◆ The status of a law otherwise “saved” as a law that regulates insurance is not changed even if the law has the effect of indirectly regulating the substance of ERISA plans that purchase insurance.
- ◆ While states can regulate the business of insurance and the terms of insurance contracts purchased by employee welfare benefit plans, they cannot apply those laws directly to employee welfare benefit plans.
- ◆ A state law is “saved” to the extent that it regulates insurance even if the law’s application to noninsurers is preempted.

**Deleted:** Those state laws that are designed to regulate the business of insurance or insurance contracts are “saved” from ERISA preemption even if the laws have the effect of indirectly regulating the substance of ERISA plans that purchase insurance.

**Formatted:** Bullets and Numbering

ERISA’s impact on a particular state law requires a case-by-case analysis of the statute in question, the parties involved, and the facts at issue.

**Deleted:** While court decisions typically have rested upon the broad nature of ERISA preemption, the recent *Travelers* case may be a harbinger that the Court has begun to focus on the limits of ERISA preemption of state law.<sup>151</sup>

# ERISA PLAN CHARACTERISTICS AND RELATIONSHIP TO STATE REGULATION

The relevance of the preemption analysis discussed in the preceding section presupposes the existence of an ERISA-covered plan. However, not all entities meet the criteria defining an ERISA-covered plan.<sup>152</sup> In addition, some arrangements that meet the criteria to be a plan are exempted from ERISA coverage generally or specifically from the ERISA preemption provisions. Such entities are generally subject to state law. Problems occur when certain operators seek to take advantage of the complexities in ERISA and illegitimately claim exemption from state laws under ERISA. It is crucial that state regulators understand what constitutes an ERISA-covered plan.

**Deleted:** U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT: A GUIDE TO FEDERAL AND STATE REGULATION (1992)

This chapter begins with an overview of the scope of ERISA’s coverage and the criteria that a benefit arrangement must meet to be an ERISA plan. In the health insurance context, ERISA addresses three specific forms of employee welfare benefit plans:

**Deleted:** which

- ◆ Single employer plans (including certain groups of closely affiliated employers);
- ◆ Multiemployer plans (Plans established pursuant to bona fide collective bargaining agreements); and
- ◆ Multiple employer welfare arrangements (MEWAs).<sup>153</sup>

The following pages contain discussions of these three different ways in which employee benefit arrangements can be structured and their relationship to state law. This section also includes a discussion of MEWAs and the ERISA Section 3(40)(A) exception to the definition of MEWA for plans established or maintained under or pursuant to one or more collective bargaining agreements.

**Deleted:** Starting on page 23, there are

**Deleted:** on

**Deleted:** the relationship between ERISA and Taft-Hartley trusts

<sup>152</sup> Questions related to the existence of an ERISA-covered plan are further complicated by the fact that [state insurance regulators generally do not have the jurisdiction to determine whether a plan is covered by ERISA.] **QUESTION: IS THIS STATEMENT ACCURATE??** Furthermore, while DOL does have that jurisdiction, the law does not require a plan to receive authorization from DOL prior to plan operation. State insurance regulators may seek assistance from the DOL’s Pension and Welfare Benefits Administration Office of Regulations and Interpretations for a formal or informal opinion on the status of a particular arrangement as an employee welfare benefit plan.

<sup>153</sup> It should be noted that many MEWAs are not actually employee welfare benefit plans, a fact which is recognized by the statutory definition. ERISA requirements for employee benefit plans do not apply directly to a MEWA which is not a plan, although the Department of Labor has taken the position that each employer participating in the MEWA sponsors a plan. **U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT: A GUIDE TO FEDERAL AND STATE REGULATION (Revised September 2002). Available on the internet at www.dol.gov/ebsa. [DOL GUIDE].** State insurance regulators should not assume that an arrangement which has sought to comply with the requirements for ERISA-covered plans is actually covered by ERISA.

**Non-Covered Benefit Arrangements**

Certain types of benefit arrangements are not covered by ERISA, even though they meet the basic defining criteria for employee welfare benefit plans because of the nature of the plan or the nature of the employer. with state, For Example, ERISA exempts plans maintained solely for the purpose of compliance with state workers' compensation, unemployment, and disability laws.<sup>154</sup> ERISA also excludes governmental plans and church plans.

**Deleted:** excluded from coverage  
**Deleted:** To avoid federal interference  
**Deleted:** workers' compensation, unemployment, or disability laws.  
**Deleted:** those

Regulators will find that some arrangements obviously fall under the governmental and church plan exceptions to ERISA coverage, such as state employees' retirement and health plans, plans covering police and firefighters, and plans covering employees of a specific church. However, many more plans fall outside the coverage of ERISA than may be immediately obvious. For example, many hospitals are publicly funded, and their plans may be governmental plans under ERISA. The same is true of community educational institutions. Similarly, many hospitals, schools, and nursing homes are owned by religious organizations. The plans that these organizations offer may be church plans.

Plans excluded from ERISA coverage normally fall within the jurisdiction of the state unless they are specifically excluded under state statutes. Knowledge of the exclusion of certain types of plans from ERISA may be useful when a state wishes to assess the potential impact of legislation on entities within the insurance department's jurisdiction, or seeks to assist a consumer who may appear at first glance to be covered by an ERISA plan.<sup>155</sup>

**Deleted:** Plans excluded from ERISA coverage normally fall within the jurisdiction of the state unless they are specifically excluded under state statutes

**General Characteristics Of An ERISA Plan**

The statutory definition of an employee welfare benefit plan outlines four elements. State insurance regulators should look for whether each of the elements are met when analyzing whether an arrangement is a plan, fund, or program:

- ◆ established or maintained;
- ◆ by an employer or by an employee organization, or by both;
- ◆ for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits;
- ◆ to participants or their beneficiaries.<sup>156</sup>

<sup>154</sup> 29 U.S.C. § 1003(b) (1985).

<sup>155</sup>The implications of the "governmental plan" exclusion, for example, are not always taken into consideration in drafting or implementing state legislation, resulting in a lack of clarity as to the nature and scope of regulatory oversight of self-funded state and local governmental plans.

<sup>156</sup> 29 U.S.C. § 1002(1) (1985).

Arrangements that do not meet the definition of an ERISA plan and whose activities fall under the state's definition of the business of insurance must acquire a state certificate of authority as an insurer or cease operations. Such arrangements that do not comply with state law are subject to the unauthorized insurer statutes of the various states.<sup>157</sup>

Deleted: which

As with much of the language in ERISA, the definition of employee welfare benefit plan raises more questions than it answers. The administrative and judicial branches have been left with the task of providing guidance to state insurance regulators and legislators, insurance industry representatives, and employers on what makes an arrangement an employee welfare benefit plan within the meaning of ERISA.

To provide guidance, the Department of Labor (DOL) has issued regulations discussing certain payroll practices, including those related to group benefits, and advisory opinion letters. Circuit courts have issued a number of opinions, which have also helped somewhat to clarify the meaning of the term. Below is a review of some of the criteria that DOL and the circuit courts have identified as useful in determining whether an arrangement is an ERISA plan.

Deleted: which

**Plan, Fund, or Program Established or Maintained Requirement**

The first element of the definition of an employee welfare benefit plan is whether an arrangement is a “plan, fund, or program” that has been “established or maintained”. The Eleventh Circuit specifically discussed this requirement in the much cited *Donovan v. Dillingham*.<sup>158</sup> In its analysis, the court stated that the minimum criteria to use to determine whether there was a plan, fund, or program was whether there were:

- ◆ intended benefits,
- ◆ intended beneficiaries,
- ◆ a source of financing, and
- ◆ a procedure to apply for and collect benefits.”<sup>159</sup>

The *Donovan* court noted that a plan, fund, or program has been “established or maintained” if “a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.”<sup>160</sup>

The Court noted that an employer does not “establish” a plan merely by deciding to offer benefits. To prove the existence of an employee benefit plan, the employer must provide

<sup>157</sup> *Bell v. Employee Security Benefit Ass'n*, 437 F.Supp. 382 (D. Kan. 1977).

<sup>158</sup> *Donovan v. Dillingham*, 688 F.2d. 1367 (11th Cir. 1982), At issue in *Donovan* was whether the District Court had subject matter jurisdiction to decide if a particular multiple employer trust was subject to the fiduciary requirements of ERISA. The Eleventh Circuit held that the District Court did have subject matter jurisdiction. The Court stated that a consensus existed among the courts, congressional committees, and the Secretary of the U.S. Department of Labor that multiple employer trusts are generally not employee welfare benefit plans. *Id.* at 1372. However, they may be subject to ERISA's fiduciary responsibilities if they are fiduciaries to employee benefit plans established by others, such as in this case. *Id.* at 1372, n. 10.

<sup>159</sup> *Id.* at 1372.

<sup>160</sup> *Id.* at 1373.

## DRAFT 3-11-04

*ERISA: Guidelines for State and Federal Regulation*

evidence that its decision has actually been implemented. Furthermore, although the purchase of health insurance is substantial evidence that a plan has been established, the Court stated that it is not by itself conclusive proof.<sup>161</sup>

In 1978, DOL provided guidance in the matter by issuing a safe harbor regulation for certain group arrangements. An employer or employee organization providing group health insurance has not established an employee benefit program if all four of the following criteria apply:

- ◆ No contributions are made by an employer or employee organization;
- ◆ Participation [in] the program is completely voluntary for employees or members;
- ◆ The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
- ◆ The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.<sup>162</sup>

In *Johnson v. Watts*,<sup>163</sup> the First Circuit discussed the “established and maintained” requirement in the context of this regulation. It specifically focused on the meaning of the third criterion of employer neutrality. The court stated that the employer “would be said to have endorsed a program ... if, in light of all the surrounding facts and circumstances, an objectively reasonable employee would conclude on the basis of the employer’s actions that the employer had not merely facilitated the program’s availability but had exercised control over it or made it appear to be part and parcel of the company’s own benefit package.”<sup>164</sup>

In this case, the court held that the employer had not endorsed the program although it had collected premiums through payroll deductions, remitted insurance premiums to CIGNA, issued certificates, kept track of employee eligibility, distributed sales brochures and other materials necessary for enrollment, and recommended enrollment through a letter to employees in which the letter specifically stated that the decision was exclusively the employees’. The court also noted that the employees paid the entire cost of their own insurance, and that the employer did not participate in designing the plan, working out its structural components, determining eligibility for coverage, interpreting policy language, investigating, allowing, and disallowing claims, handling litigation, or negotiating settlements.<sup>165</sup> The court contrasted the facts in this case with the facts of *Hansen v.*

---

<sup>161</sup> *Id.* at 1373.

<sup>162</sup> 29 C.F.R. § 2510.3-i(j) (1996).

<sup>163</sup> *Johnson v. Watts*, 63 F.3d 1129 (1st Cir. 1995).

<sup>164</sup> *Id.* at 1135.

<sup>165</sup> *Id.* at 1135-36.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

*Continental Ins. Co.*<sup>166</sup> In *Hansen*, the employer performed many of the same functions as the employer in *Johnson*. Nevertheless, the court held that the employer had endorsed the plan because the employer had distributed material about the insurance program in a booklet embossed with the corporate logo. In addition, the booklet referred to the plan as the company’s plan.<sup>167</sup>

Other courts that have considered this question have focused on similar factors in their analysis when determining whether an arrangement has been established or maintained. Specific indications that have been identified as particularly relevant are evidence of whether:

- ◆ the employer intended to provide benefits on a regular and long-term basis;
- ◆ the employer financially contributed to the plan; and
- ◆ the employer had sufficient involvement with the administration of the plan.<sup>168</sup>

**Employer or Employee Organization Requirement**

The second element is whether an arrangement is sponsored by the “employer or employee organization”. An arrangement is not an ERISA plan unless the entity that establishes or maintains it is an employer or employee organization of the individuals covered by the plan. Employer is defined in ERISA 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.”<sup>169</sup>

The statute’s definition of employer includes an employer association. To be a bona fide association, the employers ~~that~~ constitute the association must have direct or indirect control over the benefit plan. DOL has identified a variety of factors that are relevant to determining whether a bona fide employer association exists. These factors include:

Deleted: which

- ◆ 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;
- ◆ 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

---

<sup>166</sup>*Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991).  
<sup>167</sup> *Johnson*, 63 F.3d at 1137.  
<sup>168</sup> See, e.g., *Wickman v. Northwestern National Ins. Co.*, 908 F.2d 1077 (1st Cir. 1990); *Grimo v. Blue Cross/Blue Shield, of Vt.*, 34 F.3d 148 (2nd Cir. 1994), 899 F. Supp. 196 (D. Vt. 1995).  
<sup>169</sup> 29 U.S.C. § 1002(5)(Supp. 1996).

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

- ◆ who actually controls and direct the activities and operations of the benefit program.<sup>170</sup>

Associations of otherwise unrelated employers established for the purpose of sponsoring a profit-making plan which is made generally available and which is not controlled by employer members do not meet the definition of bona fide employers, and their plans are not ERISA plans.<sup>171</sup>

An employee organization may also establish or maintain an employee welfare benefit plan. The statute defines employee organization to mean:

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; or any employees' beneficiary association organized for the purpose, in whole or in part, of establishing such a plan.<sup>172</sup>

The meaning of the term employee organization was discussed in *Bell v. Employee Security Benefit Ass'n*. At issue in *Bell* was an association that claimed that it offered an employee welfare benefit plan. The Kansas Commissioner of Insurance filed suit to enjoin the association from conducting business in Kansas on the grounds that the association was offering insurance, not an employee benefit plan. The court found for the Commissioner of Insurance.<sup>173</sup>

In analyzing whether the association was an employee organization, the court looked at (1) the participation of the employees, (2) the purpose of the organization, and (3) the relationship between the employees. The court found that the employees had no meaningful participation in the activities of the association and the organization did not exist, in whole or in part, for the purpose of dealing with employers since there was no employer interaction at all with the plan. Additionally, in inquiring whether the organization was an employees' beneficiary association, the court noted that commonality of interest was a dominant factor in the analysis. The court found that there was no commonality of interest among the employees since the association did not limit the benefits to any particular employer, union, or industry, but made the benefits available to any individual who was employed.<sup>174</sup> Consequently, the entity did not meet the definition of an employee organization.

**Purpose Requirement**

---

<sup>170</sup> Department of Labor Opinion 94-07A re: *United Service Association for Health Care 4* (March 14, 1994).

<sup>171</sup> *Id.*

<sup>172</sup> 29 U.S.C. § 1002(4) (Supp. 1996).

<sup>173</sup> *Bell v. Employee Security Benefit Ass'n*, 437 F.Supp. 382, 396 (D. Kan. 1977).

<sup>174</sup> *Id.*

The next element is the “purpose” requirement. The ERISA statute delineates the specific welfare benefits that are covered under ERISA. The plan must be established or maintained for the purpose of providing “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 any benefit described in section 186 (c) [referring to Taft-Hartley trusts] of this subchapter (other than pensions on retirement or death, and insurance to provide such pensions).”<sup>175</sup>

As mentioned previously however, ERISA specifically exempts plans maintained solely to provide disability, workers’ compensation, and unemployment compensation.<sup>176</sup>

**Participants Requirement**

The last element is the “participants” requirement. This last requirement relates to whether the benefits are provided to plan participants or their beneficiaries. The statute defines a participant as “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.”<sup>177</sup>

There is no threshold requirement in the text of ERISA for the number of participants that an employee benefit plan must have. There are DOL opinions and case law ~~that~~ suggest that a plan can have as few as one employee participant and still be governed by ERISA.<sup>178</sup>

Deleted: which

**Conclusion**

As the discussion above indicates, evaluating whether an arrangement meets each of these elements is an imprecise and complex process. Regulators will want to be familiar with ERISA statutory and regulatory provisions, DOL advisory opinions, and the relevant case law applicable to their state. Of particular import in the analysis is determining who the plan sponsor is and whether the plan is providing benefits to the employer’s employees or the employee organization’s members. If the arrangement does not meet the requirements of the statutory definition or falls within a statutory exception, then the state must evaluate the appropriate application of state laws. Determining that an arrangement is an ERISA plan, however, does not end the analysis.

---

<sup>175</sup> 29 U.S.C. § 1002 (1) (Supp. 1996).  
<sup>176</sup> 29 U.S.C. § 1003(b) (1985). For more information on state regulation of these benefits see discussion in *Questions & Answers About Insurance Department Jurisdiction* on page 38.  
<sup>177</sup> 29 U.S.C. § 1002(7) (Supp. 1996).  
<sup>178</sup> See, e.g., *Williams v. Wright*, 927 F.2d 1540, 1545 (11th Cir. 1991).

The form of the organization that sponsors the plan will also have a significant impact upon the applicability of state law. The remainder of this section will include a description of each of the three types of health-related employee welfare benefit arrangements: single-employer plans, multiple employer plans, and multiple employer welfare arrangements, and will highlight ERISA's relationship to Taft-Hartley trusts.

