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

Guidelines for State and Federal Regulation
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ERISA Working Group of the Health Insurance and Managed Care (B) Committee

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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.

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INTRODUCTION

The Employee Retirement Income Security Act of 1974 (ERISA)1 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.2

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.3

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.4 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.

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?

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1 Public Law 93-406, codified at 29 U.S.C. § 1001 et seq. (2004). 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.”
2 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 “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) (2004).
3 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.
4 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.
2. Does the state law “relate to” the ERISA plan?\(^5\)
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?\(^6\)
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?\(^7\)

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.\(^8\) 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 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 contains a number of appendices that include various regulatory alerts, the Department of Labor Form M-1, an NAIC model law, Department of Labor (DOL) advisory opinion letters,\(^9\) and key U.S. Supreme Court cases.

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5 29 U.S.C. § 1144(a) (2004). 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) (2004).
6 29 U.S.C. § 1144(b)(2)(A) (2004). 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).
8 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.
9 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.

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

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. 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.”

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

♦ 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 relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.”

13 FMC, 498 U.S. at 64.
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.\textsuperscript{15} 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.”\textsuperscript{16} 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.”\textsuperscript{17}

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.\textsuperscript{18} 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.”\textsuperscript{19} 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.”\textsuperscript{20} 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 regulation by the entities.”\textsuperscript{21} 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 (MEWAs).

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 federal court where cases usually are dismissed on the grounds of preemption.

\begin{itemize}
\item \textsuperscript{15} 29 U.S.C. § 1002(1) (2004).
\item \textsuperscript{17} 29 U.S.C. § 1002(4) (2004).
\item \textsuperscript{18} 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”].
\item \textsuperscript{19} Id. at 10.
\item \textsuperscript{20} Id. at 11.
\item \textsuperscript{21} Id.
\end{itemize}
The Saving Clause

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.”22 In other words, ERISA generally does not prohibit states from applying state insurance laws to entities engaged in the business of insurance.

The “saving clause” is consistent with the McCarran-Ferguson Act,23 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 to alter, amend, modify, invalidate, impair, or supersede any law of the United States ... or any rule or regulation issued under any such law.”24 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 purpose 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....”25

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

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§ 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.


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entities with which the employee welfare benefit plan has contracted to purchase insurance for its employees.

**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.”

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 result 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*[^26], when it announced a “clean break” from the tests 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 (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.[^27]

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.”[^28] The Human Rights statute prevented employers from structuring their employee benefit plans in a discriminatory fashion on the basis of pregnancy. The

[^28]: *Id.* at 96-97.
Disability Benefits statute required employers to include certain benefits in their employee welfare benefit plan.29

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.30 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.”31

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.32

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.”33 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.34

**METROPOLITAN LIFE INS. CO. v. MASSACHUSETTS,**

*471 U.S. 724 (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.35 The Commonwealth did claim, however, that the law regulated the business of insurance, and thus, was saved from ERISA preemption.36

In its analysis, the Court highlighted that ERISA does not distinguish between “traditional and innovative insurance laws.”37 Further, the Court noted that “[t]he presumption is against preemption, and

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29 Id. at 97.
30 Id. at 98.
31 Id. at 100 n. 21.
32 Id. at 103-04.
33 Id. at 106; See 29 U.S.C. § 1003(b)(3) (2004).
34 Id. at 107-08.
36 Id. at 733.
37 Id. at 741.
we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope.”\textsuperscript{38} The Court also noted that Congress did not intend to preempt areas of traditional state regulation.\textsuperscript{39}

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.\textsuperscript{40} 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.’”\textsuperscript{41} 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.’”\textsuperscript{42} The Court reviewed the McCarran-Ferguson “reverse preemption” cases as an aid to determine if a practice is the “business of insurance”:\textsuperscript{43}

\begin{enumerate}
\item Does the practice have the effect of “spreading a policyholder’s risk”?
\item Is the practice an “integral part of the policy relationship between the insurer and the insured”?
\item Is the practice “limited to entities within the insurance industry”?
\end{enumerate}

The Supreme Court opinion that established this three-pronged test, \textit{Union Labor Life v. Pireno}\textsuperscript{44}, specifically stated 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.\textsuperscript{45}

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

\begin{enumerate}
\item 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;
\item The law directly regulated an integral part of the relationship between the insurer and the policyholder;
\item The law met the third prong because it only imposed requirements on insurers.\textsuperscript{46}
\end{enumerate}

\textsuperscript{38} \textit{Id.} at 741.
\textsuperscript{39} \textit{Id.} at 740.
\textsuperscript{40} \textit{Id.} at 740.
\textsuperscript{41} \textit{Id.} at 742–43.
\textsuperscript{43} \textit{Id.} at 742, quoting \textit{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 \textit{Metropolitan Life} and/or \textit{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.
\textsuperscript{44} \textit{Union Labor Life v. Pireno}, 458 U.S. 119 (1982).
\textsuperscript{45} \textit{Id.} at 133.
\textsuperscript{46} \textit{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 of which Congress is aware and one it has chosen not to alter.”

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 (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.

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.” 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. 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.”

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 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.” The Court concluded that all state laws that “supplemented or supplanted” the causes of action and remedies available under ERISA were preempted, whether or not they “regulated insurance” within the meaning of the saving clause.

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47 *Id.* at 747


49 *Id.* at 50 (Emphasis supplied).

50 *Id.* at 57.

51 *Id.* at 54.

52 481 U.S. at 56–57.

53 *Id.* at 56. The Court based its analysis on legislative history, submitted by the Solicitor General as *amicus curiae*, 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.

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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.”\textsuperscript{54} In a companion case to \textit{Pilot Life, Metropolitan Life Ins. Co. v. Taylor},\textsuperscript{55} 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,\textsuperscript{56} was equally applicable to
ERISA preemption.\textsuperscript{57}

The deference that the Court afforded to the civil enforcement scheme of ERISA stressed the need for
exclusivity and uniformity of ERISA plan remedies.\textsuperscript{58} 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 \textit{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.

\textbf{\textit{FMC Corp. v. Holliday,}}
\textbf{\textit{498 U.S. 52 (1990)}}

At issue in \textit{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.\textsuperscript{59}

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.\textsuperscript{60} The Court also concluded that the statute fell within the “saving” clause as an insurance
regulation.\textsuperscript{61}

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.\textsuperscript{62} The Court

\textsuperscript{54} 28 U.S.C. § 1441(a) (1994).
\textsuperscript{56} See \textit{Avco Corp. v. Machinists}, 390 U.S. 557 (1968). In \textit{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.
\textsuperscript{57} \textit{Taylor}, 481 U.S. at 66-67. However, as noted by the U.S. Supreme Court in \textit{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
\textsuperscript{58} William A. Chittenden, III, \textit{ERISA Preemption: The Demise of Bad Faith Actions in Group Insurance Cases}, 12 S. Ill.
\textsuperscript{60} \textit{Id.} at 58-60.
\textsuperscript{61} \textit{Id.} at 60-61.
\textsuperscript{62} \textit{Id.} at 65.
reaffirmed that the “saving” clause “retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee welfare benefit plans.”\(^{63}\) 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.”\(^{64}\)

**DISTRICT OF COLUMBIA v. GREATER WASHINGTON BOARD OF TRADE, 506 U.S. 125 (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.\(^{65}\)

The Court noted that the statute clearly “related to” employee welfare benefit plans because it specifically mentioned them.\(^{66}\) 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 District of Columbia law did not do so.\(^{67}\) The benefit it mandated was tied directly to the terms of the employer’s ERISA plan.\(^{68}\)

**NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS v. TRAVELERS INS. CO., 514 U.S. 645 (1995)**

In *New York State Conference of Blue Cross & Blue Shield 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.”\(^{69}\)

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

\(^{63}\) Id. at 64.  
\(^{64}\) Id.  
\(^{66}\) Id. at 130.  
\(^{67}\) Id. at 132.  
\(^{68}\) Id. at 132.  
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surcharge was imposed irrespective of whether the insurance was purchased by an ERISA plan, private individual, or other purchaser.\textsuperscript{70}

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.”\textsuperscript{71}

The \textit{Travelers} Court clarified that state statutes that “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.”\textsuperscript{72} 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.

\textbf{CALIFORNIA DIVISION OF LABOR STANDARDS ENFORCEMENT v. DILLINGHAM, 519 U.S. 316 (1997)}

At issue in \textit{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.\textsuperscript{73}

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 \textit{Mackey}, or where the existence of ERISA plans is essential to the law’s operation, as in \textit{Greater Washington Board of Trade} and \textit{Ingersoll-Rand}, that “reference” will result in preemption.”\textsuperscript{74} 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.”\textsuperscript{75} In applying the “connection with” standard, the Court looked to the “objectives of the ERISA statute as a guide to

\textsuperscript{70} Id. at 1677.
\textsuperscript{71} Id. at 1680.
\textsuperscript{72} Id. at 1683.
\textsuperscript{74} Id. at 325.
\textsuperscript{75} Id. citing \textit{Travelers}, 514 U.S. at 656.

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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.”76

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.77 In Travelers, the Court stated that
“the preemption of areas of traditional state regulation where ERISA has nothing to say would be
‘unsettling.’”78 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.”79 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.”80 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.81 The Court stated that “[t]he [California]
law only alters the incentives, but does not dictate the choices facing ERISA plans.”82 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.”83

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 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.84

76 Id. citing Travelers, 514 U.S. at 658-659.
77 Id. citing Travelers, 514 U.S. at 655, quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)(citation omitted).
78 Id. at 330, citing Travelers, 514 U.S. at 665 n. 7.
79 Id. at 330, citing Travelers, 514 U.S. at 661 (quoting Shaw, 463 U.S. at 98).
80 Id. at 328 (citations omitted).
81 Id. at 332.
82 Id. at 334.
83 Id. at 334, citing Travelers, 514 U.S. at 668.
84 514 U.S. 645.
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 fund’s assets.\textsuperscript{85}

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.\textsuperscript{86} The Court’s decision in Travelers rejected a strict and literal interpretation of “relates to.”\textsuperscript{87}

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.\textsuperscript{88} 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.”\textsuperscript{89}

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.\textsuperscript{90} 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.\textsuperscript{91} Consequently, the Fund had the “considerable burden” of overcoming the presumption against preemption of state law.\textsuperscript{92}

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.\textsuperscript{93} The Court observed that “any state tax or 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.”\textsuperscript{94} In a footnote the Court reiterated 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.\textsuperscript{95} 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.\textsuperscript{96}

\textsuperscript{85} Id. at 812 citing NYSA-ILA Medical Center and Clinical Services Fund v. Axelrod, 520 U.S. 806.