## **Single-Employer Plans**

### **Characteristics of a Single-Employer Plan**

A single-employer plan is one that is sponsored by one employer for its employees. However, a plan operated by two or more employers under common ownership or control may also be considered a single-employer plan for purposes of ERISA. The statute refers to "businesses within the same control group" and defines control group to mean a "group of trades or businesses under common control."<sup>179</sup> The term "common control" must be defined by DOL in a manner consistent with section 414(c) of the Internal Revenue Code.<sup>180</sup> Factors ~~that~~ DOL considers in determining whether two or more employers are under common control include whether the employers are affiliated service groups or "share ownership interests in such a way as to be within the same control group."<sup>181</sup> Those trades or businesses with less than 25 percent ownership interest do not meet the standards for common control.<sup>182</sup>

### **Single-Employer Plans and State Regulation**

State insurance regulators faced with a suspected unauthorized health insurance operation should look to determine the true status of a purported "single employer plan." In the first instance, it is the obligation of the insurance licensee to ensure that the health benefit arrangement into which he or she is placing an employer and its employees is either insured with an authorized insurer, or that a single employer, self-insured plan is being established.

Conceptually, a "single employer plan" seems intuitive: it is a plan in which the employees (and their eligible dependents) of an individual employer, are afforded certain [health] benefits pursuant to contract. The employer can be a sole proprietor, a partnership, a corporation, or some other entity. For the limited purpose of this definition, it does not matter whether the benefits are provided via an authorized insurer (fully insured) or are paid from the funds of the employer (self-funded). However, that distinction is important for other analyses, such as, determining state insurance regulatory jurisdiction. As might be expected, a plan sold by an insurance agent is highly unlikely to be a "single-employer" plan.

<sup>179</sup> See 26 U.S.C. § 414(c) (Supp. 1996); 26 C.F.R. § 1.414 (1996).

<sup>180</sup> 29 U.S.C. § 1301(b)(1) (1985).

<sup>181</sup> Department of Labor Opinion 95-29A re: *Employee Staffing of America, Inc.* 4 (December 7, 1995).

<sup>182</sup> DOL GUIDE.

ERISA preempts state insurance regulation to the extent it directly regulates a self-funded single-employer plan. The convergence of a true single employer plan with true self-insurance results, in the context of health coverage, in an ERISA-qualified plan over which state insurance regulators do not have direct regulatory authority.

**Deleted:** The ability of states to regulate single-employer plans is very limited.

Persons, including licensed insurance agents, who promote unauthorized insurance under the guise of “ERISA” have come to recognize that if they are to sound plausible at all, they must at least use the term, “single employer plan”. Unfortunately, many times the only real relation to a single employer plan is that terminology. Health arrangements that do not meet these requirements are subject to the unauthorized insurer statutes of the various states.<sup>183</sup> As noted in the discussion of MEWAs below, some employee leasing companies and PEOs claim to offer “single employer plans” to their clients, but such a plan will almost certainly be considered a MEWA for ERISA purposes.<sup>184</sup> Similarly some operations have claimed to “employ” each enrollee, usually to promote the plan or ostensibly some product or service. It is usually quite apparent that the “employment” is pro forma.

**Deleted:** Many h

**Deleted:** , however,

**Deleted:** , and so

True single employer plans are not required to comply with state benefit mandates or solvency standards, nor may they be required to pay premium taxes and assessments, or adopt complaint resolution procedures which might otherwise be required by the state, except to the extent that the ERISA plan uses insurance arrangements to provide its benefits. The states may regulate the insurer and the insurer’s contracts used by a single employer ERISA plan (in accordance with the “saving” provision in the statute), but may not regulate the ERISA plan directly (in accordance with the “deemer” provision in the statute).

**Deleted:** States may not require

**Deleted:** s

**Conclusion**

ERISA plans sponsored by one employer or employers under common ownership or control are exempted from state laws as a result of ERISA preemption. Since the critical analysis of whether a single-employer plan exists usually arises when analyzing a suspected unauthorized insurer claiming ERISA exemption to state insurance regulation, these statutory definitions serve as a starting point for any analysis. Two other forms of arrangements—multiemployer plans and MEWAs—are also governed by ERISA. They each have their own unique characteristics and relationship to state law.

**Multiemployer Plans**

**Characteristics of a Multiemployer Plan**

A multiemployer plan is one in which more than one employer contributes and which is maintained pursuant to a collective bargaining agreement between one or more employee

<sup>183</sup> *Bell v. Employee Security Benefit Ass'n*, 437 F.Supp. 382 (D. Kan. 1977).

<sup>184</sup> Some states have chosen to treat such plans as single employer plans, but that is a matter of state law and is not mandated by ERISA. Those states usually require a license or registration.

organizations and more than one employer.<sup>185</sup> As a practical matter, the definition of a multiemployer plan refers to plans established by labor organizations. These are commonly referred to as “union plans”. Whether the agreement is a bona fide collective bargaining agreement is a fact-specific inquiry based on such factors as the terms of the agreement, the status of the parties, and the nature of the bargaining process.<sup>186</sup> As discussed above, plans operated by businesses under common control are considered single employer plans not multiemployer plans, even if contributions are made pursuant to a collective bargaining agreement. Multiemployer plans receive contributions from unrelated employers who make the contributions for participants. These plans are usually administered by a board that consists of employer and union trustees.

**Multiemployer Plans and State Regulation**

As with single employer plans, the ability of states to regulate multiemployer plans is very limited. States do not have the authority to regulate directly a multiemployer plan, although it retains the authority to regulate organizations that contract with multiemployer plans to provide benefits coverage and the authority to regulate the underlying insurance contracts. As will be discussed below in the section on multiple employer welfare arrangements, not all arrangements that ostensibly involve collective bargaining agreements are covered by ERISA or are exempted from the application of state law. They may, in fact, be multiple employer welfare arrangements and consequently, subject to state insurance law.

**Conclusion**

Multiemployer plans are exempted from state laws as a result of ERISA preemption. However, not all arrangements that involve collective bargaining arrangements are subject to ERISA coverage or ERISA preemption. Arrangements that do not involve bona fide collective bargaining agreements are MEWAs and are subject to state law.

**Multiple Employer Welfare Arrangements**<sup>187</sup>

**Characteristics of MEWAs**

ERISA defines a multiple employer welfare arrangement (MEWA) as: “[A]n employee welfare benefit plan, or any other arrangement...which is established or maintained for the purpose of offering or providing any benefit described in paragraph 1<sup>188</sup> to the

Deleted: , supra n. 68, at 33-34  
Deleted: For  
Deleted: , regulators are encouraged to read U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT: A GUIDE TO FEDERAL AND STATE REGULATION (1992)  
Deleted: 1992  
Deleted: Revised September 2002). Available on the internet at [www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
Inserted: Revised September 2002  
Inserted: Available on the internet at  
Deleted: employees who are union members

Deleted: and Taft-Hartley trusts, however

Deleted: also  
Deleted: which

Formatted

<sup>185</sup> 29 U.S.C. § 1002 (37)(A) (Supp. 1996).

<sup>186</sup> DOL GUIDE.

<sup>187</sup> [Regulators are encourage to read the DOL GUIDE for](#) a more detailed discussion of MEWAs and state regulation.

<sup>188</sup> The benefits may include, *inter alia*, 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

employees of two or more employers (including one or more self employed individuals), or to their beneficiaries.”<sup>189</sup>

While such an arrangement may be an ERISA-covered plan, most MEWAs are not ERISA-covered plans since they are usually not established or maintained by an employer or employee organization. Significantly, states may regulate MEWAs whether or not they are employee welfare benefit plans or covered by ERISA.

In practice, MEWAs are commonly formed by several types of entities. Associations of employers in a common trade, industry or profession (e.g., bankers, retail grocers) often make health plans available to employer members and their employees, as do associations that have no employment related commonality. Employee leasing organizations (or professional employer organizations (PEOs)), that describe their business as leasing employees to a variety of unrelated businesses, may also sponsor health plans for these employees. Such leasing arrangement can relieve smaller employers from the administrative costs of personnel and payroll record keeping, and the leasing organization’s benefit plans can make pricing economies of scale available to an employer that would otherwise be only a very small group purchaser.<sup>191</sup> The DOL has consistently determined such employee leasing or PEO leasing health plans to be MEWAs.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a filing requirement for MEWAs. The Form M-1 filing requirement is designed to keep the Department of Labor informed about MEWAs’ compliance with the requirements of Part 7 of ERISA (including the provisions of the Health Insurance Portability and Accountability Act, the Mental Health Parity Act, the Newborns’ and Mothers’ Health Protection Act, and the Women’s Health and Cancer Rights Act). The one-page Form M-1 is filed with DOL once a year, usually on March 1. The MEWA M-1 forms that have been filed with DOL are accessible online at www.dol.gov/ebsa.

**MEWAs and State Regulation**

Whether a MEWA is covered by ERISA or not, the states have authority to regulate MEWAs. A state may generally regulate a MEWA that is not an ERISA covered plan in the same manner it regulates insurers. The extent of state regulatory authority over a MEWA that is also an ERISA covered plan depends on whether it is “fully insured.” A MEWA is “fully insured” when all of the benefits of the arrangement are guaranteed under an insurance contract.<sup>192</sup> If a MEWA is a “fully insured” ERISA covered plan, state

<sup>189</sup> 29 USCA ss. 40(A)  
<sup>191</sup> See discussion below regarding self-funded employee leasing plans’ status as MEWAs notwithstanding their claim to be single-employer plans.  
<sup>192</sup> 1144 (b)(6)(D) (Supp. 1996) states, “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.”

**Deleted:** in Questions and Answers about Insurance Department Jurisdiction on Page 43

**Deleted:** \*  
A multiple employer welfare arrangement (MEWA) is an employee welfare benefit plan or other benefit arrangement established or maintained for the benefit of employees of two or more employers to provide health care and/or other welfare benefits to those employees and their dependents.

**Deleted:** The definition of a MEWA does not include plans or other arrangements established or maintained pursuant to one or more agreements found by the Secretary to be a bona fide collective bargaining agreements, or by a rural collective cooperative or rural telephone cooperative association.

**Inserted:** one or more agreements found by the Secretary to be

**Inserted:** s

**Deleted:** 190

**Deleted:** \*

**Deleted:** which

**Deleted:** which hold themselves out to be the “employers” of workers leased.

**Deleted:** their

**Deleted:** Plans established through collective bargaining may also be MEWAs, if the bargaining agreement is not found to be bona fide.

**Deleted:** In these cases, “unions” are formed consisting of employees of unrelated employers for the purpose of establishing a health plan, but no legitimate bargaining occurs between employers and employees concerning wages, hours, working conditions, or benefits.

**Deleted:** The union itself usually is not associated with a recognizable tra ... [1]

**Deleted:** Finally, other entities known as Voluntary Employee Beneficia ... [2]

**Inserted:** .

**Deleted:** arrangement

**Deleted:** The scope of

**Deleted:** authority to

**Deleted:** under ERISA is not limited by federal law

**Deleted:** under ERISA

**Deleted:** the Secretary finds that

**Deleted:** the

**Deleted:** employee benefit

Deleted: NAIC Model No. 220.

regulatory authority is primarily directed at the insurance policy; however states may also enforce such requirements on the “fully insured” MEWA as minimum reserving and contribution standards.<sup>193</sup> If a MEWA is not “fully insured,” even if it is an ERISA covered plan, states may enforce virtually all insurance regulations, including requiring the MEWA to qualify for and obtain a certificate of authority as an insurer. Purchasing reinsurance or stop loss coverage does not make a MEWA “fully insured.”

Deleted: "

Deleted: employee benefit

No state is required to take legislative action in order to regulate MEWAs. States may regulate MEWAs under their general insurance statutes. However, some states have chosen to adopt MEWA-specific laws. A MEWA is an insurer under state law unless the state has adopted such a specific MEWA licensing law. In either case the MEWA is illegal under state law unless it is licensed as an insurer, or licensed under a state's specific MEWA licensing scheme. Laws such as the NAIC Reporting Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs Model Regulation<sup>195</sup> are designed to assist states in becoming aware of the operation of MEWAs within their jurisdiction before an insolvency occurs.<sup>196</sup> In addition, several states have enacted specific statutory structures that govern PEOs.

Deleted: Many

Deleted: states have

Deleted: taken legislative action

Deleted: to clarify their insurance regulatory authority over MEWAs by incorporating NAIC models such as the Jurisdiction to determine Jurisdiction of Providers of Health Care Benefits Model Act<sup>194</sup>

Deleted: nd

Deleted: .

Deleted: These models

Deleted: colorful

**General Background: The Erlenborn Amendment**

MEWAs have had a troubled history since the enactment of ERISA. While Congress had intended that multiple employer plans be set up at the grassroots level by small business owners and local unions, Congress had not anticipated the involvement of third party promoters using multiple employer plans as profit making vehicles. The 1977 Activity Report of the House Committee on Education and Labor indicates that abuses started almost as soon as ERISA became law in 1974.<sup>197</sup> The lack of adequate consumer protection standards at the federal level and misunderstanding the scope of ERISA preemption of state laws facilitated abusive and fraudulent practices by MEWAs that resulted in significant sums of unpaid claims and the loss of health insurance for participants.

Deleted: opportunities

Deleted: the

Deleted: through

Congress enacted the Erlenborn-Burton Amendment in 1983 because of a concern regarding the financial insolvency of multiple employer welfare arrangements and a desire to remove impediments to action by state regulators to prevent those abuses. The

<sup>193</sup> 29 U.S.C. § 1144(b)(6)(A)(i) (1985).

<sup>195</sup> In 1982, the NAIC adopted the Jurisdiction to determine Jurisdiction of Providers of Health Care Benefits Model Act (No. 95), to assist states in becoming aware of the operation of MEWAs within their jurisdiction before an insolvency occurs. However, this Model was determined to be obsolete and has been withdrawn. In 1992, the NAIC adopted the Reporting Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs Model Regulation (No. 220).

<sup>196</sup> These models and the status of states' actions on them are included in Appendix A

<sup>197</sup> COMM REPT., supra n. 18, at 10.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

amendment saved state regulation of MEWAs from ERISA’s preemption and deemer provisions.<sup>198</sup> Congress intended to permit state insurance regulators to regulate risk-bearing MEWAs as insurance companies. The extent to which state law applies to a MEWA depends on whether the MEWA is an ERISA covered plan and whether it is “fully insured” or not.

**Deleted:** The Congressional intent was  
**Deleted:** The scope of this exemption from the ERISA preemption provision is dependent  
**Deleted:** employer welfare benefit plan of the

**State Regulation of “Fully Insured” MEWAs**

Under the 1983 Erlenborn Amendment, state insurance law that regulates “fully insured” MEWAs is preempted to the extent that the state’s laws “provide 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 [state] law able to pay benefits in full when due, and ... provisions to enforce such standards.”<sup>199</sup> Operators of MEWAs have claimed to be exempt from state insurance law because they are “fully insured.” However, ERISA does not preempt state See the discussion on this specific type of scam below in the section titled “Typical Illegal Operations Claiming ERISA Status.”

**Deleted:** Through  
**Deleted:** states were provided with the specific authority to regulate  
**Deleted:** that are plans  
**Deleted:**  
**Deleted:** Consequently,  
**Deleted:** if a  
**Deleted:** MEWAs

**State Regulation of MEWAs that are not “Fully Insured”**

Obviously, if a MEWA is not an ERISA covered plan—and many MEWAs are not—ERISA preemption does not apply at all. Furthermore, even if a MEWA is an ERISA covered plan, if it is “not fully insured,” (i.e., the plan itself bears some insurance risk), any state law that regulates insurance may apply, to the extent that the state law is not inconsistent with ERISA as modified by the 1983 amendment. The plain language of federal law, the legislative history, administrative interpretation and the limited case law indicate that a state may apply the full range of its regulations, with few exceptions, to a MEWA which is not “fully insured.”

**Inserted:** s  
**Deleted:** that is a plan is  
**Deleted:** “fully insured,”  
**Deleted:** federal preemption is waived specifically to  
**Deleted:** allow  
**Deleted:** the

DOL has statutory authority under 29 U.S.C. § 1144 (b)(6)(B) (1985) to adopt regulations to exempt MEWAs that are plans and that are not “fully insured” from state regulatory requirements. The DOL, in support of state efforts to regulate MEWAs, has repeatedly declined to adopt preemptive regulations.

**Deleted:** states to enforce reserving laws, or laws regarding contributions, including enforcement provisions in aid of those laws, such as cease and desist orders.  
**Deleted:** “Not Fully Insured”  
**Deleted:** employee benefit  
**Deleted:** employee benefit  
**Deleted:** it  
**Deleted:** clearly  
**Deleted:** “

**Exception to the MEWA Definition for Collectively Bargained Plans**

Excepted from the definition of MEWA are plans that the Secretary of Labor finds to be established or maintained pursuant to one or more collective bargaining agreements.<sup>200</sup> Unscrupulous operators have claimed to meet this exception to the definition of MEWA

**Deleted:** However,  
**Deleted:** is permitted  
**Deleted:** “

<sup>198</sup> See 29 U.S.C. § 1144(b)(6)(1985).