\textsuperscript{86} Id. at 813 citing Shaw v. Delta Airlines, Inc., 463 U.S. 85.

\textsuperscript{87} Id at 812.

\textsuperscript{88} Id. at 813 citing Travelers, 514 U.S. at 655, citing Rice v. Sante Fe Elevator Corp., 331 U.S. 218, 230.

\textsuperscript{89} Id. at 813, 814 citing Travelers, 514 U.S. at 656.

\textsuperscript{90} Id at 814.

\textsuperscript{91} Id.

\textsuperscript{92} Id.

\textsuperscript{93} Id. at 815 citing Travelers, 514 U.S. at 668.

\textsuperscript{94} Id. at 816.

\textsuperscript{95} Id. at n.16 citing Travelers, 514 U.S. at 668.

\textsuperscript{96} Id. at 816-817.
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(1967), 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 in 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 not 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. 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” of whether a law regulates insurance. The Court clarified that the three McCarran-Ferguson factors are not mandatory requirements. Each factor does not need to be met individually, but instead serve as “guideposts” or “considerations to be weighed” 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

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97 526 U.S. at 367.
98 Id. at 372.
99 Id. at 374.
100 Id. at 373.
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.101 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.102 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.103 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.104

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”105 and would “virtually read the saving clause out of ERISA.”106 The Court, citing Metropolitan Life107 and FMC Corp108 points out that the Court has repeatedly held that state laws mandating insurance contract terms are saved from preemption under §514(b)(2)(A).109

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 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.110

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.”111 Therefore, the Elfstrom rule “relates to” an ERISA plan and is preempted.

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101 Id. at 374.
102 Id. citing United States as Amicus Curiae 14.
103 Id. at 374-375.
104 Id. at 375 (citations omitted).
105 Id.
106 Id. at 376.
107 471 U.S. at 758.
108 498 U.S. at 64.
109 Id. at 375-376.
110 Id. at n.7.
111 Id. at 379.

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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 superseded unless it was the clear and manifest purpose of Congress.”

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” 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. 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. 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. The Court stated that the application of the law to HMOs acting solely as administrators did not lead to preemption of its application to HMOs acting as insurers.

The Court applied the three McCarran-Ferguson factors. All three factors are not required in order for a law to regulate insurance within the meaning of the saving clause. 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 HMO’s medical obligations” 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.

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” because

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112 536 U.S. 355, 364-365 (citations omitted).
113 Id. at 2159.
114 Id. at 2160.
115 Id.
116 Id. at 2160-2161.
117 Id. at 2163.
118 See discussion of *Metropolitan Life v. Massachusetts*.
119 Id. at 2163.
120 Id. at 2164.
121 Id. at 2163-2164.
122 Id. at 2166.
the Illinois law “provides no new cause of action under state law and authorizes no new form of ultimate relief.”

The Court made clear that ERISA does not require that a plan’s benefit determinations be discretionary or receive deferential review. 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.”

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].” 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. The Court explained that disuniformities are the inevitable result of the congressional decision to save state insurance laws and that HMOs have to establish procedures for conforming with local laws in any event.

**KENTUCKY ASSOCIATION OF HEALTH PLANS v. MILLER, 123 S.Ct. 1471 (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. The first part of the new test requires that the state law be “specifically directed towards entities engaged in insurance.” To explain this test, the Court refers to its previous opinions in *Pilot Life, Rush Prudential* and *FMC Corp.* In order for a state law to be “specifically directed toward” the insurance industry, the state law must be more than a law of

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123 *Id.* at 2167.
124 *Id.* at 2169-2171.
125 *Id.* at 2170.
126 *Id.* at 381 n.11.
127 *Id.*
128 *Id.*
129 123 S.Ct. 1471, 1479.
130 *Id.*
131 *Id.* at 1475.

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general application with some bearing on insurers. But even a law specifically directed at the insurance industry must regulate an insurer with respect to the insurer’s insurance practices.

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. 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; and (2) their application to “self-insurer or multiple employer arrangements not exempt from state regulation by ERISA” and HMOs that provide administrative services only to self-insured plans. 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. 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.” 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. ERISA’s deemer clause prevents states from regulating self-funded ERISA plans that they could otherwise regulate.

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. 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.

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” and does not require that the state law actually “spread risk,” or “alter or control the actual terms of insurance policies” in order to regulate insurance within the meaning of the

134 Id. at 1476.
135 Id. at 1475-1476.
136 Id. at 1476 n.1.
137 Id.
138 Id. at 1475.
139 Id. at 1476 n.1.
140 Id.
141 ERISA §514(b)(2)(B).
142 123 S.Ct. at 1476 n.1.
143 Id.
144 Id.
145 Id. at 1479.
146 Id. at 1478 n.3.
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 prejudice rule [] sustained in UNUM, and the independent review provisions [] approved in Rush Prudential.”

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 that 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.

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.

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.

- Subject to the saving clause, state laws that “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 that 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.
- 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.

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147 *Id.* at 1477.

148 *Id.* at 1477-1478.
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.

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.
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. 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.

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:

- 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).

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.

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. For example, ERISA exempts plans maintained solely for the purpose of compliance with state workers’ compensation, unemployment, and disability laws. ERISA also excludes governmental plans and church plans.

149 State insurance regulators may seek assistance from the DOL’s Employee Benefits Security Administration Office of Regulations and Interpretations by requesting a formal or informal opinion on the scope of ERISA preemption as it applies to a particular arrangement. However, this should not delay the state regulator’s investigation and enforcement action. A DOL Advisory opinion is helpful, but it is only advisory, based on assumed facts, and is not required as the basis to issue an enforcement action.

150 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 DOL has taken the position that each employer participating in a non-plan MEWA sponsors its own 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 2004). Available on the internet at www.dol.gov/ebsa. (DOL GUIDE). State insurance regulators should not assume that an arrangement that has sought to comply with the requirements for ERISA-covered plans is actually covered by ERISA.

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 public 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.\footnote{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.}

**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.\footnote{29 U.S.C. § 1002(1) (2004).}

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.\footnote{Bell v. Employee Security Benefit Ass’n, 437 F.Supp. 382 (D. Kan. 1977).}

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 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.

**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*. 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.

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.”

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 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.

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.

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155 *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.

156 *Id.* at 1372.

157 *Id.* at 1373.

158 *Id.* at 1373.

159 29 C.F.R. § 2510.3-i(j) (2004).
In *Johnson v. Watts*, 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.”

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. The court contrasted the facts in this case with the facts of *Hansen v. Continental Ins. Co.* 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.

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.

**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.”

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160 *Johnson v. Watts*, 63 F.3d 1129 (1st Cir. 1995).
161 Id. at 1135.
162 Id. at 1135-1136.
164 *Johnson*, 63 F.3d at 1137.
The statute’s definition of employer includes an employer association. To be a bona fide employer 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:

- 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
- who actually controls and direct the activities and operations of the benefit program.\(^{167}\)

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.\(^{168}\)

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.\(^{169}\)

The meaning of the term employee organization was discussed in *Bell v. Employee Security Benefit Ass’n*.\(^{170}\) 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.

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 among 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,\(^{167}\) Department of Labor Opinion 94-07A re: *United Service Association for Health Care* (Mar. 14, 1994).

\(^{168}\) *Id*.


union, or industry, but made the benefits available to any individual who was employed. Consequently, the entity did not meet the definition of an employee organization.

**Purpose Requirement**

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).” As mentioned previously however, ERISA specifically exempts plans maintained solely to provide disability, workers’ compensation, and unemployment compensation.

**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.”

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.

**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 is the plan sponsor 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.

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

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171 Id.
173 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.
175 See, e.g., Williams v. Wright, 927 F.2d 1540, 1545 (11th Cir. 1991).
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.” The term “common control” must be defined by DOL in a manner consistent with section 414(c) of the Internal Revenue Code. 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.” Those trades or businesses with less than 25 percent ownership interest do not meet the standards for common control.

**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 is a single employer, self-funded plan.

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 marketed to the general public by an insurance agent is highly unlikely to be a “single-employer” plan.

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.

Persons, including licensed insurance agents, who promote unauthorized insurance under the guise of “ERISA covered plans” 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 the requirements for being a

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179 DOL GUIDE.
single employer ERISA plan are subject to the unauthorized insurer statutes of the various states.\textsuperscript{180} As noted in the discussion of MEWAs below, some employee leasing companies and professional employer organizations claim to offer “single employer plans” under ERISA to their clients, but such an arrangement will almost certainly be a MEWA for ERISA purposes.\textsuperscript{181} Other types of operations have claimed to “employ” each enrollee, usually to promote the plan or ostensibly some product or service. In those situations, it is usually quite apparent that the “employment” is pro forma.

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).

\textit{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 from 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.

\textbf{Multiemployer Plans}

\textit{Characteristics of a Multiemployer Plan}

A multiemployer plan is one in which more than one employer contributes and which is maintained pursuant to a \textit{collective bargaining} agreement between one or more employee organizations and more than one employer.\textsuperscript{182} As a practical matter, the definition of a multiemployer plan refers to plans jointly established by employers and 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.\textsuperscript{183} 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.


\textsuperscript{181} 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.


\textsuperscript{183} DOL GUIDE.
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

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 to the employees of two or more employers (including one or more self employed individuals), or to their beneficiaries.”