<sup>199</sup> 29 U.S.C. § 1144(b)(6)(A)(i) (1985).

<sup>200</sup> 29 U.S.C. § 1002(40)(A) (ERISA Section 3(40)(A)) states that the term MEWA “does not include any such plan or arrangement which is established or maintained—(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements; (ii) by a rural electric cooperative, or (iii) by a rural telephone cooperative association.

**Deleted:** It appears that the Secretary of DOL can make either or both of the following determinations:<sup>¶</sup>  
<sup>¶</sup> (a) Whether a MEWA that is a plan is “fully insured”, and<sup>¶</sup>  
<sup>¶</sup> (b) If the Secretary concludes that it is “not fully insured,” to what extent that particular MEWA that is a plan or class of MEWA plan will be exempted from state regulation.<sup>¶</sup>  
**Deleted:** Department of Labor

Formatted

Formatted

Formatted

to avoid complying with state laws. States should be aware that plans purportedly established through collective bargaining may in fact be MEWAs subject to state insurance laws. Recognizing plans that legitimately meet the “collectively bargained” exception to the definition of MEWA is the subject of two Department of Labor final rules published in the Federal Register on April 9, 2003.<sup>201</sup>

Formatted

*History of the Collective Bargaining Exception*

MEWA operators have established **purported** unions and **purported** collective bargaining agreements to market **health coverage** while claiming to be exempt from state regulation pursuant to ERISA’s statutory exception to the definition of a MEWA for plans **established or maintained pursuant to collectively bargained agreements.** The **DOL** has received requests to make findings with respect to whether a plan **was established or maintained pursuant to a collective bargaining agreement.**<sup>202</sup> The **DOL** determined that it would not make individualized findings with respect to whether specific plans met the exception for collectively bargained plans.<sup>203</sup> In 1995, the Fourth Circuit held that the **DOL** did not have any statutory obligation to make individualized findings about whether a particular entity met the exception to the definition of a MEWA for collectively bargained plans.<sup>204</sup> The **DOL’s** refusal to make an individualized finding in the *Virginia Beach* case had the same effect as a refusal to grant the exception. The lower court found that “only if the Secretary chooses to make a finding, would a MEWA receive exemption from state regulation.”<sup>205</sup>

Formatted

Formatted

On August 1, 1995 the **DOL** published a Notice of Proposed Rulemaking setting forth criteria that must be met in order for the Secretary of Labor to find that an agreement is a collective bargaining agreement for purposes of the exception to the MEWA definition.<sup>206</sup> The proposed rule also set forth criteria for determining when an employee benefit plan is established or maintained under or pursuant to such an agreement. The **DOL** received many critical comments. Due to the numerous concerns raised in those comments, rather than publish a final rule, the **DOL** decided in 1998 to promulgate a rule by negotiated rulemaking. The ERISA Section 3(40) Negotiated Rulemaking Advisory Committee completed its report to the Secretary with attached draft notices of proposed rulemaking on November 16, 1999. The final rules were published in the Federal Register April 9, 2003.

*Final Rules Regarding Section 3(40) of ERISA*

Formatted

The first rule, Employee Retirement Income Security Act of 1974; Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section

Formatted

<sup>201</sup> 68 F.R. 17472-17491, April 9, 2003.

<sup>202</sup> See *Virginia Beach Policemen’s Benevolent Association V. Reich* 881 F. Supp. 1059 (Ed. Va. 1995) affirmed, 96 F.3d 1440 (4<sup>th</sup> Cir. (Va.) 1996); 60 F.R. 39209, August 1, 1995, Note 3.

<sup>203</sup> 60 F.R. 39209, August 1, 1995, Note 3.

<sup>204</sup> See *Virginia Beach*, 881 F. Supp. 1059, 1069-70.

<sup>205</sup> *Id.* at 1070.

<sup>206</sup> 60 F.R. 39209.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

3(40)(A) of ERISA,<sup>207</sup> sets forth criteria for determining whether an agreement is a bona fide collective bargaining agreement, and whether a plan is established or maintained pursuant to one or more collective bargaining agreements in accordance with the exception to the definition of a MEWA in ERISA Section 3(40) for collectively bargained plans. The second rule, Procedures for Administrative Hearings Regarding Plans Established or Maintained Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA,<sup>208</sup> establishes a procedure whereby an entity may petition the DOL for an individualized finding when a state’s jurisdiction has been asserted against the entity through any state enforcement action.

Formatted  
Formatted

Successful cooperation and coordination between the states and the DOL will be critical to the successful implementation of these rules, and the administrative procedures rule in particular. The DOL contact for these rules is 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. Ideally, these rules will assist state regulators in determining whether an entity legitimately meets the 3(40) exception to the definition of MEWA for collectively bargained plans, or whether it is actually a MEWA that is subject to state regulation. Copies of the rules are available on the DOL website: [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

Deleted:  
Formatted  
Field Code Changed

**Conclusion**

ERISA has established a unique regulatory framework for MEWAs, which recognizes the states’ experience and expertise in consumer protection in the insurance context. State regulation of MEWAs has diminished the extent to which abusive practices are taking place in the MEWA market. However, because of the complex nature of ERISA, abusive practices by MEWAs have not been entirely eliminated.

Presently, some MEWAs fraudulently claim that they meet the exemption requirements for single employer plans or collective bargaining arrangements. MEWAs which operate fraudulently and which do not comply with state regulatory requirements harm both employers and employees, often in a relatively short period of time. Employers contributing to these fraudulent MEWAs have lost their investment in the employee benefit they sought to offer and employees are left with unpaid claims and no health insurance. Because employee welfare benefit plans offered through single employer plans and collective bargaining arrangements are exempted from state regulation under ERISA, effective regulation of MEWAs requires an ongoing cooperative relationship with the DOL. The states and the DOL have worked together to make great strides to curtail this fraudulent activity and maximize the effective regulation of MEWAs.

**TYPICAL ILLEGAL OPERATIONS CLAIMING ERISA STATUS**

<sup>207</sup> 68 Federal Register No. 68, 17472 – 17485.

<sup>208</sup> 68 Federal Register No. 68, 17485 – 17491.

Formatted  
Formatted  
Formatted

Concern with unauthorized insurance activity is driven by a number of factors. Some of the factors include:

1. The ongoing, and not isolated, nature of the activity;
2. The potential for dishonest or criminal activity within the business of insurance. This potential exists both with respect to the creators of the illicit plans, and the minions recruited to sell the plans, enroll consumers and service claims;
3. Adverse consequences to authorized insurers and other insurance licensees;
4. The potential for large quantities of unpaid claims due to dishonesty in the operation, actuarial unsoundness, or both;
5. The absence of any state or federal guaranty fund to cover the unpaid claims of an unauthorized insurer;
6. The possible adverse impact on future insurability of participants under statutes mandating guaranteed-issue health coverage (i.e. creditable coverage issues); and
7. The public perception that it is the duty of state insurance regulators to protect them from illicit insurance schemes, and to ensure that benefits are paid as contracted.

Formatted: Bullets and Numbering

State insurance regulators will be better able to protect the public from illicit insurance schemes if insurance departments are aware of the characteristics of some of the more common health plan scams. The following are some descriptions of typical entities that falsely claim exemption from state laws under ERISA.

Deleted: ¶  
Inserted: ¶  
Formatted

**Purported Single Employer Plan Enrolling Consumers as “Agents”**

ERISA’s preemption provision does not apply to a plan covering “agents” who are not employees of an entity. ERISA’s preemption provision, 29 U.S.C. § 1144, applies only to laws that “relate to” an “employee welfare benefit plan.”

Formatted

An employee welfare benefit plan is “any plan, fund, or program established or maintained by an employer or by an employee organization for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment etc.”<sup>209</sup> “Participant” under ERISA means “any employee . . . of an employer, . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer.”<sup>210</sup> Employee is defined as “any individual employed by an employer.”<sup>211</sup> The term

Formatted  
Formatted  
Formatted  
Formatted  
Formatted  
Formatted

<sup>209</sup> 29 U.S.C.S. § 1002(1)(A).

<sup>210</sup> 29 U.S.C. § 1002(7).

<sup>211</sup> 29 U.S.C. § 1002(6).

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

“beneficiary” is defined as “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.”<sup>212</sup>

An arrangement that purportedly provides coverage of an entity’s “agents” is an insurer under state insurance law. ERISA does not preempt state insurance regulation because:

A. The plan is not established for the purpose of providing benefits for participants (employees and former employees) and their beneficiaries. Such a plan is not an “employee welfare benefit plan” governed by ERISA. The ERISA definition of “employee welfare benefit plan” explicitly requires that the plan cover “participants” (defined as employees or former employees) and their beneficiaries. A “beneficiary” must attain his or her interest through an employee or retired employee. A plan that covers “agents” as independent beneficiaries is not an employee welfare benefit plan.

A few courts have construed the ERISA definition of “beneficiary” as permitting an employee welfare benefit plan to include any one by its terms.<sup>213</sup> However these cases are not consistent with *Nationwide v. Darden*.<sup>214</sup> In that case the U.S. Supreme Court rejecting applying ERISA to an agent’s claim for benefits, holding that the agent was not an “employee.” The Court did not consider a contention that the agent was nevertheless a “beneficiary” because the lower court disposed of that argument:

“(B)eneficiary,” for the purposes of ERISA, is a person other than one whose service resulted in the accrual of the benefits, but who is designated as the recipient of benefits accrued through the service of another. 29 U.S.C. § 1002(8).”<sup>215</sup>

B. Such a plan is a “multiple employer welfare arrangement” and subject to state insurance regulation as provided by 29 U.S.C. § 1044 (6). A “multiple employer welfare arrangement” is defined 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) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, ...”<sup>216</sup> Since the consumer enrollees are not employees of the entity offering the coverage (regardless of whether they are in fact “agents”) they are either employees of multiple employers, or self-employed, and the plan is a multiple employer welfare arrangement subject to state insurance jurisdiction.

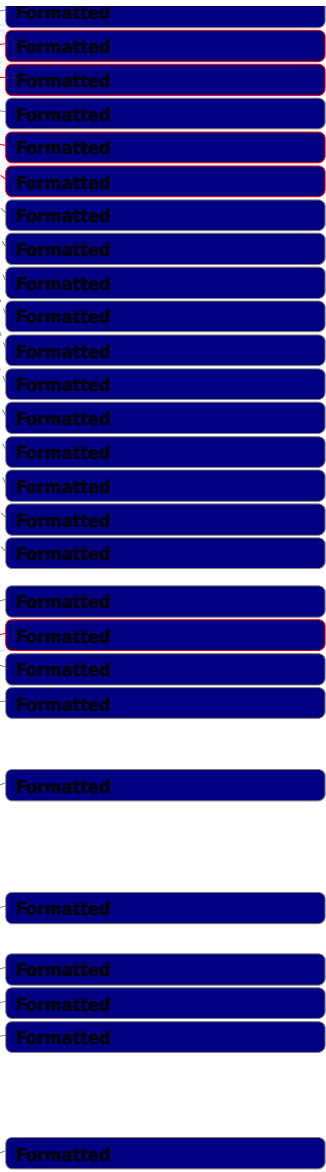
<sup>212</sup> 29 U.S.C. § 1002(8).

<sup>213</sup> See *Turnoy v. Liberty Life Assurance Co.*, 2003 U.S. Dist. LEXIS 1311; 29 Employee Benefits Case (BNA) 260.

<sup>214</sup> 503 U.S. 318 (1992).

<sup>215</sup> *Id.* at 705.

<sup>216</sup> 29 U.S.C. § 1002 (40).



C. The “agency” relationship with the enrollee consumers is usually fictitious. The enrollees in fact enroll to obtain the offered coverage, not to act as agent for the entity. The entity is an entrepreneur operation, and therefore not an employee welfare benefit plan.<sup>217</sup>

Formatted

Formatted

Formatted

Formatted

**Purported “Single Employer” Plans—Out Of State Trusts and Stop Loss Arrangements**

Formatted

These plans can be described as synthetic group health insurance. By bundling together a purportedly “self-funded” employer-sponsored benefit plan, stop-loss coverage, prepackaged plan design, and third-party administrative services – and setting the stop-loss attachment point so low that the “self-insured retention” can simply be treated as a routine cost of the plan – the employer can pay a fixed monthly amount and obtain a defined health benefit package for its employees, just like traditional group health insurance. Indeed, these plans are designed to look just like traditional group health insurance from the perspective of the employer and employee – as long as things are going well. However, once problems arise, each component of the plan is likely to point the finger at someone else, and all of them will claim immunity from state regulation.

Formatted

Formatted

Formatted

Formatted

This type of MEWA differs from the others in that the entity operating the MEWA is not necessarily acting as an insurer. Indeed, in many of these arrangements, the insurance coverage is issued by a licensed insurance company, and the MEWA’s role is focused on sales and third-party administrative services. In order to conduct effective enforcement, it is essential for states to understand how these plans work, and to make sure that their laws do not have loopholes through which these plans can escape meaningful regulation. What this type of plan has in common with other MEWAs is that insurance coverage is packaged as something else, and then marketed under false claims of ERISA immunity from state regulation. As one marketing brochure describes it:

Formatted

Formatted

Formatted

Formatted

As the costs of health insurance sky rockets, our clients are turning to self-funding as an alternative to fully-insured health plans. Through the guidelines of ERISA, employers can take advantage of demographic discounts and good health risks. Also, through ERISA, employer can modify coverage such as mental health and chiropractor.... Once the employer has created their ERISA plan then the risk of the self-funded plan is reinsured through various markets. This allows the employer to know the maximum costs in a plan year.

Formatted

Formatted

Formatted

The most important thing for regulators to remember is that these plans are not truly self-funded, and ERISA does not preempt meaningful state regulation of these plans. Self-insurance is not something employers can buy—self-insurance simply means the employer has not bought insurance! There is no philosopher’s stone that can take the risk

Formatted

Formatted

<sup>217</sup> See *Bell v. Employee Security Benefit Association*, 437 F. Supp. 382 (1977).

out of self-insurance. If someone is paying a fixed amount for a defined package of benefits, they are buying insurance, and ERISA reserves the right to regulate insurance to the states, even when that insurance is connected with an employee benefit plan. Some plans of this type are out-and-out frauds.

Formatted

Formatted

The stop-loss coverage might be placed with an unlicensed company, or might not exist at all. The employer's "trust contributions" might be commingled with other employers' payments, or might go straight into the pockets of the promoters. When this level of fraudulent behavior is involved, the arrangement is not materially different from other unlicensed entity scams, and should be pursued in the same manner, although it may be necessary to address some of the jurisdictional issues discussed below, depending on how the promoters respond.

Formatted

Formatted

On the other hand, as noted above, the insurance coverage is often provided by a licensed insurer. This makes damage control easier, since there may be ways to hold the insurer responsible for unpaid claims even though there is no direct contractual relationship between the insurer and the covered individuals. However, the participation of a licensed insurer also lends an aura of legitimacy to the scheme, which makes it easier for participants to argue that they didn't know any illegal transactions were involved.

Formatted

Formatted

That aura of legitimacy is misplaced. The regulatory arbitrage carried out by substituting stop-loss coverage for traditional health insurance harms consumers, employers, and the overall health insurance market in a number of ways, including but not limited to the following:

Formatted

1. The coverage is medically underwritten. This is what makes it "affordable," allowing a licensed company to undercut the market price because it is not playing by the same rules. This in turn adds to the stresses on the legitimate guaranteed-issue small employer market. Similarly, stop-loss coverage is also exempt from small group rating laws in states that regulate rates.
2. The patient has no contractual relationship with the insurer. At worst, the shell game could leave the claimant holding the bag with a claim against an uncapitalized shell entity. In any event, there is no regulatory authority to resolve a claim dispute, unless the state orders the insurer to assume direct responsibility for claims as part of its remedial action. Even if the Insurance Department is prepared to do this, the consumer complaint may never be processed correctly because the intake person takes at face value the representation that the plan in question is a "self-insured ERISA plan."
3. The benefit contract does not contain the dispute resolution mechanisms, minimum benefits, or other consumer protection provisions required by state law. In fact, strictly speaking it's not a "contract" at all.
4. The employer may be surprised by gaps in coverage or onerous contract conditions such as "pay when paid" clauses, and the employer remains responsible for paying the claimants whether or not the stop-loss carrier pays the employer.

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

Although these plans are designed to “hide the ball” by stacking multiple layers of contracts, it is usually fairly easy to identify who is acting as an insurer and who is acting as a producer. The hard work, when pursuing enforcement actions, is being able to respond effectively to their defenses and excuses:

Formatted

- “It’s only reinsurance.” Recall the marketing blurb quoted at the beginning of this section: “Once the employer has created their ERISA plan then the risk of the self-funded plan is reinsured through various markets.” However, a contract is not legally considered reinsurance unless the ceding company is regulated as an insurer. The point at which an unregulated entity first cedes risk to a regulated entity is a regulated insurance transaction.<sup>218</sup>
- “This is a self-insured plan.” It is a complex web of transactions (which should already be a red flag), which (if it is “done right,”) includes both a self-insured component and an insurance policy. The self-insured component of the plan will likely be of interest to federal investigators, but our concern is the state-regulated insurance policy. Our lack of authority to regulate the self-insured component of these plans is no great loss, since the self-insured component typically represents 5% or less of the dollar value and essentially none of the risk.
- “ERISA preempts state regulation of stop-loss insurance.” Although nothing in the text of ERISA or the relevant Supreme Court jurisprudence would remotely suggest such a result, the Fourth Circuit has ruled that ERISA places some limitations on how states can regulate stop-loss insurance.<sup>219</sup> However, even in jurisdictions where *American Medical Security* is considered binding precedent or persuasive authority, that opinion makes clear that even under ERISA, the authority to “regulate stop-loss insurance policies ... is clearly reserved to the states.”<sup>220</sup>
- “Your state has no regulatory interest in the insurance coverage.” This argument is based on the notion that neither the employer nor the employees are parties to the stop-loss contract, which is typically issued to an out-of-state benefit trust. However, even if a valid out-of-state trust exists (it often does not!), the employer

Formatted: Bullets and Numbering

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

<sup>218</sup> In some states, state statutes expressly clarify this point. In Maine, for example, “The transaction of employee benefit excess insurance does not constitute the conduct of the business of reinsurance.” 24-A M.R.S.A. § 707(1)(C-1).

<sup>219</sup> *American Medical Security v. Bartlett*, 111 F.3d 358 (4th Cir. 1997). The NAIC has taken the position that this decision is at odds with the plain language of the ERISA saving clause, which gives the states free rein to regulate “insurance,” not just “health insurance,” and with the Supreme Court’s ERISA jurisprudence, which acknowledges that the saving clause creates “a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not.” *Metropolitan Life v. Massachusetts*, 471 U.S. 724, 747 (1985). The Fourth Circuit elaborated on this doctrine by drawing the line between insured and uninsured plans on the basis of the kind of insurance they purchase, an approach that has become even more questionable now that the Supreme Court has further clarified the broad scope of state regulatory authority in *Kentucky Ass’n of Health Plans v. Miller*, No. 00-1471 (April 2, 2003).

<sup>220</sup> *American Medical Security*, 111 F.3d at 365.

Formatted

is the real party in interest,<sup>221</sup> since it is the employer’s risk that is covered by the policy.<sup>222</sup>

- “Your state has no jurisdiction because the policy is issued out of state.” This is a variation on the same theme, and has no more merit than saying that the policy is governed exclusively by Delaware law if the employer establishes a Delaware corporation. These “extraterritorial” jurisdictional issues have been dealt with extensively in the traditional group insurance market in context of association group policies and multiemployer trust policies, and states can and should exercise the same regulatory authority here.
- “What we were selling wasn’t insurance.” The producers, licensed or unlicensed, who sell this product to the employer will try to distance themselves by claiming that they only market the ERISA plan, not the insurance. However, the employer would not buy the product if it weren’t made clear somehow that the plan is not truly self-funded. Sometimes the producer slips up and actually offers an “insurance quote” in so many words. However, even if the producer avoids that pitfall, somewhere in the marketing or application of materials there will have to be some discussion of the stop-loss coverage.
- “Any sales, solicitation, or negotiation of insurance took place out of state.” Despite the out-of-state trust documentation, the product was bought and paid for by the employer, who was almost certainly solicited at the employer’s place of business. Almost invariably, all subsequent transactions involving the employer also took place within the state.

Formatted

Formatted

Formatted

Formatted

Formatted

Formatted

All this being said, there is nothing inherently illegal about prepackaged partially-insured plans, in which plan design, administrative services, and stop-loss insurance are marketed as an integrated product. However, both the stop-loss insurer and the producer must be properly licensed and appointed, and the insurance must be issued in compliance with all applicable state laws regulating rates, forms, and adequate disclosure to the purchaser of what the product does and does not provide. The state in which the trust is domiciled and the stop-loss policy is issued will need to be particularly diligent, since the promoters of the plan will be relying on that state’s regulatory approval, acquiescence, or lack of knowledge when dealing with regulators in the other states where the covered employers are doing business.

Formatted

Formatted

Which laws apply to these plans will vary from state to state. The lack of any direct contractual relationship between the insurer and the plan participants takes it outside most states’ definitions of “health insurance,”<sup>223</sup> even though the self-insured retention is a nominal amount which from the employer’s perspective is simply part of the premium. Under the NAIC Stop Loss Insurance Model Act, a stop loss policy cannot be issued

Formatted

<sup>221</sup> If state law regulates the policy as health insurance, the employees may also have a legal interest in the coverage.

<sup>222</sup> If the benefit plan purports to create no liability for benefits on the part of the employer, then the trust is acting as an unlicensed, undercapitalized insurer. Perhaps because of the fiduciary liability exposure that is created, these plans tend not to be structured in this manner.

<sup>223</sup> As discussed above, *American Medical Security* prohibits states in the Fourth Circuit from classifying indirect-payment coverage as health insurance.

unless, among other requirements, its aggregate attachment point for small groups is at least 120% of expected claims and its specific attachment point (if there is specific coverage) is at least \$20,000. In states that have adopted this model act, or a similar regulation, an insurer is prohibited from issuing a stop loss policy with the minimal retention these schemes purport applies to their arrangements.

Formatted

### Purported “Fully Insured” Plans

Formatted

Formatted

Formatted

Formatted

This type of MEWA is in some sense the mirror image of synthetic group health insurance. In each case, there is often a reverse-fronting arrangement in which an unlicensed entity cedes risk to a licensed entity. The difference between these plans and the plans discussed in the previous section is which layer is actually acting as an insurer. In synthetic group health insurance arrangements, the fronting “single-employer” plan holds itself out as self-funded, concealing the fact that the insurance risk is actually passed on to the stop loss insurer. Here, by contrast, an unlicensed insurer, usually structured as a multiple-employer trust, holds itself out as “fully insured” by virtue of its reinsurance arrangements.

Unlike many MEWAs, these entities will often admit to being MEWAs, because the provision of ERISA they seek to exploit applies by its terms to MEWAs. The ultimate goal is to try to have it both ways – to argue that the MEWA is exempt from regulation because it is fully insured, but then to turn around and argue that the insurer standing behind the MEWA is somehow also exempt from state regulation, even though this is the same insurer that purportedly “fully insures” the MEWA!

To see why these arguments lack merit, it is necessary to analyze the relevant provision in ERISA, which does create a limited exception to states’ authority to regulate MEWAs as insurers. ERISA §§514(b)(6)(A)(i) [(29 U.S.C. § 1144(b)(6)(A)(i)] provides that:

[I]n the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured ... 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.

And ERISA §§ 514(b)(6)(D) [(29 U.S.C. § 1144(b)(6)(D)] clarifies when this clause applies by clarifying that:

[A] multiple employer welfare arrangement shall be considered fully insured only if the terms of the

**DRAFT 3-11-04***ERISA: Guidelines for State and Federal Regulation*

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.

This means that in order to be exempt from the full range of state insurance regulation, a MEWA must:

- Be an employee welfare benefit plan;
- Have a state-authorized insurer which is fully responsible for the payment of all benefits; and
- Remain subject to applicable state solvency laws ensuring the payment of benefits when due.

Formatted: Bullets and Numbering

Most entities claiming to be “fully insured MEWAs,” like most other entities making abusive preemption claims, fail the threshold test because they are not ERISA plans in the first place. Regulators must never take for granted a MEWA’s claim to be an employee benefit plan. Remember that a MEWA can provide ERISA benefits without being an ERISA plan.<sup>224</sup> In that case, the state can regulate the MEWA as an insurer (or if it chooses, as a state-licensed MEWA) without ERISA entering the picture at all.

Often, however, it is easier to refute the claim that the MEWA is “fully insured,” because compliance with the entire framework of state and federal regulatory requirements for fully insured plans is precisely what the promoters are trying to avoid. In particular, many such plans have claimed to be fully insured by virtue of a purported “reinsurance” contract, surety bond, or other contract between a state-licensed or surplus-lines-eligible insurer and the MEWA. However, when ERISA defines “fully insured” in terms of the insurer’s contractual guarantee that benefits will be paid, the insurer must make this guarantee to the individual plan participants, not merely to the MEWA or even to the covered employers.<sup>225</sup> Furthermore, a MEWA is entitled to federal recognition as a fully insured MEWA, only if “the Secretary determines” that the amount of all plan benefits “are guaranteed under a contract, or policy of insurance.” Thus, in the event of a dispute between the MEWA and state regulators, the burden is on the MEWA to obtain an affirmative ruling from the DOL.

Most important, even if the MEWA does qualify as a fully insured employee benefit plan, ERISA is designed to dovetail with state insurance regulation, not to preempt it. States might not be able to regulate the MEWA as an insurer, but that is because they can regulate the insurer as an insurer. The prototypical fully insured MEWA, after all, is the traditional multi-employer group health policy.

<sup>224</sup> See : e.g.USDOL Advisory Opinion 92-21A regarding MEWAs that are not “established or maintained” by an employer: MEWAs that allow participation by one-family group or other groups that are not considered employee groups under ERISA

<sup>225</sup> See, e.g., USDOL Advisory Opinion 94-07A, USA for Healthcare, for further discussion of this requirement from the Department of Labor’s perspective.

Although the promoters of “reverse fronting” MEWAs are eager to point out that the federal definition of fully insured MEWA is not limited to traditional group health policies, that point is not nearly as significant as the MEWA promoters make it out to be, for two reasons. First, insurers have shown no interest in offering an alternative product with the kind of endorsements that would truly guarantee the payment of all benefits to all plan participants—if they wanted to bear that risk, they would have written a traditional group health policy rather than inventing something different. And second, the kinds of guarantees that qualify a product as “full insurance” for a MEWA are the same ones that bring it within state law definitions of “health insurance.”

As noted earlier, this is no accident. MEWA promoters try to distract regulators by seizing on ERISA’s phrase “qualified to conduct business in a State,” arguing that “qualified” could mean surplus lines authority, and “a state” does not mean “every state where covered employers do business.” Let the analogy of traditional multiemployer group health policies be your guide here. As a threshold matter, the coverage must be issued in compliance with the laws of the state where the master group policy is issued. That is enough to satisfy the requirements of ERISA. Beyond that point, it is entirely up to the other states to decide whether and how their laws will apply when their employers are covered under the policy—ERISA neither requires such regulation nor does ERISA restrict it in any way.

Finally, regulators must also keep in mind that ERISA does not preempt state solvency regulation of fully insured MEWAs. As the DOL explains in its MEWA GUIDE, “it is the view of the Department of Labor that 514(b)(6)(A)(i) clearly enables states to subject [fully insured] 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.”

**Multiple Employer Arrangements Claiming “Single Employer” Plan Status—Issues Related to Employee Leasing and Professional Employee Organizations**

Whether a self-funded benefit arrangement sponsored by an employee leasing company (or professional employer organization (PEO)) is exempt from state regulation because of ERISA preemption depends upon whether the arrangement is an ERISA-covered single-employer plan or a MEWA.

Some PEO’s claim to offer a “self-funded, single-employer plan.” However, if the employees are actually under the control of the individual client employer, the arrangement is an ERISA single-employer plan established by each of the involved employers individually. This is true despite a contract purporting to designate the PEO as the employer. Both state and federal law look to the economic realities in determining whether the clients businesses are in fact acting as employers. Although operators of PEO’s occasionally cite the ERISA provision treating employers “under common control” as single employers, that does not apply even if the PEO can be said to manage

- Formatted
- Deleted: Purported
- Formatted
- Formatted
- Deleted: Plans
- Formatted
- Deleted: (“PEOs”)
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted
- Formatted

its clients' businesses, because client businesses are not all under common ownership, which is the basis of the statutory test for single-employer status.<sup>226</sup> Thus, the plan cannot qualify as a single-employer plan unless the PEO is actually the sole common law employer of all of the individuals under the arrangement.

The presence of the employer-employee relationship depends upon the specific circumstances of the case. In *Nationwide Mutual Ins. Co. v. Darden*,<sup>227</sup> the Supreme Court held that federal common law principles of employment govern the definition of employee contained in ERISA. . Whether the PEO is a "co-employer"<sup>228</sup> is irrelevant. If the client businesses employ the participating employees the PEO self-funded plan arrangement is a MEWA. The Court noted the following factors should be applied to determine the existence of an employer-employee relationship. Each factor must be separately weighed and none is decisive. Moreover, the actual practices, rather than the contractual terms, are determinative.

Formatted

Formatted

Formatted

Formatted

Formatted

1. the hiring party's right to control the manner and means by which the product is accomplished;
2. the skill required;
3. the source of the instrumentalities and tools;
4. the duration of the relationship between the parties;
5. the location of the work;
6. the right of the hiring party to assign additional projects to the hired party;
7. the extent of the hired party's discretion over when and how long to work;
8. the method of payment;
9. the hired party's role in hiring and paying assistants;
10. whether the work is part of the regular business of the hiring party;
11. whether the hiring party is in business;
12. the provision of employee benefits; and,
13. the tax treatment of the hired party.<sup>229</sup>

Formatted: Bullets and Numbering

The DOL opinions on this topic have generally concluded that, since the client businesses in these arrangements are the common law employer of the employees the arrangement is a MEWA. (The arrangement includes employees of multiple employers.) In an opinion letter to the Virginia Department of Insurance, the DOL evaluated whether the health benefit program offered by the employee leasing company, Employers Resource

<sup>226</sup> See 29 U.S.C. § 1002(40)(B). This assumes that the plan is sponsored by a commercial PEO, not a captive staffing entity that is genuinely under common ownership and control with all its "clients." Such an entity could serve as the vehicle for a *bona fide* single-employer plan for a group of affiliated employers, and is outside the scope of this discussion.

<sup>227</sup> *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318 (1992).

<sup>228</sup> The DOL opinions finding PEO benefit plans to be MEWAs do not adopt the dual employment doctrine, but they do not reject it either. The key to the analysis is that the client is an employer. Depending on the circumstances of the particular PEO-client relationship, the PEO might also be entitled to claim an employer-employee relationship with its leased employees, but that does not alter the plan's status as a MEWA. An employee may have more than one employer-see *Vizcaino v. US District Court*, 173 F 3<sup>rd</sup> 713, 723 (9<sup>th</sup> Cir. 1999).

<sup>229</sup> *Id.* at 323-324.

Management Company, Inc. (ERM), constituted a single employer plan or a MEWA. The DOL concluded that the arrangement was a MEWA under the facts as presented. The Department noted several non-exclusive factors which it considers when making a determination of whether the participants are employees of the client business, including who has the right to control and direct the individual who performs the services, the result to be accomplished, the means by which it is accomplished, and the right to discharge the individual performing the services. The Department also stated that the payment of wages, taxes, and provision of benefits do not in and of themselves establish an employer-employee relationship.<sup>230</sup>

Formatted

The DOL opinions on this topic have generally concluded that, since the client businesses in these arrangements are the common law employer of the employees the arrangement is a MEWA. (The arrangement includes employees of multiple employers.) In an opinion letter to the Virginia Department of Insurance, the DOL evaluated whether the health benefit program offered by the employee leasing company, Employers Resource Management Company, Inc. (ERM), constituted a single employer plan or a MEWA. The DOL concluded that the arrangement was a MEWA under the facts as presented. The Department noted several non-exclusive factors which it considers when making a determination of whether the participants are employees of the client business, including who has the right to control and direct the individual who performs the services, the result to be accomplished, the means by which it is accomplished, and the right to discharge the individual performing the services. The Department also stated that the payment of wages, taxes, and provision of benefits do not in and of themselves establish an employer-employee relationship.<sup>231</sup>

Formatted

Formatted

Formatted

Formatted

Another analysis of an employee leasing company's relationship to the leased worker can be found in *Professional & Executive Leasing Inc. v. Commissioner*. In that case, the Ninth Circuit affirmed the United States Tax Court's holding that the employee leasing company was not the employer of the worker.<sup>232</sup> At issue in the case was whether the employee leasing company's pension and profit-sharing plan met certain qualification requirements under the tax code. The court found that it did not because it included persons who were not employees of the employee leasing company. The tax court analyzed the nature of the arrangement between the employee leasing company, the worker, and the recipient company in the context of common law principles and I.R.S. regulation. The court reviewed some of the factors that are considered in determining whether an employment relationship exists. Notably, it stated that while no particular factor is determinative, the most fundamental factor is whether the recipient company can control the activities of the worker.<sup>233</sup> The Circuit Court further noted that the employer need not have actually controlled the worker, it was only important that the employer had

Formatted

Formatted

<sup>230</sup> Department of Labor Opinion 93-29A re: *Employers Resource Management Company, Inc.* (October 22, 1993).

<sup>231</sup> Department of Labor Opinion 93-29A re: *Employers Resource Management Company, Inc.* (October 22, 1993).

<sup>232</sup> *Professional & Executive Leasing Inc. v. Commissioner, Internal Revenue Service*, 862 F.2d 751 (9th Cir. 1988).