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 describe their business as leasing employees to a variety of unrelated businesses. Professional employer organizations describe their business as co-employing a client workforce. An employee leasing firm or PEO may also sponsor health plans for these employees. An employee leasing or PEO arrangement can relieve smaller employers from the administrative costs of personnel and payroll record keeping, and the leasing organization’s or PEO’s benefit plans can make pricing economies of scale available to an employer that would otherwise be only a very small group

184 Regulators are encouraged to read the DOL GUIDE for a more detailed discussion of MEWAs and state regulation.
185 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.
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 DOL informed about MEWAs’ compliance with the requirements of Part 7 of ERISA (including the provisions of HIPAA, the Mental Health Parity Act, the Newborns’ and Mothers’ Health Protection Act, and the Women’s Health and Cancer Rights Act). A sample Form M-1 form is contained in Appendix B. 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 itself an ERISA covered plan 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.\(^\text{188}\) If a MEWA is a “fully insured” ERISA covered plan, state 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.\(^\text{189}\) 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.”

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 self-funded MEWA is an insurer under state insurance law unless the state has adopted such a specific MEWA licensing law. In either case, the self-funded MEWA is illegal under state law unless it is licensed.

ERISA is clear that a MEWA is subject to state insurance regulation. States may apply certain standards to “fully-insured” MEWAs, may regulate the insurer of a “fully-insured” MEWA and has full regulatory discretion with regard to all other MEWAs. Some states have enacted specific MEWA licensing statutes, but ERISA does not require the states to have done so in order to exercise their authority. The NAIC Reporting Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs Model Regulation\(^\text{190}\) is designed to assist states in becoming aware of the operation of

\(^{187}\) See discussion below regarding self-funded employee leasing plans’ status as MEWAs notwithstanding their claim to be single-employer plans.

\(^{188}\) § 1144(b)(6)(D) (2004) 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.”


\(^{190}\) 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).

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MEWAs within their jurisdiction before an insolvency occurs. In addition, several states have enacted specific statutory structures that govern PEOs.

**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. 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 through by MEWAs that resulted in significant sums of unpaid claims and the loss of health insurance for participants.

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 amendment saved state regulation of MEWAs from ERISA’s preemption and deemer provisions. 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.

**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.” Operators of MEWAs have claimed to be exempt from state insurance law because they are “fully insured.” However, ERISA does not preempt state regulation of the insurance contract nor a state’s ability to enforce standards such as those related to reserves and contributions. See the discussion on this specific type of scam in the section titled “Typical Illegal Operations Claiming ERISA Status.”

**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. 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.”

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191 These models and the status of states’ actions on them are included in Appendix A  
192 COMM REPT., supra n. 18, at 10.  

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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.

**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 under or pursuant to one or more collective bargaining agreements. Unscrupulous operators have claimed to meet this exception to the definition of MEWA 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 DOL final rules published in the Federal Register on April 9, 2003.

**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. The DOL determined that it would not make individualized findings with respect to whether specific plans met the exception for collectively bargained plans. 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. 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.”

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. 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.

195 29 U.S.C. § 1002(40)(A) (2004) (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.


198 60 F.R. 39209, August 1, 1995, Note 3.


200 Id. at 1070.

201 60 F.R. 39209.
Final Rules Regarding Section 3(40) of ERISA

The first rule, Employee Retirement Income Security Act of 1974; Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA,\textsuperscript{202} sets forth criteria for determining whether an agreement is a bona fide collective bargaining agreement, and whether a plan is established or maintained under or 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,\textsuperscript{203} 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.

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) 693-8523. 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.

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 that operate fraudulently and that 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.

\textsuperscript{202} 68 F.R. 17472 – 17485.
\textsuperscript{203} 68 F.R. 17485 – 17491.

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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 - both with respect to the creators of the illicit plans, and those recruited to sell the plans, enroll consumers and service claims;
3. The 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.

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.

**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.”

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.”

“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.” Employee is defined as “any individual employed by an employer.” The term “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.”

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:

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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. However, these cases are not consistent with Nationwide v. Darden. In that case the U.S. Supreme Court rejected 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).”

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, …” 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.

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 agents for the entity. The entity is an entrepreneurial operation, and therefore not an employee welfare benefit plan.

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

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

210 Id. at 705.
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.

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:

As the cost 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.

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 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.

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.

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.

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:
1. The coverage is not 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.

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:

- “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.\(^\text{213}\)

- “This is a self-insured plan.” It is a complex web of transactions (which should already be a red flag) that, 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.\(^\text{214}\) However, even in jurisdictions where American Medical Security is considered

\(\text{213}\) 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).

\(\text{214}\) 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, 123 S. Ct. 1471 (2003).
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.”

- **“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 is the real party in interest, since it is the employer’s risk that is covered by the policy.

- **“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.

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.

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,” 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 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

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215 American Medical Security, 111 F.3d at 365.
216 If state law regulates the policy as health insurance, the employees may also have a legal interest in the coverage.
217 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.
218 As discussed above, American Medical Security prohibits states in the Fourth Circuit from classifying indirect-payment coverage as health insurance.
insurer is prohibited from issuing a stop loss policy with the minimal retention these schemes purport applies to their arrangements.

**Purported “Fully Insured” Plans**

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 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.
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. 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. Furthermore, ERISA provides that a MEWA is “fully insured” only if “the Secretary determines” that the amount of all plan benefits “are guaranteed under a contract, or policy of insurance.” The Secretary has issued no such findings.

More important, even if the MEWA does qualify as a fully insured employee benefit plan, only state regulation of the MEWA is subject to preemption, not regulation of the insurer and the insurance policy that “fully insures” the MEWA and participating employers. 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. A state may, and many do, require that the insurer be licensed and the policy filed and approved.

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.

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219 See, 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.  
220 See, USDOL Advisory Opinion 94-07A, United Association for Healthcare (Mar. 14, 1994) for further discussion of this requirement from the Department of Labor’s perspective.
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.”

Self Funded Multiple Employer Arrangements Claiming “Single Employer” Plan Status—Issues Related to Employee Leasing and Professional Employer 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. Under ERISA, the first inquiry of the state regarding an employee leasing company or PEO arrangement should be related to whether the arrangement is fully-insured or whether it is self-funded. Many PEOs across the country provide fully insured benefit arrangements with authorized carriers.

In the case of a fully-insured benefit, the state has authority to regulate the carrier and to establish certain standards for the MEWA itself. The state has far greater authority in the situation where the MEWA is not fully-insured.

All DOL examinations of employee leasing or PEO self-funded plans to date have determined these arrangements to be MEWAs. Regardless of the employer status of the PEO or the employee leasing company, the DOL has indicated in these decisions that if one or more of the client companies is also deemed to be an employer under common law standards, the arrangement is a MEWA and the self-funded plan is subject to state regulation.

This is true despite a contract purporting to designate the PEO as the sole employer. Both state and federal law look to common law factors, including day to day control of the employees, in determining whether the clients’ businesses are in fact acting as employers.

Some operators of PEO’s occasionally cite the ERISA provision treating employers “under common control” as single employers. However, that provision does not apply even if the PEO can be said to manage its clients’ businesses, because client businesses are not all under common ownership, which is the basis of the statutory test for single-employer status.221

The DOL has consistently said that a PEO or employee leasing company plan cannot qualify as a single-employer plan under ERISA unless the PEO is actually the sole common law employer of all of the individuals under the arrangement. The question of whether or not a common law employer-employee relationship exists depends upon the specific circumstances of the case. In Nationwide Mutual Ins. Co. v. Darden,222 the Supreme Court held that federal common law principles of employment govern the

221 See 29 U.S.C. § 1002(40)(B)(2004). 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.

definition of employee contained in ERISA. Whether the PEO is a “co-employer” 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.

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.

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.

A PEO-operated or employee leasing company “self-funded” health benefit plan covering co-employees or “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 self-funded arrangement would be 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.

223 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 3rd 713, 723 (9th Cir. 1999).
224 Id. at 323-324.
226 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.)

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As the saying goes, an ounce of prevention is worth a pound of cure; 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.

**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 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.

**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 a 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.

**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 that 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.

**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 businesses and their trade associations.

**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

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
- “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 Act at Appendix C).

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, “fully insured” MEWA plan, or not “fully insured” MEWA plan. After accurately classifying the plan, regulators should proceed to step 3 of the analysis.

**Step 3:** Once the type of plan under consideration is determined, consider 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 a rural electric cooperative or a rural telephone cooperative association.

• 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.
Table: Regulatory Jurisdiction of ERISA Plans.

<table>
<thead>
<tr>
<th>Single Employer Plans</th>
<th>Multiemployer Plans</th>
<th>Multiple Employer Welfare Arrangements*</th>
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<tr>
<td>SUBJECT TO FEDERAL REGULATION ONLY</td>
<td>SUBJECT TO FEDERAL AND STATE REGULATION ONLY</td>
<td>SUBJECT TO STATE REGULATION ONLY</td>
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<tr>
<td>♦ Meets ERISA Coverage Test  ♦ Not Excepted from ERISA Coverage</td>
<td>♦ Meets ERISA Coverage Test  ♦ Is Sponsored by more Than One Employer as Defined in ERISA  ♦ Established Pursuant to a Bona Fide Collective Bargaining Agreement</td>
<td>♦ Meets ERISA Coverage Test  ♦ Does Not Meet ERISA Coverage Test  ♦ Provides Benefits to Employees of More Than One Employer And Does Not Meet Exceptions to MEWA Definition  ♦ Fully or Not Fully Insured</td>
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*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 under or 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 under or 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.227

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.

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:

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• The payments contributed to the trust be used exclusively for funding benefits for employees and their dependents.  

• 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.

• The written agreement between the employer and the labor organization specify the detailed basis upon which payments are to be made.

• 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.

• The written agreement provide for an annual audit of the trust fund that is open to inspection by interested persons.

• Pension and annuity trusts be kept separate from health and welfare trusts.

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. 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 plans and authorization for disbursement of funds. 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). 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.

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

231 Id.
232 Id.
236 29 C.F.R. § 402.3(a) (2004).
organization may file form LM-3, and with gross receipts of less than $10,000, the organization may file
form LM-4. 238

Persons who handle the funds of a labor organization or a trust in which a labor organization is
interested must be bonded. 239 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. 240

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. 241 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. 242 These forms are also open to public
inspection at EBSA’s Public Disclosure Room in Washington, D.C.

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 243 and plans
must retain supporting documentation for six years after reports are filed with EBSA. 244 A review of
these records may be useful during any investigation. While a valid Taft-Hartley trust 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 purported 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*, 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 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.

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.

**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.

**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

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mandated benefits through an ERISA plan, or requiring an employer to provide mandated workers’ compensation through a separately administered plan.

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.”246 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,247 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 that complies with state law 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.248 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.”249

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.250 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.251 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

248 Id. at 108.
249 Employee Staffing Services v. Aubry, (“Stafcor”), 20 F. 3d 1038, 1039 (9th Cir. 1994).
251 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.)

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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’ 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 apply 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). Its operations are substantially devoted to providing for the payment of life, sickness, 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.

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. 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). The organization must be controlled by its membership, independent trustees, or trustees designated by, or on behalf of, the members.

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

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Code does 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.\textsuperscript{257}

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 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.

**If a MEWA that is not “fully insured” 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 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.

\textsuperscript{257} 26 C.F.R. 1.501(c)(9)-7 (1996).
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.”258

The term “benefit” when used in ERISA “uniformly refers only to payments due the plan participants or beneficiaries.”259 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.,260 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 DOL has issued an advisory opinion that states a MEWA is not fully insured solely because it has a stop-loss policy.261 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 an “employee welfare benefit plan” covered by ERISA.”262 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.

262 DOL Advisory Opinion 94-07A re: United Service Association for Health Care (March 14, 1994).
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?**

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.263

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 State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,264 the Court 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

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263 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.


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available insurers or forces an ERISA plan to adopt a certain scheme of coverage, may be held to “relate to” the ERISA plan.265

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,266 the Supreme Court held that a state law that mandated that insurers cover certain mental health benefits was saved from ERISA preemption.267 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.268

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 that 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.269 Courts place significant weight on how a state’s laws classify an entity’s activities.270 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.

265 Id. at 1683.
267 Id. at 743.
268 Id. 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).
269 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).
270 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? 271

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. 272

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, 273 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. 274

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 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. 275

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, 276 the court held that Florida statutes,

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271 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.
274 K.R.S. 304.9-052.
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.

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.

In *E-Systems, Inc. v. Pogue*, the appeals court upheld a district court opinion that 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*, 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 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*. 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*, 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

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279 *NGS American, Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993).
280 *Self-Insurance Institute of America v. Korioth*, 53 F.3d 694 (5th Cir. 1995).
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 TPA laws 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. 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 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 the Supreme 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.


9. MULTIEMPLOYER 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.
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.


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.
APPENDICES

Appendix A1 – Consumer Alert

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

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].

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• 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.]

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.
Appendix A2 – Agent Alert

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.
- You are asked to avoid certain insurance terminology, even though the plan operates like insurance.
- The plan is covered only by “stop loss insurance” or refers to “reinsurance.”
- You are asked to sell an “ERISA” plan or “union” plan.
- You are asked to sell an “employee leasing” arrangement with self-funded health coverage.

The plan targets individuals or groups with employees that have pre-existing conditions.

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• 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].
Appendix A3 – Regulatory Alert

Regulatory Alert to Stop Loss Carriers and Third Party Administrators

You are asked to immediately review your internal controls and business practices to ensure that your company does not become an unwitting supporter of unlicensed (illegal) health insurance plans. Your company’s urgent effort to strengthen its internal controls in this area is warranted by your company’s commitment to good business practices. Unlicensed (illegal) health plans have left millions in unpaid claims. Moreover, your company’s failure to establish or strengthen appropriate internal controls may lead to substantial liability. Your company may be subject to regulatory penalties and may be liable for all unpaid claims under [insert reference to your state’s equivalent to Section 4 of the Nonadmitted Insurance Model Act].

The department asks you to establish or strengthen internal controls designed to ensure that:

Unlicensed MEWAs

Your company will not issue or purchase a stop loss policy or undertake to administer unlicensed “self-funded” health plans that cover the employees of two or more employers unless all covered employers are under common ownership [or the plan is licensed in this state as a multiple-employer welfare arrangement]. These plans are insurers under the laws of this state and are transacting the business of insurance without a license. They commonly, and wrongly, claim to be exempt from state insurance law under the federal Employee Retirement Income Security Act of 1974 (“ERISA”). Since these entities meet the definition of “multiple employer welfare arrangement” (“MEWA”) under ERISA they remain subject to state insurance law.

Note: States that have MEWA-specific licensing laws should add the language in brackets or make other modifications to this paragraph consistent with their laws.

Professional Employee Organizations (“PEOs”) Unlicensed Health Plans

Your company will not issue or purchase a stop loss policy or undertake to administer an unlicensed “self-funded” health plan for an employee leasing or professional employee organization. These firms commonly refer to their client’s employees as “co-employed” or as “leased” employees of the PEO. These self-funded health plans are Multiple Employer Welfare Arrangements under ERISA rather than single employer plans. Under ERISA an individual is an employee only if the employer actually controls and directs the individual’s work. As indicated above, self-funded MEWAs are subject to state regulation as insurers. Your company should exercise care that it does not assist a “self-funded” benefit plan of a PEO or employee leasing company that is an unlicensed insurer under the laws of this state.

Note: Some states have statutes allowing or licensing PEOs or employee leasing firms to self-fund health benefits. Individual insurance departments should modify this paragraph to incorporate a description of the specific requirements of your state law.

Out of State Trusts / Stop Loss “Reinsurance” For Unlicensed Health Plans

Your company will not issue or purchase unapproved stop loss coverage for employers located in this state through an out of state trust, and will not undertake to administer an unlicensed “self-funded” health plan for employers located in this state unless all stop loss coverage has been

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Operators of these arrangements purport they are exempt from this state’s insurance laws because they solicit employers in this state to apply for stop loss coverage through a trust established in an out of state bank. Often these schemes falsely characterize the stop loss policy as “reinsurance.” They also represent that all claims will be paid under the “self-funded” plan in return for a fixed contribution.

Each of these claims is legally wrong and factually false. An insurer or producer that solicits the sale of stop loss coverage in this state is subject to this state’s laws. Stop loss coverage is insurance, not “reinsurance,” and usually there are substantial gaps in the coverage. Most important, only licensed insurers and producers may solicit the sale of stop loss policies in this state. A licensed insurer may offer only a filed and approved policy form.

The department asks that you take immediate steps to ensure that your company will avoid providing unwitting support to these illegal operations. You can find a discussion of ERISA provisions governing this topic on the U.S. Department of Labor website at [http://www.dol.gov/ebsa/Publications/mewas.html]. You may contact [insert contact information for the department MEWA contact] to discuss any questions you may have regarding this bulletin. Your company is encouraged to work with the department MEWA contact to resolve any questions about a particular operation. The insurance departments of other states will provide the same assistance, and may be contacted through the MEWA contact listed on the NAIC website [insert web address]. The department also asks you to establish policies that direct your company’s staff and agents to promptly report any operation described in this bulletin to the MEWA contact.
2003

Form M-1
Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)

Web-based filing now available!

This package contains the following form and related instructions:

Form M-1
Instructions
Self-Compliance Tool

Enjoy these additional benefits not available for paper filings:

Greater Accuracy
- Electronic-filing data is checked for errors to improve accuracy
- Built-in error checks mean fewer corrections and faster processing of your return

Increased Security
- Encryption of submitted data assures a high level of security
- Assigned Personal Identification Numbers (PINs) and secure filing website provide protected and secure access
- Direct processing reduces the manual handling of your return

Automated
- Website submission occurs immediately
- Eliminate postage expenses

Participation is easy!
- For information on Form M-1 electronic filing, please visit www.askebsa.dol.gov/mewa

Package Form M-1
If you have additional questions about the Form M-1 filing requirement or the ERISA health coverage requirements, there’s help for you.

Form M-1 Filing Requirement
(1) For questions on completing the Form M-1, contact the Employee Benefits Security Administration’s (EBSA) Form M-1 help desk at 202-693-8360.
(2) For inquiries regarding electronic filing capability, contact the EBSA computer help desk at 202-693-8600.
(3) For inquiries regarding the Form M-1 filing requirement, contact the Office of Health Plan Standards and Compliance Assistance at 202-693-8335.

ERISA Health Coverage Requirements
(1) For questions about ERISA’s health coverage requirements, contact EBSA by calling toll-free 1-866-444-EBSA (3272) or electronically at www.askebsa.dol.gov.
(2) EBSA’s Health Benefits Education Campaign offers compliance assistance seminars across the country addressing a wide variety of health care issues, including HIPAA, COBRA and the benefit claims procedure regulation. For information on upcoming compliance assistance seminars, go to www.dol.gov/ebsa/hbec.html.

The Department of Labor’s EBSA has many helpful compliance assistance publications on ERISA’s health benefits requirements, including:

- MEWAs (Multiple Employer Welfare Arrangements): A Guide to Federal and State Regulation
- Compliance Assistance Guide: Recent Changes in Health Care Law
- Compliance Assistance for Group Health Plans: HIPAA and Other Recent Health Care Laws
- New Health Laws Notice Guide
- Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Laws (included as an attachment to this document)
- Your Rights After a Mastectomy . . . Women’s Health and Cancer Rights Act of 1998
- Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Compliance Assistance for Group Health and Disability Plans - The Benefit Claims Procedure Regulation

EBSA also has many publications to assist participants and beneficiaries. EBSA’s publications are available on the Internet at www.dol.gov/ebsa or by calling toll-free 1-866-444-EBSA (3272).
PART I REPORT IDENTIFICATION INFORMATION

Complete either Item A or Item B (as applicable) and Item C.

A If this is an annual report, specify whether it is for:
   (1) ☐ The 2003 calendar year; or
   (2) ☐ The fiscal year beginning __________ and ending __________.

B If this is a special filing, specify whether it is:
   (1) ☐ A 90-day origination report;
   (2) ☐ An amended report; or
   (3) ☐ A request for an extension.