<sup>233</sup> *Professional & Executive Leasing Inc. v. Commissioner of Internal Revenue*, 89 T.C. 225 (1987).

the authority to do so.<sup>234</sup> In this case, the court said that the employee leasing company had minimum control over the worker, did not control the details of what work was to be performed, or when and how it was to be performed, did not invest in the work facilities or equipment, did not experience profit or loss associated with the worker except for the leasing fees received, and merely performed a bookkeeping or payroll function.<sup>235</sup> Consequently, the employee leasing company was not the employer of all of the workers covered under the arrangement.

A PEO-operated “self-funded” health benefit plan covering “leased” employees is highly likely, under the criteria outlined above, to constitute a MEWA under ERISA. In those cases, state insurance law is not preempted and the PEO or employee leasing arrangement is an unauthorized insurer unless it is operating solely in states that have a specific PEO regulatory scheme and it is in compliance with those regulations.<sup>236</sup>

## IV. Prevention

Formatted

As the saying goes, an ounce of prevention is worth a pound of cure; and so it is with unauthorized insurers. Getting the word out to the public about common health insurance scams and enlisting the assistance of agents and authorized insurers in identifying potential scams are the keys to stopping these criminals before they start.

### A. Consumer Education

One of the biggest problems regulators encounter with illegal unauthorized entities is educating the public about the problem and how they can assist in prevention. Consumer alerts, bulletins, pamphlets and public service announcements (both television and radio) are all ways to alert the public to the presence and dangers of sham health plans. Some states have undertaken entire media campaigns to educate the public, complete with billboards and radio and television spots. For example, Florida has conducted a statewide media campaign urging Floridians to “Verify Before You Buy.” They have incorporated a cartoon figure in a gaping hospital gown with the slogan “Unlicensed Insurance –Think You’re Covered? Check to see if your company is licensed.” This cartoon is on the Florida Department of Insurance website as well as on billboards and television spots. The Nevada Department of Insurance has also implemented a media campaign designed to alert consumers to the presence of unlicensed insurers in the state. Using the image of a dark forest with red eyes peering out, the Nevada slogan cautions “Don’t fall prey to

---

<sup>234</sup> 862 F. 2d at 753.

<sup>235</sup> 89 T.C. at 233-34.

<sup>236</sup> In Maine, for example, if the plan is fully insured it is subject to the small group rating law, and a plan that is not fully insured may not be offered unless it is licensed as a MEWA. (32 Me. Rev. Stat. Ann. § 14055(1)(A); 24-A Me. Rev. Stat. Ann. § 6603-A.) Other states, such as New York, recognize a PEO as a single employer for purposes of offering fully insured health coverage on a large group basis (31 N.Y. Labor Code § 922(5)), and some states, such as Oklahoma, exempt PEO welfare benefit plans from licensing requirements. (40 Okla. Stat. § 600.7.F.2.)

phony insurance.” There is a Nevada Insurance Alert Website that is dedicated to providing additional information about avoiding unauthorized health insurance and how to choose a licensed insurer. These media campaigns utilize simple slogans and memorable images to help alert consumers to the existence of a potential problem—a crucial first step in preventing the proliferation of unlicensed entities. Unfortunately, most consumers have never heard of unlicensed insurers until tragedy strikes.

Consumer alerts are also effective tools for educating insurance consumers. All consumer alerts should be simply worded and provide concrete examples of questions to ask when purchasing insurance as well as a list of “red flags.” All attempts to educate the public should include a name and phone number of someone to contact in the state insurance department who is able to answer any questions about unauthorized insurers. The easier it is for a consumer to alert authorities to a potential unauthorized insurer, the more likely it becomes that a consumer will make the effort. The insurance department can only stop the unauthorized entities it knows about—stop them from stealing money from their state’s consumers and taking the scam into other states to do the same thing to another state’s consumers. A sample Consumer Alert is contained in Appendix A.

#### B. Agent Education

Many unauthorized entities utilize conventional marketing channels that involve producers (e.g. agents, brokers, administrators, solicitors and others). To initiate marketing, unauthorized entities solicit producers to enter into various commission contracts. Producer information packets or bulletins developed by the unauthorized entities are often the first activities one can detect in the insurance marketplace.

It is critical that the law-abiding producer community be made aware of unauthorized insurance issues, how to recognize a potential problem or fraudulent scheme, and where to refer it. Producers are the crucial first line of defense in finding out about unlicensed entities before they start to enroll the public. Producers should obtain as much information as possible about suspicious entity and immediately provide that information to their department of insurance.

The producer community should also be made aware of the negative civil and criminal consequences of selling an unlicensed insurance product. Once a plan has been shown to be unauthorized, most states have the ability to take disciplinary action against the insurance agents who participated in selling the plan. Such action can take the form of license revocation, a fine, or an order to make restitution. In some states, the sale of illegal insurance is a felony, so the attorney general or a district attorney may prosecute criminal charges.

A bulletin is one way to inform the producer community of the problem of unauthorized insurance, the responsibilities of the agent community to assist the insurance department in combating the problem and who to contact in the insurance department with any information. A sample agent alert is contained in Appendix A.

C. Licensed Insurer Education

Insurance departments should look to enlisting the assistance of licensed insurers in identifying unauthorized entities. Because of the adverse consequences suffered by authorized insurers as a result of sham plans, most are eager to aid insurance departments in this endeavor. Moreover, insurers that provide coverage to unauthorized entities may be liable under state law for claims they incur, as well as for penalties. In addition unauthorized entities may expose insurers to liability by falsely representing the insurer is providing coverage. Insurers should be encouraged to try to maintain procedures and controls to ensure that they do not assist unauthorized entities and to report as much information as possible about a suspected unauthorized entity. The more details that an insurer can provide the insurance department, the faster the insurance department will be able to take action against an entity and inform other states and the federal government to prevent the entity from extending its illegal activities into other states.

D. Education of other Industries.

Insurance departments should make efforts to educate other industries that may be affected by unauthorized entities. Employee leasing/PEOs and preferred provider networks should be encouraged to learn the characteristics of illegal programs, and to maintain controls and procedures to avoid assisting, or being victimized by, such an operation. Educational efforts are also particularly appropriate for small business and their trade associations.

E. Conclusion

The public, insurance producers and licensed companies all need to work together to bring suspicious entities to the attention of the departments of insurance. In order to make sure that the insurance department is made aware of any suspicious entities, insurance departments should make sure that the department website address is widely publicized. Insurance department websites can be a critical resource for consumers, producers and licensed insurers. Department websites should include tools to verify whether an entity is licensed. Insurance departments should designate one individual to answer all MEWA and unlicensed insurer– related inquiries and have that individual’s contact information prominently displayed on the website. In addition, the entire department should know to refer all related inquiries to that individual. The NAIC website contains links to the individual state insurance department websites as well as a list of 50 state MEWA contacts.

**Analytical Checklist for Determining State Jurisdiction Over Entities Offering Health Care Benefits**

Deleted: .....Page Break.....

A state's jurisdiction to regulate health plans depends upon whether the arrangement is a plan covered under ERISA and if so, whether it is a:

- single employer plan;
- multiemployer plan; or,

## **DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

- “fully insured” or not “fully insured” MEWA plan.

Each state should adopt a procedure for identifying and classifying arrangements. States should consider requiring all arrangements providing health care and all persons (such as agents) selling such products to:

- notify the state insurance department of such arrangement's existence;
- classify the arrangement as an arrangement not covered by ERISA, a single employer plan, a multiemployer plan, a “fully insured” MEWA or a not “fully insured” MEWA plan; and,
- provide appropriate documentation so that the insurance department can determine whether the arrangement was properly labeled. (See NAIC Model Acts at Appendix A).

### **ERISA Analysis**

The analysis of a state’s jurisdiction over an arrangement involves several key stages. These stages are outlined briefly below. Regulators may want to refer to the applicable sections of this handbook and other relevant sources when undertaking this analysis.

**Step 1:** Upon learning that an unlicensed entity is selling health care in your state, the first step is to determine whether the entity is offering an arrangement covered by ERISA. If the arrangement is not an ERISA plan, ERISA does not preempt state insurance regulation at all. If the plan is an ERISA plan, ERISA may preempt state insurance regulation to some degree and regulators should proceed to step 2 of the analysis.

**Step 2:** If the arrangement is an ERISA-covered plan, the next step of the analysis is to classify the arrangement. Determine whether the arrangement is a single employer plan, multiemployer plan, or, “fully insured” or not “fully insured” MEWA plan. After accurately classifying the plan, regulators should proceed to step 3 of the analysis.

**Step 3:** The type of plan under consideration will affect considerably the degree of state jurisdiction.

- If the arrangement is either a bona fide single employer plan OR found by the Secretary of Labor to be established or maintained pursuant to a bona fide collective bargaining agreement, the Department may not regulate the plan.
- If the arrangement is a MEWA, even if it is covered by ERISA, it is also subject to state insurance regulation unless it is established or maintained pursuant to agreements the Secretary finds to be collectively bargained agreements, by a rural electric cooperative, or a rural telephone cooperative association.

## DRAFT 3-11-04

### ERISA: Guidelines for State and Federal Regulation

- If the arrangement is a “fully insured” MEWA, the state insurance department may regulate the insurance contract and enforce standards such as those related to reserves and contributions.
- If the arrangement is a not “fully insured” MEWA, then the state can regulate the MEWA in the same manner that it regulates any other insurer.
- If the arrangement is subject to state insurance laws and an insurance license has not been obtained, then there is probably a violation of the state's Unauthorized Insurers Act. Go to step (4) below.

**Step 4:** If the entity is in violation of the state's Unauthorized Insurers Act (i.e., it is not a bona fide single employer plan or bona fide multiemployer plan), the next step is to take the enforcement action your Department would take against any other kind of unauthorized insurer offering insurance in your state. You might also check the NAIC's database to see if the organization or its principals are in the Special Activities Database (SAD).\*

\* For further discussion on state regulation and unauthorized entities, see NAIC's Unauthorized Entities Manual for State Departments of Insurance developed by the NAIC's Unauthorized Entities Working Group in 1996, [revised in 1998](#).

**DRAFT 3-11-04***ERISA: Guidelines for State and Federal Regulation*

Table 2. Regulatory Jurisdiction of ERISA Plans.

	<b>SUBJECT TO FEDERAL REGULATION ONLY</b>	<b>SUBJECT TO FEDERAL AND STATE REGULATION</b>	<b>SUBJECT TO STATE REGULATION ONLY</b>
<b>Single Employer Plans</b>	<ul style="list-style-type: none"> <li>◆ Meets ERISA Coverage Test</li> <li>◆ Not Excepted from ERISA Coverage</li> </ul>		
<b>Multiemployer Plans</b>	<ul style="list-style-type: none"> <li>◆ Meets ERISA Coverage Test</li> <li>◆ Is Sponsored by more Than One Employer as Defined in ERISA</li> <li>◆ Established Pursuant to a Bona Fide Collective Bargaining Agreement</li> </ul>		
<b>Multiple Employer Welfare Arrangements*</b>		<ul style="list-style-type: none"> <li>◆ Meets ERISA Coverage Test</li> <li>◆ Provide Benefits to Employees of More Than One Employer</li> </ul>	<ul style="list-style-type: none"> <li>◆ Does Not Meet ERISA Coverage Test</li> <li>◆ Provides Benefits to Employees of More Than One Employer And Does Not Meet Exceptions to MEWA Definition</li> <li>◆ Fully <i>or</i> Not Fully Insured</li> </ul>

\*Note: Under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, Congress has granted the Secretary of the Department of Labor authority to subject multiple employer welfare arrangements that are not ERISA plans to reporting requirements.

# QUESTIONS AND ANSWERS ABOUT INSURANCE DEPARTMENT JURISDICTION

State insurance departments frequently are confronted with questions about ERISA and its relationship to state insurance regulation. Below is a quick reference guide to some of the most commonly asked questions and accompanying answers. This guide includes questions about both long-standing issues with respect to ERISA as well as questions related to contemporary concerns. Because the interpretation of the law in this area is evolving, state insurance regulators should be mindful of any recent, relevant court and administrative decisions related to these questions, which may not be reflected in this handbook.

## What is a Taft Hartley Trust?

An arrangement established pursuant to a collective bargaining agreement may be a single employer or multiemployer plan. A Taft-Hartley trust is a multiemployer plan that, in addition to being established or maintained pursuant to one or more collective bargaining agreements, also meets criteria outlined in the Labor-Management Relations Act of 1947 (referred to as the Taft-Hartley Act). Regulators should be aware that plans established or maintained pursuant to collective bargaining agreements may be governed by both the Taft-Hartley Act and ERISA.

The Taft-Hartley Act described, among other things, the manner in which collectively bargained fringe benefits could be paid by employers to unions. The Taft-Hartley Act required the establishment of a trust administered by an equal number of management and union representatives for the purpose of paying “medical or hospital care, pensions on retirement or death of employees, compensation for injuries or illness resulting from occupational activity or insurance to provide any of the foregoing, or unemployment benefits or life insurance, disability and sickness insurance, or accident insurance” for employees and their dependents.<sup>237</sup>

The drafters of ERISA recognized the existence of Taft-Hartley trusts and included them within the definition of employee welfare benefit plan. Taft-Hartley plans that provide accident and health benefits are, with few exceptions, employee welfare benefit plans as defined in 29 U.S.C. § 1002(1) of ERISA. As a result, Taft-Hartley plans normally must meet the requirements of both the Taft-Hartley Act and ERISA. This general rule has certain exceptions, as noted in the discussion of state regulation below.

The requirements for a bona fide Taft-Hartley trust are very specific. Familiarity with these requirements will be useful to an insurance department in determining its jurisdiction over a plan.

<sup>237</sup> 29 U.S.C. § 186(c)(5)(A) (Supp. 1996).

**Deleted:** \*

**Deleted:** **Special Highlight:** ERISA, Collectively bargained benefit arrangements and Taft-Hartley Trusts\*

**Deleted:** ly

**Deleted:** bargained

**Deleted:** On the other hand,

**Deleted:** an arrangement ostensibly established pursuant to a collectively bargained agreement may in fact be a MEWA. Regulators should be aware that collectively bargained arrangements may be governed by both the Labor-Management Relations Act of 1947 (referred to as the Taft-Hartley Act) and ERISA.

**Characteristics of a Taft-Hartley Trust**

The characteristics of a Taft-Hartley trust can be found in 29 U.S.C. § 186(c)(5). These provisions include a requirement that:

The payments contributed to the trust be used exclusively for funding benefits for employees and their dependents.<sup>238</sup>

The benefits provided be for medical or hospital care, pensions on retirement or death of employees, compensation for injuries or illness resulting from occupational activity or insurance to provide any of the foregoing, or unemployment benefits or life insurance, disability and sickness insurance, or accident insurance.<sup>239</sup>

A written agreement between the employer and the labor organization specifying the detailed basis upon which payments are to be made.<sup>240</sup>

The trust be jointly administered by an equal number of persons representing the employees and employers, as well as by any neutral persons that have been agreed upon by the employee and employer representatives.<sup>241</sup>

The written agreement provides for an annual audit of the trust fund that is open to inspection by interested persons.<sup>242</sup>

Pension and annuity trusts be kept separate from health and welfare trusts.<sup>243</sup>

Taft-Hartley trusts are required to file certain information with DOL that states may find useful to obtain as they research a particular entity. All of the reports are available to the public at the Office of Labor-Management Standards (OLMS) National Office in Washington, D.C. and the field office in the geographical district where a particular labor organization reports. These reports and documents may be given to state agencies without charge upon request of the governor of the state.<sup>244</sup> Reporting requirements include the following:

Labor organizations that are engaged in an industry affecting commerce, except public employee organizations, are required to adopt a constitution and bylaws and file two copies with the OLMS and an initial report (Form LM-1) giving details about the organization's procedures, including membership qualifications, participation in benefit

---

<sup>238</sup> 29 U.S.C. §186(c)(5) (Supp. 1996).

<sup>239</sup> 29 U.S.C. §186(c)(5)(A) (Supp. 1996).

<sup>240</sup> 29 U.S.C. §186(c)(5)(B) (Supp. 1996).

<sup>241</sup> *Id.*

<sup>242</sup> *Id.*

<sup>243</sup> 29 U.S.C. §186(c)(5)(C) (Supp. 1996).

<sup>244</sup> 29 U.S.C. § 435(c) (1985).