C If this is a final report, check here

PART II MEWA OR ECE IDENTIFICATION INFORMATION

1a Name and address of the MEWA or ECE

1b Telephone number of the MEWA or ECE

1c Employer Identification Number (EIN)

1d Plan Number (PN)

2a Name and address of the administrator of the MEWA or ECE

2b Telephone number of the administrator

2c EIN

2d E-mail address of the Administrator

3a Name and address of the entity sponsoring the MEWA or ECE

3b Telephone number of the sponsor

3c EIN

PART III REGISTRATION INFORMATION

4 Specify the most recent date the MEWA or ECE was originated

5 Complete the following chart. (See Instructions for Item 5)

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<td>Enter all States where the entity provides coverage.</td>
<td>Is the entity a licensed health insurance issuer in this State?</td>
<td>If you answer “yes” to 5b, list any NAIC number.</td>
<td>If you answer “no” to 5b, is the entity fully insured?</td>
<td>If you answer “yes” to 5d, enter the name of the insurer and its NAIC number.</td>
<td>Does the entity purchase stop-loss coverage?</td>
<td>If you answer “yes” to 5f, enter the name of the stop-loss insurer and its NAIC number.</td>
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For Paperwork Reduction Act Notice, see page 8 of the instructions.
6. Of the States identified in Item 5a, list those States in which the MEWA or ECE conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care under the MEWA or ECE).

7. Total number of participants covered under the MEWA or ECE

PART IV INFORMATION FOR COMPLIANCE WITH PART 7 OF ERISA

8a. Has the MEWA or ECE been involved in any litigation or enforcement proceeding in which noncompliance with any provision of Part 7 of Subtitle B of Title I (Part 7) of ERISA was alleged? Answer for the year to which this filing applies and any time since then up to the date of completing this form. Answer “Yes” for any State or Federal litigation or enforcement proceeding (including any administrative proceeding), whether the allegation concerns a provision under Part 7 of ERISA, a corresponding provision under the Internal Revenue Code or Public Health Service Act, a breach of any duty under Title I of ERISA if the underlying violation relates to a requirement under Part 7 of ERISA, or a breach of a contractual obligation if the contract provision relates to a requirement under Part 7 of ERISA. (The instructions to this form contain additional information that may be helpful in answering this question.)

8b. If you answered “Yes” to Item 8a, identify each litigation or enforcement proceeding. With respect to each, include (if applicable): (1) the case number, (2) the date, (3) the nature of the proceedings, (4) the court, (5) all parties (for example, plaintiffs and defendants or petitioners and respondents), and (6) the disposition. You may answer this question by attaching a copy of the complaint with the name of the MEWA or ECE, the disposition of the case, and the phrase “Item 8b Attachment,” noted in the upper right corner.

9. Complete the following. (Note: The instructions to this form contain a Self-Compliance Tool which may be helpful in completing this item. Please read the instructions carefully before answering the following questions.)

9a. Is the coverage provided by the MEWA or ECE in compliance with the portability provisions of the Health Insurance Portability and Accountability Act of 1996 and the Department of Labor’s (Department’s) regulations issued thereunder? (See Part I of the Self-Compliance Tool)

9b. Is the coverage provided by the MEWA or ECE in compliance with the Mental Health Parity Act of 1996 and the Department’s regulations issued thereunder? (See Part II of the Self-Compliance Tool)

9c. Is the coverage provided by the MEWA or ECE in compliance with the Newborns’ and Mothers’ Health Protection Act of 1996 and the Department’s regulations issued thereunder? (See Part III of the Self-Compliance Tool)

9d. Is the coverage provided by the MEWA or ECE in compliance with the Women’s Health and Cancer Rights Act of 1998? (See Part IV of the Self-Compliance Tool)

IF MORE SPACE IS REQUIRED FOR ANY ITEM, YOU MAY ATTACH ADDITIONAL PAGES. (SEE INSTRUCTIONS SECTION 2.4)

Caution: Penalties may apply in the case of a late or incomplete filing of this report.

Under penalty of perjury and other penalties set forth in the instructions, I declare that I have examined this report, including any accompanying attachments, and to the best of my knowledge and belief, it is true and correct. Under penalty of perjury and other penalties set forth in the instructions, I also declare that, unless this is an extension request, this report is complete.

Signature of administrator ___________________________ Date ___________________________

Type or print name of administrator ___________________________
Introduction

This form is required to be filed under sections 101(g) and 734 of ERISA and 29 CFR 2520.101-2.

The Department of Labor, EBSA, is committed to working together with administrators to help them comply with this filing requirement. Additional copies of the Form M-1 are available by calling the EBSA toll-free hotline at 1-866-444-3272 and on the Internet at: www.dol.gov/ebsa. If you have any questions (such as whether you are required to file this report) or if you need any assistance in completing this report, please call the EBSA Form M-1 help desk at (202) 693-8360.

All Form M-1 reports are subject to a computerized review. It is in the filer's best interest that the responses accurately reflect the circumstances they were designed to report.
SECTION 1

1.1 Definitions

“Administrator”
For purposes of this report, the “administrator” is the person specifically designated by the terms of the MEWA or ECE. However, if the MEWA or ECE is a group health plan and the administrator is not so designated, the “plan sponsor” is the administrator. (“Plan sponsor” is defined in ERISA section 3(16)(B) as (i) the employer in the case of an employee benefit plan established or maintained by a single employer; (ii) the employer organization in the case of a plan established or maintained by an employee organization; or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.) Moreover, in the case of a MEWA or ECE for which an administrator is not designated and a plan sponsor cannot be identified, the administrator is the person or persons actually responsible (whether or not so designated under the terms of the MEWA or ECE) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent or trustee designated by such person or persons.

“Employer Identification Number” or “EIN”
An EIN is a nine-digit employer identification number (for example, 00-1234567) that has been assigned by the IRS. Entities that do not have an EIN should apply for one on Form SS-4, Application for Employer Identification Number as soon as possible. You can obtain Form SS-4 by calling 1-800-TAX-FORM (1-800-829-3676) or at the IRS website at www.irs.gov. EBSA does NOT issue EINs.

“Entity Claiming Exception” or “ECE”
For purposes of this report, the term “entity claiming exception” or “ECE” means any plan or other arrangement that is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, and that claims it is not a MEWA because the plan or other arrangement claims the exception relating to plans established or maintained pursuant to one or more collective bargaining agreements (see section 3(40)(A)(i) of ERISA and 29 CFR 2510.3-40 of the Department’s regulations.) The administrator of an ECE must file this report each year for the first 3 years after the ECE is “originated.” (Warning: An ECE may be “originated” more than once. Each time an ECE is “originated” more filings are triggered.)

“Employee Welfare Benefit Plan”
In general, an employee welfare benefit plan means any plan, fund, or program established or maintained by an employer or by an employee organization, or by both, to the extent such plan, fund, or program provides its participants or beneficiaries the benefits listed in section 3(1) of ERISA (including benefits for medical care).

“Excepted Benefits”
Part 7 of Subtitle B of Title I (Part 7) of ERISA does not apply to any group health plan or group health insurance issuer in relation to its provision of excepted benefits. Certain benefits that are generally not health coverage are excepted in all circumstances. These benefits are: coverage only for accident (including accidental death and dismemberment), disability income insurance, liability insurance (including general liability insurance and automobile liability insurance), coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, automobile medical payment insurance, credit-only insurance (for example, mortgage insurance), and coverage for on-site medical clinics.

Other benefits that generally are health coverage are excepted if certain conditions are met. Specifically, limited scope dental benefits, limited scope vision benefits, and long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the group health plan. For more information on these limited excepted benefits, see the Department of Labor’s regulations at 29 CFR 2590.732(b)(3).

In addition, noncoordinated benefits may be excepted benefits. The term “noncoordinated benefits” refers to coverage for a specified disease or illness (such as cancer-only coverage) or hospital indemnity or other fixed dollar indemnity insurance (such as insurance that pays $100/day for a hospital stay as its only insurance benefit), if three conditions are met. First, the benefits must be provided under a separate policy, certificate, or contract of insurance. Second, there can be no coordination between the provision of these benefits and another exclusion of benefits under a group health plan maintained by the same plan sponsor. Third, benefits must be paid without regard to whether benefits are provided with respect to the same event under a group health plan maintained by the same plan sponsor. For more information on these noncoordinated excepted benefits, see the Department of Labor’s regulations at 29 CFR 2590.732(b)(4).

Finally, supplemental benefits may be excepted if certain conditions are met. Specifically, the benefits are excepted only if they are provided under a separate policy, certificate or contract of insurance, and the benefits are Medicare supplemental (commonly known as “Medigap” or “MedSupp”) policies, TRICARE supplements, or supplements to certain employer group health plans. Such supplemental coverage cannot duplicate primary coverage and must be specifically designed to fill gaps in primary coverage, coinsurance, or deductibles.
Note that retiree coverage under a group health plan that coordinates with Medicare may serve a supplemental function similar to that of a Medigap policy. However, such employer-provided retiree "wrap around" benefits are not excepted benefits (because they are expressly excluded from the definition of a Medicare supplemental policy in section 1882(g)(1) of the Social Security Act). For more information on supplemental excepted benefits, see the Department of Labor’s regulations at 29 CFR 2590.732(b)(5).

“Group Health Plan”
In general, a group health plan means an employee welfare benefit plan to the extent that the plan provides benefits for medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. See ERISA section 733(a).

“Health Insurance Issuer” or “Issuer”
The term “health insurance issuer” or “issuer” is defined, in pertinent part, in §2590.701-2 of the Department’s regulations as “an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law which regulates insurance . . . . Such term does not include a group health plan.”

“Multiple Employer Welfare Arrangement” or “MEWA”
In general, a multiple employer welfare arrangement (MEWA) is an employee welfare benefit plan or other arrangement that is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that the term does not include any such plan or other arrangement that is established or maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association. See ERISA section 3(40) and 29 CFR 2510.3-40 of the Department’s regulations. (Note: Many States regulate entities as MEWAs using their own, State definition of the term. Whether or not an entity meets a State’s definition of a MEWA for purposes of regulation under State law is a matter of State law.)

For more information on MEWAs, visit EBSA’s Web site at www.dol.gov/ebsa or call the EBSA toll-free hotline at 1-866-444-3272 and ask for the booklet entitled, “MEWAs: Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation.”

For information on State MEWA regulation, contact your State Insurance Department.

“Originated”
For purposes of this report, a MEWA or ECE is “originated” each time any of the following events occur:

(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals);

(2) The MEWA or ECE begins offering or providing such coverage after any merger of MEWAs or ECES (unless all MEWAs or ECES involved in the merger were last originated at least 3 years prior to the merger); or

(3) The number of employees to which the MEWA or ECE provides coverage for medical care is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless such increase is due to a merger with another MEWA or ECE under which all MEWAs and ECES that participate in the merger were last originated at least 3 years prior to the merger).

Therefore, a MEWA or ECE may be originated more than once.

“Plan Number” or “PN”
A PN is a three-digit number assigned to a plan or other entity by an employer or plan administrator. For plans or other entities providing welfare benefits, the first plan number should be number 501 and additional plans should be numbered consecutively. For MEWAs and ECES that file a Form 5500 Annual Return/Report of Employee Benefit Plan (Form 5500), the same PN should be used for the Form M-1. (For more information on the Form 5500 you can access www.efast.dol.gov or call toll-free at 1-866-463-3278.)

“Sponsor”
For purposes of this report, the “sponsor” means:

(1) If the MEWA or ECE is a group health plan, the sponsor is the “plan sponsor,” which is defined in ERISA section 3(16)(B) as (i) the employer in the case of an employee benefit plan established or maintained by a single employer; (ii) the employee organization in the case of a plan established or maintained by an employee organization; or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan; or

(2) If the MEWA or ECE is not a group health plan, the sponsor is the entity that establishes or maintains the MEWA or ECE.

1.2 Who Must File

General Rules
The administrator of a MEWA generally must file this report for every calendar year, or portion thereof, that the MEWA offers or provides benefits for medical care to the employees of two or more employers (including one or more self-employed individuals). The administrator of an ECE must file the report if the ECE was last originated at any time within 3 years before the annual filing due date. (See the definition of “originated” in Section 1.1 and the discussion of When to File in Section 1.3.) (Caution: An ECE may be “originated” more than once. Each time an ECE is “originated,” more filings are triggered.)

Page 3
Exceptions
(1) Irrespective of the general rules (described above), in no event is reporting required by the administrator of a MEWA or ECE if the MEWA or ECE meets any of the following conditions:

(i) It is licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees (or to their beneficiaries).

(ii) It provides coverage that consists solely of excepted benefits (defined above), which are not subject to Part 7 of ERISA. (However, if the MEWA or ECE provides coverage that consists both of excepted benefits and other benefits for medical care that are not excepted benefits, the administrator of the MEWA or ECE is required to file the Form M-1.)

(iii) It is a group health plan that is not subject to ERISA, including a governmental plan, church plan, or plan maintained only for the purpose of complying with workers’ compensation laws within the meaning of sections 4(b)(1), 4(b)(2), or 4(b)(3) of ERISA, respectively.

(iv) It provides coverage only through group health plans that are not covered by ERISA, including governmental plans, church plans, and plans maintained only for the purpose of complying with workers’ compensation laws within the meaning of sections 4(b)(1), 4(b)(2), or 4(b)(3) of ERISA, respectively.

(2) In addition, in no event is reporting required by the administrator of an entity that would not constitute a MEWA or ECE but for the following circumstances:

(i) It provides coverage to the employees of two or more trades or businesses that share a common control interest of at least 25 percent at any time during the plan year, applying principles similar to the principles applied under section 414(b) or (c) of the Internal Revenue Code.

(ii) It provides coverage to the employees of two or more employers due to a change in control of businesses (such as a merger or acquisition) that occurs for a purpose other than avoiding Form M-1 filing and is temporary in nature (i.e., it does not extend beyond the end of the plan year in which the change in control occurs).

(iii) It provides coverage to persons (excluding spouses and dependents) who are not employees or former employees of the plan sponsor, such as nonemployee members of the board of directors or independent contractors, and the number of such persons who are not employees or former employees does not exceed one percent of the total number of employees or former employees covered under the arrangement, determined as of the last day of the year to be reported or, in the case of a 90-day origination report, determined as of the 60th day following the origination date.

1.3 When to File
General Rule
The Form M-1 must be filed no later than March 1 following any calendar year for which a filing is required (unless March 1 is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the next business day).

Exception for 2003 Filings
The deadline for this year's Form M-1 has been extended from March 1, 2004 to May 1, 2004 and the automatic 60-day extension has been extended from May 1, 2004 to July 1, 2004.

90-Day Origination Report
In general, an expedited filing is also required after a MEWA or ECE is originated. To satisfy this requirement, the administrator must complete and file the Form M-1 within 90 days of the date the MEWA or ECE is originated (unless the last day of the 90-day period is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the next business day).

Exception to the 90-Day Origination Report Requirement
No 90-Day Origination Report is required if the entity was originated in October, November, or December.

Extensisions of Time
A one-time extension of time to file will automatically be granted if the administrator of the MEWA or ECE requests an extension. To request an extension, the administrator must: (1) complete Parts I and II of the Form M-1 (and check Box B(3) in Part I); (2) sign, date, and type or print the administrator's name at the end of the form; and (3) file this request for extension no later than the normal due date for the Form M-1. In such a case, the administrator will have an additional 60 days to file a completed Form M-1. A copy of this request for extension must be attached to the completed Form M-1 when filed.

1.4 How to File
The 2003 Form M-1 can be filed electronically with the Department of Labor by going to www.askebsa.dol.gov/mewa.

In addition, completed paper copies of the Form M-1 can be sent to:

Public Documents Room, EBSA
Room N-1513, U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

1.5 Penalties
ERISA provides for a civil penalty for failure to file a Form M-1, failure to file a completed Form M-1, and late filings. In the event of no filing, an incomplete filing, or a late filing, a penalty may apply of up to $1,100 a day for each day that the administrator of the MEWA or ECE fails or refuses to file a complete report (or a higher amount if adjusted pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996). In addition, certain other penalties may apply.
SECTION 2

2.1 Year to be Reported

General Rule
The administrator of a MEWA or ECE that is required to file must complete the Form M-1 using the previous calendar year's information. (For example, for a filing due by March 1, 2004, calendar year 2003 information should be used.) See Exception for 2003 Filings in Section 1.3 on when to file.

Fiscal Year Exception
The administrator of a MEWA or ECE that is required to file may report using fiscal year information if the administrator of the MEWA or ECE has at least 6 continuous months of fiscal year information to report. (Thus, for example, for a filing that is due by March 1, 2004, fiscal year 2003 information may be used if the administrator has at least 6 continuous months of fiscal year 2003 information to report.) In this case, the administrator should check Box A(2) in Part I and specify the fiscal year. See Exception for 2003 Filings in Section 1.3 on when to file.

2.2 90-Day Origination Report

When a MEWA or ECE is originated, a 90-Day Origination Report is generally required. (See Section 1.3 on When to File). When filing a 90-Day Origination Report, the administrator is required to complete the Form M-1 using information based on at least 60 continuous days of operation by the MEWA or ECE.

Remember, there is an exception to the 90-Day Origination Report requirement. No 90-Day Origination Report is required if the entity was originated in October, November, or December.

2.3 Signature and Date

For paper filings, the administrator must sign and date the report. The signature must be original. The name of the individual who signed as the administrator must be typed or printed clearly on the line under the signature line.

If filing online, the administrator must safeguard the EBSA-assigned Personal Identification Number (PIN) and acknowledge the online certification that the online filer is the administrator authorized to submit the filing on behalf of the MEWA or ECE. This electronic acknowledgement will bind the administrator to the information submitted on the electronic filing in lieu of an original signature.

2.4 Attaching Additional Pages

For paper filings, if more space is needed to complete any item on the Form M-1, additional pages may be attached. Additional pages must be the same size as this form (8 1/2" x 11") and should include the name of the MEWA or ECE, the Item number, and the word “Attachment” in the upper right corner. In addition, the attachment for any item should be in a format similar to that item on the form.

If filing online, these additional pages may be uploaded online at the web filing site.

2.5 Amended Report

For paper filings, to correct errors and/or omissions on a previously filed Form M-1, submit a completed Form M-1 with Part I, Box B(2) checked and an original signature. When filing an amended report on paper, answer all questions and circle the amended line numbers.

Online filers may file an amended report by selecting New Filing at the web filing site and selecting Item B(2) “An amended report.”

SECTION 3

Important: “Yes/No” questions must be marked “Yes” or “No,” but not both. “N/A” is not an acceptable response unless expressly permitted in the instructions to that line.

3.1 Line-By-Line Instructions

Part I - Report Identification Information
Complete either Item A or Item B, as applicable.

Annual Reports: If this is an annual report, check either box A(1) or box A(2).
   - Box A(1): Check this box if calendar year information is being used to complete this report. (See Section 2.1 on Year to be Reported.)
   - Box A(2): Check this box if fiscal year information is being used to complete this report. Also specify the fiscal year. (For example, if fiscal year 2003 information is being used instead of calendar year 2003 information, specify the dates the fiscal year begins and ends.) (See Section 2.1 on Year to be Reported.)

Special Filings: If this is a special filing, check either box B(1), box B(2), or box B(3).
   - Box B(1): Check this box if the filing is a 90-Day Origination Report. (See Section 1.2 on Who Must File, Section 1.3 on When to File, and Section 2.2 on 90-Day Origination Report.)
   - Box B(2): Check this box if the filing is an Amended Report. (See Section 2.5 on Amended Reports.)
   - Box B(3): Check this box if the administrator of the MEWA or ECE is requesting an extension. (See Section 1.3 on When to File.)

Final Reports: Check the box in Item C if the administrator does not intend to file a Form M-1 next year. For example, if this is the third filing following an origination for an ECE, or if a MEWA has ceased operations, the administrator must check this box.
Part II - MEWA or ECE Identification Information

Items 1a through 1d: Enter the name, address, and telephone number of the MEWA or ECE, and any EIN and PN used by the MEWA or ECE in reporting to the Department of Labor or the Internal Revenue Service. If the MEWA or ECE does not have any EINs associated with it, leave Item 1c blank. If the MEWA or ECE does not have any PNs associated with it, leave Item 1d blank. In answering these questions, list only EINs and PNs used by the MEWA or ECE itself and not those used by group health plans or employers that purchase coverage through the MEWA or ECE. For more information on EINs or PNs see Section 1.1 on Definitions.

Items 2a through 2d: Enter the name, address, telephone number and email address of the administrator of the MEWA or ECE, and the EIN used by the administrator in reporting to the Department of Labor or the Internal Revenue Service. For this purpose, use only an EIN associated with the administrator as a separate entity. Do not use any EIN associated with the MEWA or ECE itself. Inclusion of an email address allows the Department of Labor to contact the administrator in the event problems arise, particularly with an electronic filing. For more information on the definition of “administrator,” and on EINs, see Section 1.1 on Definitions.