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

plans and authorization for disbursement of funds.<sup>245</sup> These reports are required to be filed within 90 days after the labor organization first becomes subject to the Labor-Management Reporting and Disclosure Act of 1959 (LMRDA).<sup>246</sup> Any changes to the information initially reported on the LM-1 must be filed on Form LM-1-A along with the annual financial report.<sup>247</sup>

When the initial report is filed, the OLMS assigns a six-digit file number to the organization that is shown on the annual financial reports. These reports are due 90 days after the end of the organization's fiscal year using Form LM-2. If an organization has gross receipts of less than \$200,000, the organization may file form LM-3 and with gross receipts of less than \$10,000, the organization may file form LM-4.<sup>248</sup>

Deleted: which

Persons who handle the funds of a labor organization or a trust in which a labor organization is interested must be bonded.<sup>249</sup> Every surety company having such bonds in force must file an annual report with OLMS within 150 days after the end of the company's fiscal year.<sup>250</sup>

The administrator or sponsor of an employee benefit plan subject to ERISA is required to file an annual return/report with the Internal Revenue Service (IRS) by the last day of the seventh month after the plan year ends.<sup>251</sup> The IRS sends a copy of this report to the DOL Employee Benefits Security Administration (EBSA). If any benefits under the plan are provided by an insurance company, insurance service, or similar organization, a Schedule A must be attached to these forms. Schedule C details service provider and trustee information. An independent auditor's report (IPA) must also be attached unless the plan is exempt from this requirement.<sup>252</sup> These forms are also open to public inspection at EBSA's Public Disclosure Room in Washington, D.C.

Deleted: Pension and Welfare Benefits Administration (PWBA)

Deleted: PWBA's

Valid Taft-Hartley trusts should have a discernible paper trail. When attempting to determine the validity of a claimed Taft-Hartley trust, a state may want to obtain the collective bargaining agreement, the plan document, the summary plan description which must be given to employees, IRS annual report Form 5500 with the schedules attached, the LM-1 and the LM-2, LM-3, or LM-4. The reporting labor organization must keep supporting records for five years after the OLMS reports are filed<sup>253</sup> and plans must retain supporting documentation for six years after reports are filed with EBSA.<sup>254</sup> A review of these records may be useful during any investigation. While a valid Taft-Hartley trust

Deleted: PWBA

<sup>245</sup> 29 U.S.C. § 402(i) (1985); 29 U.S.C. § 431 (1985); 29 C.F.R. § 402.2 (1996).

<sup>246</sup> 29 C.F.R. § 402.3(a) (1996).

<sup>247</sup> 29 U.S.C. § 431(a)(5); 29 C.F.R. § 402.4 (1996).

<sup>248</sup> 29 U.S.C. § 431(b) (1985); 29 C.F.R. § 403.2-4 (1996).

<sup>249</sup> 29 U.S.C. § 502 (1985).

<sup>250</sup> 29 U.S.C. § 441 (1985); 29 C.F.R. § 409.2-3 (1996).

<sup>251</sup> 29 U.S.C. § 1024 (1985); 29 C.F.R. § 2520.103-1 (1996).

<sup>252</sup> 29 U.S.C. § 1023(1985); 29 C.F.R. § 2520 103-1 (1996).

<sup>253</sup> 29 U.S.C. § 436 (1985).

<sup>254</sup> 29 U.S.C. § 1027 (1985).

may have failed to comply with these reporting requirements, the absence of such filings is a warning that further investigation may be warranted.

Taft-Hartley Trusts and State Regulation

A Taft-Hartley trust is a type of plan that falls under the exception to the definition of a MEWA in Section 3(40) of ERISA as a plan established or maintained pursuant to one or more collective bargaining agreements. As such, a Taft-Hartley trust may only be subject to state regulation if it is a MEWA.

The previous discussion regarding the proposed regulation to the Section 3(40) exception to the definition of a MEWA describes the criteria that state insurance regulators can look to determine whether a plan, including a Taft-Hartley trust, has been established or maintained pursuant to one or more collective bargaining agreements. However, state insurance regulators should also be aware that certain legitimate Taft-Hartley trusts may fail to meet the definition of an employee benefit plan under ERISA and be subject to limited state jurisdiction or no state jurisdiction at all.

The courts have permitted Taft-Hartley trusts to cover a broad range of employee classes, including employees who are not in a collective bargaining unit or whose employer does not have a collective bargaining agreement. The courts have held that a Taft-Hartley trust may include retired employees, employees and officers of a union, employees of the trust fund and employees who are not union members in addition to the employees governed by the collective bargaining arrangement. For example, in *Doyle v. Shortman*,<sup>258</sup> the court refused to bar Taft-Hartley trust coverage of employees of employer members of employer associations which did not have collective bargaining agreements with the unions and of employees who were members of other unions or who were not represented by a union. The Taft-Hartley trust may provide benefits to persons between whom the employee/employer relationship or the bargaining relationship is sufficiently tenuous as to cause the arrangement to lose its character as an employee benefit plan within the meaning of ERISA.

If a Taft-Hartley trust covers employees of more than one unrelated employer other than pursuant to a collective bargaining agreement, a state insurance department should examine the state insurance code and past interpretive opinions to determine whether the trust is subject to the department's jurisdiction. If state law applies by its own terms, the state must determine whether the provision is consistent with, and not contrary to, the purpose of the Taft-Hartley Act.

States should be aware, however, that even if ERISA does not preempt state insurance regulation of a Taft-Hartley trust, a state may be nevertheless limited in, or prevented from, applying insurance regulation to a Taft-Hartley trust. The complex provisions of ERISA are superimposed over other laws that apply to Taft-Hartley trusts. These

<sup>258</sup> *Doyle v. Shortman*, 311 F. Supp. 187 (S.D.N.Y. 1970).

**Deleted:** A

**Deleted:** that is an ERISA plan

**Deleted:** The definition of MEWA in the federal statute expressly excludes a "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."<sup>255</sup> The Department of Labor has clearly indicated that a plan found by the Secretary of Labor to be established pursuant to a bona fide collectively bargained agreement is not subject to state insurance regulation. In a 1984 Advisory Opinion Letter, the Department stated:<sup>†</sup>

Section 514 (b)(6) of Title I of ERISA allows state insurance departments to regulate an employee welfare benefit plan or other arrangement which constitutes a multiple employer welfare arrangement (MEWA) as defined in section 3 (40) of ERISA; however, an employee welfare benefit plan meeting an exception from the MEWA definition specified in section 3(40)(A) (referring to agreements made pursuant to a collectively bargained arrangement) is not subject to state insurance regulation.<sup>256†</sup>

<sup>†</sup> However, this exception only applies if the plan is established pursuant to a bona fide collective bargaining agreement as found by the Secretary of DOL. As noted by DOL in a letter to the Florida Department of Insurance concerning *United Welfare Fund and Amalgamated Local Union 355*, a plan that is not established or maintained pursuant to a bona fide collective bargaining agreement is not excepted from the definition of a MEWA or removed from the jurisdiction of the state insurance department.<sup>257†</sup>

**Deleted:** Further, not every Taft-Hartley trust meets the

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

provisions may also prevent or impede application of state insurance regulation to Taft-Hartley trusts. Prior to the enactment of ERISA many states included provisions in their insurance codes that explicitly exempted Taft-Hartley trusts from regulation or which have been interpreted to exempt Taft-Hartley trusts from insurance regulation. A state may have addressed this issue by administrative interpretation. While there is very little case law on this subject, state insurance departments should be aware of any statutory or administrative provisions particular to their state.

Deleted: which

It has been argued that state insurance regulation is preempted by the Taft-Hartley Act. Unlike ERISA, the Taft-Hartley Act does not include a provision that comprehensively preempts state law. Accordingly, preemption under the Taft-Hartley Act is limited to those state provisions that actually conflict with the federal law or prevent the accomplishment of its purpose.

Deleted: which

Deleted: which

**Conclusion**

Genuine Taft-Hartley trusts that qualify as ERISA plans are exempted from essentially all state laws under ERISA. However, state regulators should be aware of two factors that may annul or limit federal preemption: an arrangement that is not ERISA-covered and failure to meet the ERISA 3(40) exception to the definition of a MEWA for collectively bargained plans. In those circumstances the plan may be subject to state insurance laws, absent a state law restriction.

Deleted: the absence of a bona fide collective bargaining agreement

***Can employers avoid state laws requiring workers’ compensation coverage by providing workers’ compensation through ERISA plans that also provide other benefits?***

No, an employer cannot use an ERISA plan to avoid complying with a state law requiring the purchase of workers’ compensation insurance. States have the option of allowing an employer to provide mandated benefits through an ERISA plan, or requiring an employer to provide mandated workers’ compensation through a separately administered plan.

*Legal Analysis:* ERISA expressly excludes workers’ compensation, unemployment compensation, and state-mandated disability insurance from its purview, leaving those areas to state regulation. The literal language of this carveout only allows state regulation of a “plan [which] is maintained solely for the purpose of complying with applicable workmen’s compensation laws or unemployment compensation or disability laws.”<sup>259</sup> The Supreme Court recognized that those laws would be impossible to enforce if the employer could avoid the state mandate by using an ERISA plan that provides other benefits. In *Shaw v. Delta Air Lines*,<sup>260</sup> a case involving a disability plan, the Court made clear that states’ authority to regulate separate state-mandated benefit plans entails the authority to require employers to maintain such plans. The Supreme Court held that while the state cannot compel the employer to alter its ERISA plan, the state may require that an employer choose between setting up a disability plan which complies with state law

<sup>259</sup> 29 U.S.C. §1003(b)(3) (1985) (emphasis added).

<sup>260</sup> *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).

## DRAFT 3-11-04

ERISA: Guidelines for State and Federal Regulation

and is separate from the ERISA plan or providing the state-mandated benefits through the ERISA plan. If the ERISA plan does not comply with the state's requirements, the state may compel the employer to maintain a separate plan.<sup>261</sup> The ability of states to prevent employers from evading compliance with state workers' compensation laws was reiterated by the Ninth Circuit when it stated: "The premise of the complaint in this case is that ERISA opened a loophole so that employers could avoid buying workers' compensation insurance. It does not."<sup>262</sup>

Most states require employers to secure coverage of their workers' compensation exposure either by purchasing a commercial workers' compensation policy, participating in a state fund, establishing a state-regulated self-insurance plan, or participating in a state-regulated self-insurance group. These laws have recently been upheld by a number of federal courts.<sup>263</sup> These decisions have rejected claims that *Delta Air Lines* does not apply to these state laws; that it only applies to state minimum benefit requirements and not state solvency requirements; or that it has been overruled or drastically modified by more recent Supreme Court cases, most notably *District of Columbia v. Greater Washington Board of Trade*,<sup>264</sup> The circuit courts observed that cases such as *Greater Washington Board of Trade* can easily be distinguished on the ground that the laws that were held to be preempted, unlike laws requiring coverage or other state-regulated security mechanisms for state law benefits, directly infringe on such core ERISA concerns as self-funded health and pension plans.

The *Delta Air Lines* analysis applies to state laws that permit employers to use ERISA plans to provide workers' compensation benefits as well as to more typical laws which require that the workers' compensation benefits be provided through a separate plan not covered by ERISA. For example, the Maine law upheld by the First Circuit in *Combined Management* allows an employer participating in state-approved 24-hour coverage pilot projects to provide comprehensive medical or disability benefits through an ERISA plan, but only upon conditions which include the employer's consent to ongoing state financial and actuarial review of the plan to verify compliance. If at any time the plan is not found to be in compliance with state requirements, pilot project approval is withdrawn and the employer must either qualify for state approval as a self-insurer or purchase a separate insurance policy for the workers' compensation benefits.

In states where participation in the workers' compensation system is voluntary, employers that opt out can provide similar coverage through employee benefit plans, which (to the extent that they are bona fide employer-maintained plans) are governed by ERISA rather than state law, because they are not set up to comply with a state workers'

---

<sup>261</sup> *Id.* at 108

<sup>262</sup> *Employee Staffing Services v. Aubry*, ("Stafcor"), 20 F. 3d 1038, 1039 (9th Cir. 1994).

<sup>263</sup> See *Stafcor*; *Combined Management v. Superintendent of Insurance of Maine*, 22 F. 3d 1 (1st Cir. 1994), cert. denied, 115 S.Ct. 350 (1994); *Contract Services Employee Trust v. Davis*, 55 F. 3d 533 (10th Cir. 1995).

<sup>264</sup> *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) (invalidating a law that required employers — even those with self-funded plans — to keep workers on the plan while they were out on workers' compensation.)

compensation law. Texas has developed a long line of unique cases dealing with various ramifications of this situation. South Carolina and New Jersey also have a unique approach to this issue. Cases from states such as New Jersey, South Carolina, and Texas, which have distinct approaches to this issue must be read very carefully before assuming that their holdings have relevance to any other state's laws.

Finally, it should be kept in mind that all of the issues involved in the determination of the status and the applicability of state regulation to a MEWA, entrepreneurial plan, labor union plan, or employee leasing arrangement applies in the workers' compensation context as well. An unlicensed insurer's spurious claim to be an ERISA plan may be uncritically accepted if the inquiry focuses too narrowly on questions such as "Can an ERISA plan satisfy the state's workers' compensation coverage requirement?" In fact, states with compulsory workers' compensation coverage laws may find that the employers that do not seek to qualify as authorized self-insurers may be less likely than other employers to incur the expense of establishing and maintaining a genuine ERISA plan.

***What is a voluntary employees' beneficiary association (VEBA)?***

A voluntary employees' beneficiary association (VEBA) is a tax-advantaged welfare benefits funding vehicle defined under the Internal Revenue Code (IRC).<sup>265</sup> Its operations are substantially devoted to providing for the payment of life, sick, accident, or other benefits to the VEBA's members and their dependents and beneficiaries. Membership in the VEBA is voluntary. Further, the net earnings of the association cannot inure to any private shareholder or individual other than from the payment of the benefits.<sup>266</sup>

Deleted:

The VEBA can be established in a number of forms, such as a trust or a corporation, organized under state law. The trust or corporation must exist independent of the member employees or their employer.<sup>267</sup> The employees are entitled to participate in the VEBA because of their employee status and because they have a common employment-related bond (such as covered by common employer or under one or more collective bargaining agreements or are members in a labor union).<sup>268</sup> The organization must be controlled by its membership, independent trustees, or trustees designated by, or on behalf of, the members.<sup>269</sup>

A VEBA may be, but is not always, associated with an employee welfare benefit plan under Title I of ERISA. To be an employee welfare benefit plan, a plan must be established or maintained by an employer or employee organization. A VEBA is not an employer association if it is not composed of related employers and does not meet other relevant criteria. A VEBA may not meet the definition of an employee organization either. The fact that a VEBA has been recognized under the Internal Revenue Code does

<sup>265</sup> 26 U.S.C. § 419(e)(3)(A) (Supp. 1996); 26 U.S.C. § 501(c)(9) (1985).

<sup>266</sup> 26 C.F.R. 1.501(c)(9)-1 (1996).

<sup>267</sup> 26 C.F.R. 1.501(c)(9)-2(c)(1) (1996).

<sup>268</sup> 26 C.F.R. 1.501(c)(9)-2(a)(1) (1996).

<sup>269</sup> 26 C.F.R. 1.501(c)(9)-2(c)(3) (1996).

## DRAFT 3-11-04

*ERISA: Guidelines for State and Federal Regulation*

not mean that it will be recognized as an employee organization under ERISA. IRC regulations clearly state that VEBAs are not coterminous with employee beneficiary associations within the meaning of ERISA.<sup>270</sup>

Further, a VEBA that is associated with an ERISA plan is likely to meet the definition of a MEWA plan unless the plan is offered by a single employer or offered pursuant to an agreement that is found to be a bona fide collectively bargained agreement.

### ***What is the difference between a Multiple Employer Trust (MET) and a Multiple Employer Welfare Arrangement (MEWA)?***

The phrases Multiple Employer Trust (MET) and Multiple Employer Welfare Arrangement (MEWA) are merely generic marketing phrases. An organization labeled a MET is subject to state regulation to the same extent as an organization labeled a MEWA.

### ***Is a state law that is used to regulate a MEWA preempted by ERISA?***

If the MEWA bears any risk (i.e., is a “not fully insured” MEWA), ERISA does not preempt state laws that regulate MEWAs. State laws that regulate MEWAs are applicable even if the MEWA is an ERISA-covered plan. If an ERISA-covered MEWA bears no risk (i.e., is a “fully insured” MEWA), states may regulate the financial solvency of the company holding the risk and enforce certain requirements, such as those relating to reserves and contributions, on the MEWA.

### ***What arrangements involving multiple employers that provide health benefits on a “self-funded” basis ease the administrative burden of providing those benefits?***

Employers that provide health benefits on a “self-funded” basis often ease the administrative burden of providing those benefits by contracting for third party administrative services. This is permitted if the money for each employer is kept completely separate from those of all other employers. If the money and/or claims are transferred and commingled, the arrangements are no longer “self-funded” and the entity holding the commingled funds must be licensed as an insurer. A pooling of risk of loss or commingling of assets to pay such losses is the essence of insurance. Unrelated employers (employers not under common control or operating pursuant to a bona fide collective bargaining agreement) that “pool” their resources have formed a MEWA and are subject to state insurance law.

Deleted: which

### ***If a not “fully insured” MEWA covers some employees in a state, but the employers are located in another state, does the state in which the MEWA covers some employees still have the authority to regulate the MEWA?***

Whether a state has authority to regulate a MEWA that covers employees in a state when the employers are located in another state depends upon the laws of the state seeking to

<sup>270</sup> 26 C.F.R. 1.501(c)(9)-7 (1996).