Items 3a through 3c: Enter the name, address, and telephone number of the entity sponsoring the MEWA or ECE, and any EIN used by the sponsor in reporting to the Department of Labor or the Internal Revenue Service. For this purpose, use only an EIN associated with the sponsor. Do not use any EIN associated with the MEWA or ECE itself. For more information on the definition of “sponsor,” and on EINs, see Section 1.1 on Definitions. If there is no such entity, leave Item 3 blank and skip to Item 4.

Part III - Registration Information

Item 4: Enter the date the MEWA or ECE was most recently “originated.” For this purpose, see the definition of “originated” in Section 1.1.

Item 5: Complete the chart. If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.) When completing the chart, complete Item 5a first. Then for each row, complete Item 5b through Item 5g as it applies to the State listed in Item 5a.

Item 5a. Enter all States in which the MEWA or ECE provides benefits for medical coverage. For this purpose, list the State(s) where the employers (of the employees receiving coverage) are domiciled. In answering this question, a “State” includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Northern Mariana Islands. Enter one State per row.

Item 5b. For each State listed in Item 5a, specify whether the MEWA or ECE is licensed or otherwise authorized to operate as a health insurance issuer in the State listed in that row. (For a definition of the term “health insurance issuer,” see Section 1.1.) For more information on whether an entity that is a licensed or registered MEWA in a State meets the definition of a health insurance issuer in that State, contact the State Insurance Department.

Item 5c. For each “yes” answer in Item 5b, specify whether the MEWA or ECE is licensed or otherwise authorized to operate as a health insurance issuer in the State listed in that row. (For a definition of the term “health insurance issuer,” see Section 1.1.) For more information on whether an entity that is a licensed or registered MEWA in a State meets the definition of a health insurance issuer in that State, contact the State Insurance Department.

Item 5e. For each “yes” answer in Item 5d, enter the name of the insurer and its NAIC number (if available). If there is more than one insurer, enter all insurers and their NAIC numbers (if available).

Item 5f. In each State listed in Item 5a, specify whether the MEWA or ECE has purchased any stop-loss coverage. For this purpose, stop-loss coverage includes any coverage defined by the State as stop-loss coverage. For this purpose, stop-loss coverage also includes any financial reimbursement instrument that is related to liability for the payment of health claims by the MEWA or ECE, including reinsurance and excess loss insurance.

Item 5g. For each “yes” answer in Item 5f, enter the name of the stop-loss insurer and its NAIC number (if available). If there is more than one stop-loss insurer, enter all stop-loss insurers and their NAIC numbers (if available).

Item 6: Of the States identified in Item 5a, identify all States in which the MEWA or ECE conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care under the MEWA or ECE).

For example, consider a MEWA that offers or provides coverage to the employees of six employers. Two employers are located in State X and 70 participants in the MEWA receive coverage through these two employers. Three employers are located in State Y and 30 participants in the MEWA receive coverage through these three employers. Finally, one employer is located in State Z and 200 participants in the MEWA receive coverage through this employer. In this example, the administrator of the MEWA should specify State X and State Z under Item 6 because the MEWA conducts 23 1/3 percent of its business in State X (70/300 = 23 1/3 percent) and 66 2/3 percent of its business in State Z (200/300 = 66 2/3 percent). However, the administrator should not specify State Y because the MEWA conducts only 10 percent of its business in State Y (30/300 = 10 percent).

If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)
Item 7: Identify the total number of participants covered under the MEWA or ECE. For more information on determining the number of participants, see the Department of Labor’s regulations at 29 CFR 2510.3-3(d).

If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Part IV - Information for Compliance with Part 7 of ERISA

Background Information on Part 7 of ERISA: On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. On September 26, 1996, both the Mental Health Parity Act of 1996 (MHPA) and the Newborns’ and Mothers’ Health Protection Act of 1996 (Newborns’ Act) were enacted. On October 21, 1998, the Women’s Health and Cancer Rights Act of 1998 (WHCRA) was enacted. All of the foregoing laws amended Part 7 ofSubtitle B of Title I (Part 7) of ERISA with new requirements for group health plans. With respect to most of these requirements, corresponding provisions are contained in Chapter 100 of Subtitle K of the Internal Revenue Code (Code) and Title XXVII of the Public Health Service Act (PHS Act). These provisions generally are substantively identical.

The Departments of Labor, the Treasury, and Health and Human Services first issued interim final regulations implementing HIPAA’s portability, access, and renewability provisions on April 1, 1997 (published in the Federal Register on April 8, 1997, 62 FR 16893). Two clarifications of the HIPAA regulations were published in the Federal Register on December 29, 1997, at 62 FR 67687. Additional interim final regulations and proposed regulations on HIPAA’s nondiscrimination provisions were published in the Federal Register on January 8, 2001, at 66 FR 1378. Regulations implementing the MHPA provisions were published in the Federal Register on December 22, 1997, at 62 FR 66931. The sunset date of these regulations has been extended through 2003. See 68 FR 18048 (April 14, 2003). Also, regulations implementing the substantive provisions of the Newborns’ Act were published in the Federal Register on October 27, 1998, at 63 FR 57545. Moreover, the notice requirements with respect to group health plans that provide coverage for maternity or newborn infant coverage are described in the Department of Labor’s summary plan description content regulations at 2520.102-3(u). Finally, the Department of Labor has published two sets of informal, question-and-answer guidance on WHCRA. These sets of question-and-answer guidance are available on the Department’s website at www.dol.gov/ebsa and from EBSA’s toll-free hotline at 1-866-444-3272.

General Information Regarding the Applicability of Part 7: In general, the foregoing provisions apply to group health plans and health insurance issuers in connection with a group health plan.

Many MEWAs and ECEs are group health plans or health insurance issuers. However, even if a MEWA or ECE is neither a group health plan nor a health insurance issuer, if the MEWA or ECE offers or provides benefits for medical care through one or more group health plans, the coverage is required to comply with Part 7 of ERISA and the MEWA or ECE is required to complete Items 8a through 9d.

Relation to Other Laws: States may, under certain circumstances, impose stricter laws with respect to health insurance issuers. Generally, questions concerning State laws should be directed to that State’s Insurance Department.

For More Information: EBSA has published four compliance assistance publications on these recent health care laws. The first, “Compliance Assistance Guide: Recent Changes in Health Care Law,” includes comprehensive information on HIPAA, MHPA, the Newborns’ Act, and WHCRA. The second, “Compliance Assistance for Group Health Plans: HIPAA and Other Recent Health Care Laws” provides key compliance considerations for group health plans. The third, the “New Health Laws Notice Guide” summarizes the new health law notice requirements and includes sample language. The fourth, “Self-Compliance Tool for Part 7 of ERISA: HIPAA and other Health Care-Related Provisions” (Self-Compliance Tool) assists health plans and issuers in assessing their compliance line by line with the health laws and is also attached to the Form M-1. You may obtain all of these publications, or speak to a benefits advisor about these laws, by calling the EBSA toll-free hotline at 1-866-444-3272. These booklets are also available on the Internet at: www.dol.gov/ebsa.

Items 8a and 8b: With respect to Item 8a, check “yes” or “no” as applicable. For this purpose, do not include any audit that does not result in required corrective action. If you answer “yes” under Item 8a, identify, in Item 8b, any such litigation or enforcement proceeding.

Item 9a: The HIPAA portability requirements added sections 701, 702, and 703 of ERISA.

General Applicability. In general, you must answer “yes” or “no” to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing benefits for medical care to employees through one or more group health plans.

Exceptions. You may answer “N/A” if either of the following paragraphs apply:

1) The MEWA or ECE is a small health plan (as described in section 732(a) of ERISA and §2590.732(a) of the Department’s regulations).

2) The MEWA or ECE offers coverage only to small group health plans (as described in section 732(a) of ERISA and §2590.732(a) of the Department’s regulations).

Self-Compliance Tool. For purposes of determining if a MEWA or ECE is in compliance with these provisions, Part I of the Self-Compliance Tool may be helpful.
**Item 9b:** MHP A added section 712 of ERISA.

**General Applicability.** In general, you must answer “yes” or “no” to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing benefits for medical care to employees through one or more group health plans.

**Exceptions.** You may answer “N/A” if any of the following paragraphs apply:

1. The MEWA or ECE is a small group health plan (as described in section 732(a) of ERISA and §2590.732(a) of the Department’s regulations).
2. The MEWA or ECE offers coverage only to small group health plans (as described in section 732(a) of ERISA and §2590.732(a) of the Department’s regulations).
3. The MEWA or ECE does not provide both medical/surgical benefits and mental health benefits.
4. The MEWA or ECE offers or provides coverage only to small employers (as described in the small employer exemption contained in section 712(c)(1) of ERISA and §2590.712(e) of the Department’s regulations).
5. The coverage has satisfied the requirements for the increased cost exemption (described in section 712(c)(2) of ERISA and §2590.712(f) of the Department’s regulations).

**Self-Compliance Tool.** For purposes of determining if a MEWA or ECE is in compliance with these provisions, Part II of the Self-Compliance Tool may be helpful.

**Item 9c:** The Newborns’ Act added section 711 of ERISA.

**General Applicability.** In general, you must answer “yes” or “no” to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing benefits for medical care to employees through one or more group health plans.

**Exceptions.** You may answer “N/A” if either of the following paragraphs apply:

1. The MEWA or ECE does not provide benefits for hospital lengths of stay in connection with childbirth.
2. The MEWA or ECE is subject to State law regulating such coverage, instead of the federal Newborns’ Act requirements, in all States identified in Item 5a, in accordance with section 711(f) of ERISA and §2590.711(e) of the Department’s regulations.

**Self-Compliance Tool.** For purposes of determining if a MEWA or ECE is in compliance with these provisions, Part III of the Self-Compliance Tool may be helpful.

**Item 9d:** WHCRA added section 713 of ERISA.

**General Applicability.** In general, you must answer “yes” or “no” to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing benefits for medical care to employees through one or more group health plans.