## **DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

apply its laws. ERISA does not preempt a state's insurance laws, including those that require an insurance company to be licensed in your state irrespective of the location of the employers and employees.

### ***Is the term “fully insured” defined in ERISA?***

Yes, 29 U.S.C. §1144(b)(6)(D) states, “For purposes of this paragraph, 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.”<sup>271</sup>

Legal Analysis: The term “benefit” when used in ERISA “uniformly refers only to payments due the plan participants or beneficiaries.”<sup>272</sup> Accordingly, 29 U.S.C. §1144(b)(6)(D) requires that to be “fully insured” a MEWA must have a contract or policy of insurance, which guarantees payment of benefits to the plan participants. A MEWA or trust is not “fully insured” if it has an insurance contract or policy which obligates the insurer only to make payments to the MEWA or trust.

The literal language of the statute and the legislative history strongly suggest that only an insurance contract or policy that directly obligates the insurer to the plan participants constitutes “fully insured.” This protects the participant from the consequences of defenses that arise between the insurer and the MEWA; avoids lengthy delays in claims payments while a receiver for a MEWA attempts to collect on the insurance contract or policy; marshals assets; and ensures claims of participants will be 100-percent paid.

Both judicial decisions and DOL opinions support this literal interpretation of the language and the legislative history of the statute. In *Bone v. Ass'n Mgt. Services, Inc.*,<sup>273</sup> the court pointed out that an insurer which has issued a stop-loss policy was obligated only to make payments to the employee benefit plan itself, and not to plan participants. The court concluded the plan was not an insured plan under the “deemer” clause. Similarly, the United States Department of Labor has issued an advisory opinion that states a MEWA is not fully insured solely because it has a stop-loss policy.<sup>274</sup> In an opinion issued to the Connecticut Commissioner of Insurance on an arrangement involving United Service Association for Health Care, the Department of Labor considered, and rejected, the contention that an insurance contract directed solely to a trust or arrangement renders the trust or MEWA “fully insured”. The Department concluded that an insurance contract creating only an obligation to the trust fails to “guarantee” directly the benefits of the participants. Also, the Department reiterated that “the question whether a MEWA is fully insured arises only if the arrangement constitutes

---

<sup>271</sup> See Department of Labor Opinion 93-11A re: *Associated Builders and Contractors* (April 15, 1993).

<sup>272</sup> *Mack Boring and Parts v. Meeker Sharkey Moffitt*, 930 F.2d 267, 273 (3d Cir. 1991).

<sup>273</sup> *Bone v. Ass'n Mgt. Services, Inc.*, 632 F. Supp. 493 (S.D. Miss. 1986).

<sup>274</sup> Department of Labor Opinion 91-05A re: *AGC Health Benefit Trust* (January 14, 1991).

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

an “employee welfare benefit plan” covered by ERISA.”<sup>275</sup> Finally, note the literal language of 29 U.S.C. §1144(b)(6)(D), which states that a MEWA is “fully insured” only if the Secretary of Labor so determines.

***May a state insurance department subpoena an ERISA plan’s books and records or conduct and charge for a financial examination?***

A state insurance agency can subpoena an organization’s records or conduct and charge for a financial examination in accordance with its express and implied legislative authority. Because states do not have regulatory authority over single employer plans and multiemployer plans, a state insurance agency does not have authority to subpoena those plan’s records or conduct and charge for a financial examination. However, states do have authority to regulate plans that are MEWAs. State insurance departments, consequently, are authorized to subpoena MEWA plans consistent with the scope of the express and implied powers for insurance regulation granted by the legislature and subject to constitutional requirements.

***Can managed care organizations that are sponsored by providers and that accept insurance risk from ERISA plans be required to obtain an insurance license and be otherwise regulated under state insurance laws?***

<sup>275</sup> Department of Labor Opinion 94-07A re: *United Service Association for Health Care* (March 14, 1994).

<sup>284</sup> For a broader discussion on other possible risk-sharing arrangements see NAIC’s white paper, *The Regulation of Health Risk-Bearing Entities*, developed by the Risk-Bearing Entities Working Group of the State and Federal Health Insurance Legislative (B) Policy Task Force in 1996.

**Deleted:** Are benefits sponsored by employee leasing companies exempt from state regulation because they are plans covered under ERISA if the employee leasing company claims that the arrangement is “self-funded” for all the leased employees?<sup>¶</sup>  
Whether a benefit arrangement sponsored by an employee leasing company is exempt from state regulation because state law is preempted under ERISA depends upon whether the employee leasing company’s arrangement is an ERISA-covered single-employer plan or a MEWA.<sup>¶</sup>  
**Legal Analysis:** If the employee leasing company is the actual common law employer of all of the individuals under the arrangement and the benefit arrangement constitutes an ERISA plan, then it is a single employer plan and exempt from state laws under ERISA. The employee leasing organization may also be considered a single employer if the employee leasing company and its clients are under common control. If, however, any of the individuals covered under the benefit arrangement is an employee of one of the organizations that is leasing the employees (that is not under common control with the employee leasing company), then the employee leasing company’s benefit arrangement is a MEWA and not exempt from sta... [3]

**Deleted:** <sup>¶</sup>  
<#>the hiring party’s right to control the manner and means by which the product is accomplished;<sup>¶</sup>  
<#>the skill required;<sup>¶</sup>  
<#>the source of the instrumentalities and tools;<sup>¶</sup>  
<#>the duration of the relationship between the parties;<sup>¶</sup>  
<#>the location of the work;<sup>¶</sup>  
<#>the right of the hiring party to assign additional projects to the hired party;<sup>¶</sup>  
<#>the extent of the hired party’s discretion over when and how long to work;<sup>¶</sup>  
<#>the method of payment;<sup>¶</sup>  
<#>the hired party’s role in hiring and paying assistants;<sup>¶</sup>  
<#>whether the work is part of the regular business of the hiring party;<sup>¶</sup>  
<#>whether the hiring party is in business;<sup>¶</sup>  
<#>the provision of employee benefits; and;<sup>¶</sup>  
<#>the tax treatment of the hired party.<sup>277 ¶</sup>  
<sup>¶</sup>  
The Court emphasized the fact-specific nature of the inquiry. None of the factors cited above are decisive and each must be weighed.<sup>278 ¶</sup>  
<sup>¶</sup>  
In an opinion letter to the Virginia... [4]

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

To the extent that such an organization assumes insurance risk through the receipt of a prepayment from a purchaser for the delivery or the arrangement of the delivery of health care benefit services, it is subject to state insurance laws.

Legal Analysis: The nature of the business of insurance has changed dramatically over the past several decades. The market dominance of traditional commercial indemnity insurers and Blue Cross and Blue Shield plans has been eclipsed by the dramatically increased market share of managed care plans. Managed care plans contract with the policyholder — individuals, employers, or other groups — to deliver or facilitate the delivery of health care services. In the contract, the managed care organization may also assume the insurance risk associated with the cost of providing health care benefits, or may arrange for some other entity to assume that risk.

Health maintenance organizations (HMOs) are the most prominent form of managed care organization, which assumes an individual’s, employer’s, or other group’s insurance risk. Recently, employers have begun to focus more on relationships with managed care organizations that are sponsored by providers. The organization may assume insurance risk in the process of delivering or facilitating the delivery of health care services.

Not all contractual transactions between employers and managed care organizations involve insurance risk. The distribution of risk must be an essential characteristic of the transaction in order to invoke the issues that insurance regulation is designed to address. Premium payment mechanisms through which employers transfer and distribute their risk to managed care organizations include arrangements, such as capitation, whereby the managed care organization is paid a fixed payment per member per month to cover the cost of all or some of the employee’s health care.<sup>284</sup>

Whether a state law that is applied to managed care organizations is preempted by ERISA depends upon if that state law “relates to” an ERISA plan, and if so, if the law is “saved” as an insurance regulation. Laws that explicitly reference ERISA plans or that involve substantive ERISA requirements may “relate to” ERISA plans. Some laws that indirectly affect ERISA plans may “relate to” ERISA plans as well. However, in *New York Blue Cross Plans v. Travelers*,<sup>285</sup> the Court recently held that a statute which has an indirect economic influence that does not bind plan administrators to any particular choice, or preclude administrative practices or the provision of uniform interstate benefit packages, is not connected with employee welfare benefit plans and does not “relate to” such plans. A state law that imposes such high costs on plans that the law restricts an ERISA plan’s choice of available insurers or forces an ERISA plan to adopt a certain scheme of coverage, may be held to “relate to” the ERISA plan.<sup>286</sup>

Deleted: which  
Deleted: which  
Deleted: which

While ERISA prohibits states from regulating employee welfare benefit plans, it does not prohibit states from regulating the business of insurance or insurance contracts. In *Metropolitan Life v. Massachusetts*,<sup>287</sup> the Supreme Court held that a state law that

Deleted: which

<sup>285</sup> 115 S.Ct. 1671 (1995).

<sup>286</sup> *Id.* at 1683.

<sup>287</sup> 471 U.S. 724 (1985).

## DRAFT 3-11-04

ERISA: Guidelines for State and Federal Regulation

mandated that insurers cover certain mental health benefits was saved from ERISA preemption.<sup>288</sup> The Court based its analysis on the test developed under the McCarran-Ferguson Act to determine whether an entity was engaged in the business of insurance:

- (1) Whether the practice has the effect of transferring or spreading a policyholder's risk;
- (2) Whether the practice is an integral part of the policy relationship between the insurer and the insured; and
- (3) Whether the practice is limited to entities within the insurance industry.

The Court held that the state statute was saved because the law regulated the spreading of risk; regulated an integral part of the policy relationship between the insurer and the insured; and applied only to entities within the insurance industry.<sup>289</sup>

When a managed care organization has assumed insurance risk on behalf of an employer to deliver health care benefit services, it is involved in the business of insurance, whether the organization is sponsored by providers or not. Under an arrangement such as capitation, the employer has transferred its risk associated with the cost of providing health care benefits to the organization. In turn, the organization distributes the employer's risk. Even if the employer states that it continues to retain the enrollee participant's risk, under a capitated (or similar risk-sharing) arrangement the organization still accepts the employer's risk. And, the employee receives benefits directly from the organization pursuant to the insurance risk arrangement. The capitated payment is an integral part of the relationship between the insurer and the insured. Further, the practice of assuming a policyholder's health insurance risk is limited to entities within the insurance industry. Under *Metropolitan*, a state statute which regulates the spreading of risk, governs some integral part of the relationship between the insurer and the insured, and is applied only to entities within the insurance industry is saved from ERISA preemption.

The arrangement between the employer and the managed care organization sponsored by providers is not substantively different from the arrangements employers enter into with HMOs that are not sponsored by providers. Regulators should be aware, however, that a few state courts have held that HMOs are not engaged in the business of insurance.<sup>290</sup> Courts place significant weight on how a state's laws classify an entity's activities.<sup>291</sup> States should become familiar with the case law on this subject involving HMOs and should be careful to classify as the business of insurance all insurance arrangements ~~that~~ involve the purposes of insurance regulation.

Deleted: which

---

<sup>288</sup> *Id.* at 743.

<sup>289</sup> *Id.* at 743. It should be noted that an arrangement need not meet all three of these criteria to be determined to be in the business of insurance. See *Union Labor Life v. Pireno*, 458 U.S. 119,129 (1982).

<sup>290</sup> See *New York State Health Maintenance Organization Conference v. Curiale* 18 Employee Benefit Cas. (BNA) 1446 (S.D.N.Y. 1994) rev'd on other grounds, 64 F.3d 794 (2d Cir. 1995); but see *Anderson v. Humana*, 24 F.3d 889 (7th Cir. 1994).

<sup>291</sup> See *In the Matter of Estate of Medicare HMO*, 998 F.2d 436 (7th Cir. 1993); *In re Family Health Services*, 143 B.R.. 232 (1992).

***To what extent may states regulate third party administrators (TPAs) ~~that~~ provide administrative services to ERISA plans?***<sup>292</sup>

Deleted: which

The case law reviewing statutes that regulate TPAs is minimal. Of the few cases ~~that~~ involve state statutes ~~that~~ directly regulate third party administrators of ERISA plans, the majority of the courts have held that such statutes are preempted by ERISA. At least one court has upheld a TPA licensing statute that established minimal criteria. However, the analysis used in existing case law may be altered by the analysis used by the Supreme Court in *N.Y.S. Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*<sup>293</sup>

Deleted: which

Deleted: which

*Legal Analysis:* While the weight of the limited existing case law in this area is that state statutes that regulate third party administrators of ERISA plans are preempted by ERISA, these cases were decided prior to the *Travelers* opinion. In *Travelers*, the Court held that an indirect economic burden on plans through taxing entities that provide services that are benefits under plans is not a sufficient connection to trigger preemption if imposing it does not bind plan administrators to any particular choice or preclude uniform administrative practices. State regulatory schemes related to third party administrators that are broad in scope and indirectly affect ERISA plans may survive an ERISA preemption analysis under *Travelers*.

Prior to the consideration of *Travelers* by the Supreme Court, at least one court permitted licensing of TPAs of self-funded ERISA plans. This court applied an analysis similar to but not as broad as the analysis used in the *Travelers* opinion. In *Benefax Corporation v. Wright*,<sup>294</sup> the TPA's motion for summary judgment was denied in an action for declaratory and injunctive relief from application of the Kentucky state insurance department's administrator licensing statute. The Kentucky statute at issue in that case requires that administrators, as defined by the statute, meet minimal eligibility criteria related to age, competency and reputation, level of financial responsibility, and education. The administrator must also have paid the established fee and have not had a previous license or application terminated for cause.<sup>295</sup>

The court rejected the TPA's argument that the state statute was preempted by ERISA and thus, the Commissioner lacked the authority to mandate a license as a requirement to conduct business in the state. The court held that ERISA did not preempt the state licensing statute. It reasoned that the statute did not "relate to" ERISA plans since the law applied to administrators irrespective of the type of plans they serviced (ERISA or non-ERISA). The court also explained that, even if the statute related to an ERISA plan in

---

<sup>292</sup> This discussion on TPAs relates to non-risk arrangements. To the extent that a contract involves the TPA assuming insurance risk on behalf of an employer, this analysis does not apply.

<sup>293</sup> *New York Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671 (1995).

<sup>294</sup> *Benefax Corporation v. Wright*, 757 F. Supp. 800 (W.D. Ky. 1990).

<sup>295</sup> K.R.S. 304.9-052.

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

some respect, it fell within the 'tenuous, remote and peripheral' exception of the ERISA preemption created by the Supreme Court in *Shaw v. Delta Air Lines*.<sup>296</sup>

Other cases, however, held that state laws relating to third party administrators of ERISA-covered plans are preempted. These cases involved more significant requirements than the Kentucky statute at issue in *Benefax*. In *Self-Insurance Institute of America v. Gallagher*,<sup>297</sup> the court held that Florida statutes, which regulated plan administrators were preempted by ERISA since the laws did not regulate the business of insurance. In *Gallagher*, the Self-Insurance Institute of America (SIIA) objected to a series of state statutes that imposed various requirements upon contract administrators of ERISA employee benefit plans. Among other things, the regulations required that administrators enter into written agreements and identified what must be contained within such agreements. The regulations also required that administrators pay a bonding fee, obtain a certificate of authority to conduct business, and file extensive organizational and financial information.

Deleted: which

SIIA asserted that the Florida statute that governed activities of SIIA members was preempted by ERISA. The state argued that the statute regulated insurance and therefore was not preempted by ERISA. The Eleventh Circuit affirmed, without opinion, the district court's holding that the state's law did not regulate the business of insurance. Consequently, the administrative requirements imposed on employer/plan sponsors or contract administrators of ERISA plans, were preempted by ERISA.

Deleted: which

In *E-Systems, Inc. v. Pogue*,<sup>298</sup> the appeals court upheld a district court opinion which granted summary judgment to plan sponsors challenging the Texas Administrative Services Tax Act (ASTA), enjoined further enforcement of the statute as it applied to ERISA plans, and held that the act was preempted by ERISA. The ASTA placed a 2.5 percent annual tax on persons receiving administrative and service fees for services provided to what are essentially ERISA plans. The state claimed that the district court did not have the jurisdiction to enjoin a tax statute under circumstances where the state courts could evoke an efficient remedy under the Tax Injunction Act. The appeals court dismissed this reasoning and held that it was Congress' intent that any law that contradicted ERISA, including state tax law, was preempted by the federal statute.

In *NGS American, Inc. v. Barnes*,<sup>299</sup> the court held that a Texas statute that indirectly regulated ERISA plans by regulating and taxing third party administrators of such plans was preempted by ERISA and granted plaintiff's motion for summary judgment. The state argued that regulation of the administrators was permissible in this case because the administrators were engaged in the business of insurance. The court responded that the administrators were not engaged in the business of insurance and that the law at issue "related to" the plan. In *NGS*, the court distinguished *Benefax* as a "mere licensing

<sup>296</sup> *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).

<sup>297</sup> *Self-Insurance Institute of America v. Gallagher*, 11 Employee Benefits Cas. (BNA) 2162 (N.D. Fla. 1989), aff'd 909 F.2d 1491 (11th Cir. 1990).

<sup>298</sup> *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir. 1991).

<sup>299</sup> *NGS American, Inc. v. Barnes*, 805 F.Supp. 462 (W.D. Tex. 1992).

statute,” since the Texas statute’s scope was considerably broader, incorporating a TPA tax and bonding requirement.

The appeals court affirmed the district court’s grant of summary judgment in *NGS American, Inc. v. Barnes*.<sup>300</sup> It agreed that the administrators did not conduct the business of insurance, and therefore, the statute did not regulate the business of insurance. Further, the appeals court agreed with the district court’s finding that the Texas statute was more than a mere licensing statute, unlike the statute at issue in *Benefax*. The Texas statute, insofar as it regulated administrators of ERISA-covered plans, because of its intrusive nature, impermissibly “related to” ERISA plans, and thus, violated the Supremacy Clause of the United States Constitution.

In *Self-Insurance Institute of America v. Korioth*,<sup>301</sup> the state of Texas did not appeal the district court's holding that ERISA preempted the state law imposing a maintenance tax on contract administrators of ERISA plans in light of the court’s ruling in *NGS*. The state did, however, successfully appeal the district court's award of attorneys' fees and the refund of taxes and fees paid by ERISA plans and administrators. The appeals court held that the association had standing with respect to seeking an injunction, but no standing with respect to the award of refunds and attorneys' fees. The court stated that the individual participation of association members would be needed to determine which association members were due the refunds since many members administered both ERISA and non-ERISA-covered plans.

The Supreme Court in the *Miller* opinion, which is not a case addressing ERISA preemption of TPAs directly, does include a footnote that addresses whether a law that applies to HMOs that act as administrators of self-funded plans is still an “insurance law” within the meaning of ERISA’s saving clause. The Petitioners argued that Kentucky’s “any willing provider” law was not a law that regulated insurance with in the meaning of ERISA’s saving clause because it was not “specifically directed at the insurance industry” because it applied to HMOs not acting as insurers, but as administrators of self-funded plans. The Court stated that this argument was not persuasive because “noninsuring HMOs would be administering self-insured plans, which we think suffices to bring them within the activity of insurance for purposes of [ERISA’s saving clause].” Some may argue that this language gives states permission to regulate TPAs without fear of ERISA preemption. However, this language must be viewed in the context of the entire *Miller* opinion, as well as the rest of ERISA, and clearly, ERISA’s deemer clause prevents states from enacting laws that have the effect of regulating self-funded ERISA plans.

Formatted

Formatted

It does not appear that the *Miller* opinion has shed any light on the analysis for determining whether a state law regulating TPAs is preempted by ERISA. The status of

**Deleted:** Only a few cases exist which speak to the validity of state statutes that regulate TPAs of ERISA plans. While some minimum level of state regulation such as that considered by the *Benefax* court was not subject to federal preemption, the existing cases are not sufficient to establish a firm understanding of the law on this topic. Moreover, all of these cases are subject to revision given the Supreme Court’s *Travelers* opinion. Consequently, the law in this area remains unclear.

<sup>300</sup> *NGS American, Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993).

<sup>301</sup> *Self-Insurance Institute of America v. Korioth*, 53 F.3d 694 (5th Cir. 1995).

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

the law remains unclear, and any preemption analysis is going to be particular to the details of a state's law. Overall, states should be mindful of this Court's opinion in *Travelers*, and draft laws that minimize the potential burden on self-funded ERISA plans. State laws that apply broadly and are not overly burdensome should not be preempted.

GLOSSARY

1. COLLECTIVE BARGAINING AGREEMENT means an agreement between an employer and a labor union that regulates the terms and conditions of employment. See Black's Law Dictionary.
2. CONTRIBUTIONS means premiums, contributions or any other sums collected to pay health and welfare benefits whether paid by an employer or an employee.
3. EMPLOYEE means a person who works for salary or wages, under the control and direction of an employer. See 29 U.S.C. §1002(6).
4. EMPLOYEE ORGANIZATION means a labor union or other organization representing employees concerning employment benefits. See 29 U.S.C. §1002(4).
5. EMPLOYEE WELFARE BENEFIT PLAN means a plan, fund or program established or maintained to provide health care or other employment benefits to employees. See 29 U.S.C. §1002(1).
6. EMPLOYER means a person who employs or hires other persons and who controls their performance and pays their salaries or wages. See 29 U.S.C. §1002(5).
7. INSURANCE SERVICE ORGANIZATION means a type of medical service corporation or other entity assuming any risk of loss for benefits to be paid and qualified to conduct business in a state.
8. LABOR ORGANIZATION means an organization described in 29 U.S.C. §1002(5) in which employees participate for the purposes described in that provision. See 29 U.S.C. §§151 to 186, inclusive.
9. MULTIPLE EMPLOYER PLAN means a plan maintained pursuant to collective bargaining agreements between one or more employee organizations and more than one employer and to which more than one employer is required to contribute. See 29 U.S.C. §1002(37)(a).
10. MULTIPLE EMPLOYER TRUST (MET) is a generic term used to market several types of health and welfare plans which may or may not be: (a) subject to ERISA; or (b) insured or self-funded.
11. MULTIPLE EMPLOYER WELFARE ARRANGEMENT (MEWA) means a plan, established by two or more employers to offer health and welfare benefits to their employees, but does not include arrangements

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

- established pursuant to bona fide collectively bargained agreements or a rural electric cooperative. See 29 U.S.C. §1002(40)(a).
12. PLAN means a written document or trust fund, a method or action, procedure or arrangement. It is not a person or corporation.
  13. SECRETARY means the Secretary of Labor. See 29 U.S.C. §1002(13).
  14. TAFT-HARTLEY TRUST means a trust established by a labor organization, pursuant to 29 U.S.C. §186(c)(5), to receive payments made by employers for benefits described in that statute. See 29 U.S.C. §§151 to 186, inclusive.
  15. UNION means an organization, association or group of employees joined together to resolve grievances with employers or to review rights of employees related to employers.
  16. WELFARE PLAN means an employee welfare benefit plan.

APPENDIX A

CONSUMERS BEWARE—ILLEGAL “ERISA” AND “UNION PLAN” SCAMS

Deleted: ¶

If it seems too good to be true, it probably is. Nationwide, the health insurance marketplace is facing tougher times. The cost of health insurance is rising. Criminals, seeking to make a profit by selling fraudulent health insurance, claim that state insurance laws don’t apply. These entities recruit insurance agents to sell “ERISA plans” or “union plans” falsely claimed to be exempt from state law.

Legitimate ERISA plans (plans governed by the federal Employee Retirement Income Security Act of 1974) and union plans may be exempt from state insurance regulation, which is why criminals try to fool people by making these claims. However, legitimate ERISA or union plans are established by unions for its own members or by an employer for the employer’s own employees. They are not sold by insurance agents.

Consumers and employers should take care to ask their agents whether the health coverage they are purchasing is fully insured by licensed insurers. A “union plan” sold by an agent, health coverage that seems unusually “cheap,” health coverage that is issued with few questions about the applicant’s health condition, or plan material that refers only to a “stop-loss” insurer should alert a consumer to question the selling agent or contact the state insurance department.

A typical fraudulent health insurance scam attempts to recruit as many local insurance agents as possible to market the coverage. The health coverage is not approved by the state insurance department. Agents are told it is regulated by federal, not state law. In fact, it is totally illegal. The coverage is typically offered regardless of the applicant’s health condition and at lower rates and with better benefits than can be found from licensed insurers. The scam seeks to collect a large amount of premium as rapidly as possible. While claims may be paid initially, the scam will soon begin to delay payment and offer excuses for failure to pay. Unsuspecting consumers who thought they were covered for their medical needs are left responsible for huge medical bills. Employers may be liable for the medical bills of their employees as well.

How can the average consumer avoid becoming the next victim? Be suspicious, ask hard questions and do your homework. Read all materials and scrutinize websites carefully. Most insurance agents will reject these scams but some are selling them:

- Coverage that boasts low rates and minimal or no underwriting should be a signal to look deeper.
- Make sure that your insurance agent is selling you a state licensed insurance product. If an insurance agent is trying to sell you a union plan, contact the [state department of insurance].

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

- Deal with reputable agents. If the person trying to sell you the coverage says he or she doesn't need a license because the coverage isn't insurance or is exempt from regulation, watch out. Contact your insurance department if you have any questions.
- Ask your agent for the name of the insurer and check the benefit booklet you receive to see whether it names a licensed insurer that is fully insuring the coverage.
- If your agent or the marketing material says that the plan is covered only by "stop loss insurance" or that the plan is an "ERISA" plan or "union" plan, call the [state insurance department.]

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

In sum: if you suspect that an insurance agent is trying to sell you fraudulent health insurance, contact your state department of insurance right away.

**AGENTS BEWARE—ILLEGAL “ERISA” AND “UNION PLAN” SCAMS**

Nationwide, the health insurance marketplace is facing tougher times. Across the country, the cost of health insurance is increasing and consumers cope with difficult choices. Into this climate enter shady operators seeking to take advantage of consumers. Calling themselves “ERISA exempt,” “ERISA plans,” “union plans,” “association plans,” or some variation thereof, these entities boast low rates and minimal or no underwriting.

Remember, if it seems too good to be true, it probably is. There is a good chance that these entities are not legitimately exempt from state laws, but instead are offering unlicensed health insurance.

These entities claim that they are not subject to state insurance regulation because of “ERISA.” Some claim that agents are used only as “labor consultants” or “business agents” to “enroll” or “negotiate” with potential members, and not to sell. Such claims should be viewed with skepticism. It is a crime to solicit or sell an unauthorized insurance product.

Legitimate ERISA plans (plans governed by the federal Employee Retirement Income Security Act of 1974) and union plans may be exempt from state insurance regulation, which is why criminals try to fool people by making these claims. However, legitimate ERISA or union plans are established by unions for its own members or by an employer for the employer’s own employees. They are not sold by insurance agents.

Read all materials and websites carefully. Consider the following list of some circumstances and plan characteristics that should prompt your very careful investigation, including contacting the insurance department:

- The plan operates like insurance but claims that it is not. ← --- **Formatted: Bullets and Numbering**
- You are asked to avoid certain insurance terminology, even though the plan operates like insurance. ← --- **Formatted: Bullets and Numbering**
- The plan is covered only by “stop loss insurance” or refers to “reinsurance.” ← --- **Formatted: Bullets and Numbering**
- You are asked to sell an “ERISA” plan or “union” plan. ← --- **Formatted: Bullets and Numbering**
- You are asked to sell an “employee leasing” arrangement with self-funded health coverage. ← --- **Formatted: Bullets and Numbering**
- The plan targets individuals or groups with employees that have pre-existing conditions. ← --- **Formatted: Bullets and Numbering**

**DRAFT 3-11-04**

*ERISA: Guidelines for State and Federal Regulation*

- The plan advertises unusually low premiums and/or unusually generous benefits, low (or no) minimum requirements for participation, and loose (or no) underwriting guidelines.

Insurance agents should contact the [state department of insurance] anytime they are approached by an entity that seems suspicious. If you are asked to sell health coverage and it is represented as exempt from insurance regulation under “ERISA” or as a “union” it is probably illegal. The insurance agent who does not inform the insurance department takes an enormous risk. An agent who fails to report, and sells, an “ERISA” or “union” plan should expect to lose his or her license, to possibly be subject to criminal prosecution and to face personal liability for any claims incurred under the unlicensed coverage.

[optional final paragraph]

Anyone with information about an entity offering health coverage without a state license should contact [state insurance department contact information].

w:\Mar04\Cmte\B\wg\ERISA\ERISA HANDBOOK REVISIONS 3-11.doc

Formatted

The union itself usually is not associated with a recognizable trade or industry (e.g., carpenters, auto workers), but instead is titled with terms such as “amalgamated,” “consolidated,” or “united.”

Finally, other entities known as Voluntary Employee Beneficiary Associations or VEBAs are also typically MEWAs unless they are established pursuant to a bona fide collective bargaining agreement, or cover employees of only one employer. A VEBA can qualify as a tax exempt organization under Internal Revenue Code § 501(c)(9), which provides health benefits to employees with an employment-related common bond within a certain geographical area.

*Are benefits sponsored by employee leasing companies exempt from state regulation because they are plans covered under ERISA if the employee leasing company claims that the arrangement is “self-funded” for all the leased employees?*

Whether a benefit arrangement sponsored by an employee leasing company is exempt from state regulation because state law is preempted under ERISA depends upon whether the employee leasing company’s arrangement is an ERISA-covered single-employer plan or a MEWA.

Legal Analysis: If the employee leasing company is the actual common law employer of all of the individuals under the arrangement and the benefit arrangement constitutes an ERISA plan, then it is a single employer plan and exempt from state laws under ERISA. The employee leasing organization may also be considered a single employer if the employee leasing company and its clients are under common control. If, however, any of the individuals covered under the benefit arrangement is an employee of one of the organizations that is leasing the employees (that is not under common control with the employee leasing company), then the employee leasing company’s benefit arrangement is a MEWA and not exempt from state laws under ERISA.

The presence of the employer-employee relationship depends upon the specific circumstances of the case. In *Nationwide Mutual Ins. Co. v. Darden*,<sup>1</sup> the Supreme Court held that federal common law principles of employment govern the definition of employee contained in ERISA. The following factors were noted for consideration in the Court’s common law test for the existence of an employer-employee relationship:

- the hiring party’s right to control the manner and means by which the product is accomplished;
- the skill required;
- the source of the instrumentalities and tools;
- the duration of the relationship between the parties;
- the location of the work;

---

<sup>1</sup> *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318 (1992).

the right of the hiring party to assign additional projects to the hired party;  
the extent of the hired party's discretion over when and how long to work;  
the method of payment;  
the hired party's role in hiring and paying assistants;  
whether the work is part of the regular business of the hiring party;  
whether the hiring party is in business;  
the provision of employee benefits; and,  
the tax treatment of the hired party.<sup>2</sup>

The Court emphasized the fact-specific nature of the inquiry. None of the factors cited above are decisive and each must be weighed.<sup>3</sup>

In an opinion letter to the Virginia Department of Insurance, the Department of Labor evaluated whether the health benefit program offered by the employee leasing company, Employers Resource Management Company, Inc. (ERM), constituted a single employer plan or a MEWA. The DOL concluded that the arrangement was a MEWA under the facts as presented. The Department noted several non-exclusive factors which it considers when making this determination, including who has the right to control and direct the individual who performs the services, the result to be accomplished, the means by which it is accomplished, and the right to discharge the individual performing the services. The Department also stated that the payment of wages, taxes, and provision of benefits do not in and of themselves establish an employer-employee relationship.<sup>4</sup>

An example of an analysis of an employee leasing company's relationship to the leased worker can be found in *Professional & Executive Leasing Inc. v. Commissioner*. In that case, the Ninth Circuit affirmed the United States Tax Court's holding that the employee leasing company was not the employer of the worker.<sup>5</sup> At issue in the case was whether the employee leasing company's pension and profit-sharing plan met certain qualification requirements under the tax code. The court found that it did not because it included persons who were not employees of the employee leasing company. The tax court analyzed the nature of the arrangement between the employee leasing company, the worker, and the recipient company in the context of common law principles and I.R.S. regulation. The court reviewed some of the factors which are considered in determining whether an employment relationship exists. Notably, it stated that while no particular factor is determinative, the most fundamental factor is whether the recipient company can control the activities of the worker.<sup>6</sup> The Circuit Court further noted that the employer need not have actually controlled the worker, it was only important that the employer had

---

<sup>2</sup> *Id.* at 323-324.

<sup>3</sup> *Id.* at 324.

<sup>4</sup> Department of Labor Opinion 93-29A re: *Employers Resource Management Company, Inc.* (October 22, 1993).

<sup>5</sup> *Professional & Executive Leasing Inc. v. Commissioner, Internal Revenue Service*, 862 F.2d 751 (9th Cir. 1988).

<sup>6</sup> *Professional & Executive Leasing Inc. v. Commissioner of Internal Revenue*, 89 T.C. 225 (1987).

the authority to do so.<sup>7</sup> In this case, the court said that the employee leasing company had minimum control over the worker, did not control the details of what work was to be performed, or when and how it was to be performed, did not invest in the work facilities or equipment, did not experience profit or loss associated with the worker except for the leasing fees received, and merely performed a bookkeeping or payroll function.<sup>8</sup> Consequently, the employee leasing company was not the employer of all of the workers covered under the arrangement.

If the employee leasing company can meet the high threshold requirements for establishing that it is the employer of all of the individuals covered under the arrangement, then the employee leasing company's benefit arrangement is exempt from state regulation. Absent such a finding, the employee leasing company is a MEWA and subject to state regulation.

---

<sup>7</sup> 862 F. 2d at 753.

<sup>8</sup> 89 T.C. at 233-34.