**Exceptions.** You may answer “N/A” if any of the following paragraphs apply:

1. The MEWA or ECE is a small health plan (as described in section 732(a) of ERISA and §2590.732(a) of the Department’s regulations).
2. The MEWA or ECE offers coverage only to small group health plans (as described in section 732(a) of ERISA and §2590.732(a) of the Department’s regulations).
3. The MEWA or ECE does not provide medical/surgical benefits with respect to a mastectomy.

**Self-Compliance Tool.** For purposes of determining if a MEWA or ECE is in compliance with these provisions, Part IV of the Self-Compliance Tool may be helpful.

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**3.2 Self-Compliance Tool**

A Self-Compliance Tool, which may be used to help assess an entity’s compliance with Part 7 of ERISA, is included on the following pages of these instructions. This tool may also be helpful in answering Items 9a through 9d of the Form M-1.

**Paperwork Reduction Act Notice**

We ask for the information on this form to carry out the law as specified in ERISA. You are required to give us the information. We need it to determine whether the MEWA or ECE is operating according to law. You are not required to respond to this collection of information unless it displays a current, valid OMB control number.

The average time needed to complete and file the form is estimated below. These times will vary depending on individual circumstances.

**Learning about the law or the form:** 2 hrs.

**Preparing the form:** 50 min. - 1 hr. and 35 min.
Section 1. Statement of Purpose

The Department has become aware that certain arrangements have been transacting unauthorized insurance in this state with the assistance and through the professional services of persons licensed by the Department. In many cases these arrangements claim that state insurance laws and regulations applicable to the entity are preempted by the federal Employee Retirement Income Security Act (ERISA). Licensees apparently have believed that they can provide professional services to such arrangements under a claimed ERISA preemption.

However, recent advisory opinions from the U.S. Department of Labor have made it clear that the ERISA preemption claims of many of these arrangements are false and that state insurance laws and regulations, including state laws related to the transaction of unauthorized insurance, are fully applicable to many arrangements that have claimed ERISA preemption.

The purpose of this regulation is to require licensed agents, brokers, third-party administrators and insurers to submit information to the Department prior to assisting in any way the transaction of insurance by certain types of multiple employer arrangements identified in this regulation. These reports will help the Department identify unauthorized insurance arrangements before the transactions occur. The reports also will help licensees identify unauthorized insurance arrangements so that they can protect themselves from potential liability for assisting in the transaction of unauthorized insurance.

Section 2. Definitions
A. “Agent” means an agent as defined under [insert reference to the state’s agent licensing statute].

B. “Arrangement” means a fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits to individuals.

C. “Broker” means a broker as defined under [insert reference to the state’s broker licensing statute].

D. “Collectively bargained arrangement” means an arrangement that provides or represents that it is providing health care benefits or coverage under or pursuant to one or more collective bargaining agreements.

E. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Wherever the word “commissioner” appears, substitute the title of the chief insurance regulatory official.

F. “Employee leasing arrangement” means a labor leasing, staff leasing, employee leasing, contract labor, extended employee staffing or supply, or other arrangement, under contract or otherwise, whereby one business or entity leases or obtains all or a significant number of its workers from another business or entity.

G. “Employee welfare benefit plan” means a plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.

H. “Fully insured by a licensed insurer” means that, for all of the health care benefits or coverage provided or offered by or through an arrangement:

   (1) A licensed insurer is directly obligated by contract to provide all of the coverage to or under the arrangement;

   (2) The licensed insurer assumes all of the risk for payment of all covered services or benefits; and

   (3) The liability of the licensed insurer for payment of the covered services or benefits is directly to the individual employee, member or dependent receiving the health care services.
I. “Licensed insurer” means an insurer, as defined in [insert reference to definition of insurer in state’s unauthorized insurers act], having a certificate of authority to transact insurance in this state.

J. “Reportable MEWA” means a person that provides health care benefits or coverage to the employees of two (2) or more employers. “Reportable MEWA” does not include:

(1) A licensed insurer;

(2) An arrangement which is fully insured by a licensed insurer;

(3) A collectively bargained arrangement;

(4) An employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative; or

(5) An employee leasing arrangement.

Drafting Note: States that have a specific licensing statute for multiple employer welfare arrangements should add an additional exclusion to this subsection as follows:

(6) A multiple employer welfare arrangement (MEWA) having a certificate of authority to transact insurance in this state pursuant to [insert reference to the state’s multiple employer welfare arrangement licensing statute].

K. “Rural electric cooperative” means:

(1) An organization that is exempt from tax under Section 501(a) of Title 26 of the United States Code and which is engaged primarily in providing electric service on a mutual or cooperative basis; or

(2) An organization described in Paragraph (4) or (6) of Section 501(c) of Title 26 of the United States Code that is exempt from tax under Section 501(a) of Title 26 and at least eighty percent (80%) of the members of which are organizations described in Paragraph (1) of this subsection.

L. “Rural telephone cooperative” means an organization described in Paragraph (4) or (6) of Section 501(c) of Title 26 of the United States Code that is exempt from tax under Section 501(a) of Title 26 and at least eighty percent (80%) of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative or other basis.

M. “Third party administrator” has the meaning provided under [insert reference to the state’s third party administrator statute].
Section 3. Agents and Brokers Prohibited from Assisting Reportable MEWAs Prior to Filing

A. An agent or broker may not solicit, advertise or market in this state health benefits or coverage from, or accept an application for, or place coverage for a person who resides in this state with, a reportable MEWA unless the agent or broker first files the information required under Section 8.

B. An agent or broker may not solicit another agent or broker to enter into an arrangement to solicit, advertise or market services, health benefits or coverage of a reportable MEWA unless the agent or broker first files the information required under Section 8.

Section 4. Agents and Brokers Prohibited from Assisting Employee Leasing Arrangements Prior to Filing

A. An agent or broker may not solicit, advertise or market in this state the services, health benefits or coverage of an employee leasing arrangement or a person or arrangement which represents itself as an employee leasing arrangement unless the agent or broker first files the information required under Section 8.

B. An agent or broker may not solicit another agent or broker to enter into an arrangement to solicit, advertise or market the services, health benefits or coverage of an employee leasing arrangement unless the agent or broker first files the information required under Section 8.

Section 5. Agents and Brokers Prohibited from Assisting Collectively Bargained Arrangements Prior to Filing

A. An agent or broker may not solicit, advertise, or market in this state health benefits or coverage from, or accept an application for, or place coverage for a person who resides in this state with, a collectively bargained arrangement or an arrangement that represents itself as a collectively bargained arrangement unless the agent or broker first files the information required under Section 8.

B. An agent or broker may not solicit another agent or broker to enter into an arrangement to solicit, advertise or market the health benefits or coverage of a collectively bargained arrangement unless the agent or broker first files the information required under Section 8.

Drafting Note: States may wish to adopt a procedure to ensure that filings made pursuant to this regulation are compared with filings made by employee leasing firms under the NAIC Employee Leasing Registration Model Act and Employee Leasing Model Regulation.

Section 6. Third-Party Administrators and Licensed Insurers Prohibited from Assisting Reportable MEWAs Prior to Filing

© NAIC 1996
A. No third party administrator may solicit or effect coverage of, underwrite for, collect charges or premium for, or adjust or settle claims of a resident of this state for, or enter into any agreement to perform any of those functions for, a reportable MEWA that provides coverage to residents of this state unless the third party administrator first files the information required under Section 8.

B. No licensed insurer may solicit or effect coverage of, underwrite for, collect charges or premiums for, adjust or settle claims of a resident of this state for, or enter into any agreement to perform any of those functions for a reportable MEWA that provides coverage to residents of this state unless the insurer first files the information required under Section 8.

C. A licensed insurer that issues or has issued any insurance coverage to a reportable MEWA that covers residents of this state, including, but not limited to, specific or aggregate stop-loss coverage, shall file the information required under Section 8 within thirty (30) days after the coverage is issued or within thirty (30) days after the date the reportable MEWA first provides coverage to a resident of this state, whichever is later.

Section 7. Lack of Knowledge Not a Defense

A. Lack of knowledge or intent to deceive with respect to the organization or status of insurance coverage of a reportable MEWA, employee leasing firm or collectively bargained arrangement is not a defense to a violation of this rule.

B. A filing under this rule is solely for the purpose of providing information to the commissioner. This rule and a filing under this rule do not authorize or license a reportable MEWA, employee leasing firm, collectively bargained arrangement or any other arrangement to engage in business in this state if otherwise prohibited by law.

Section 8. Information Required to be Filed and Kept Current

A. An agent, broker, third party administrator or insurer required to file under Sections 3 through 6 shall file all of the following information on a form prescribed by the commissioner:

(1) A copy of the organizational documents of the reportable MEWA, employee leasing firm or collectively bargained arrangement, including the articles of incorporation and bylaws, partnership agreement or trust instrument;

(2) A copy of each insurance or reinsurance contract that purports to insure or guarantee all or any portion of benefits or coverage offered by the
reportable MEWA, employee leasing firm or collectively bargained arrangement to a person who resides in this state;

(3) Copies of the benefit plan description and other materials intended to be distributed to potential purchasers; and

(4) The names and addresses of any person performing or expected to perform the functions of a third party administrator for the reportable MEWA, employee leasing firm or collectively bargained arrangement.

B. A filing under this rule is ineffective and is not in compliance with this rule if it is incomplete or inaccurate in any material respect.

C. A person who has made a filing under this Act shall amend the filing within thirty (30) days of the date the person becomes aware, or exercising due diligence should have become aware, of any material change to the information required to be filed. The amended filing shall accurately reflect the material changes to the information originally filed.

Section 9. Liability for Violation of This Rule

In the event that an arrangement that is an unauthorized insurer fails to pay a claim or loss in this state within the provisions of its contract, a person who violates this rule with respect to the arrangement shall be liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of the insurance contract.

Drafting Note: A state insurance department adopting this rule may wish to cite its statutory authority for adopting the rule. This model regulation may be enacted under the authority of the NAIC Model Unauthorized Insurers Act. State statutes which are the equivalent to the following Model NAIC Acts provide also provide authority to adopt some or all of the provisions of the rule:

1. Section 15 of the NAIC Agents and Brokers Licensing Model Act.
4. Section 4B of the NAIC Third Party Administrator Statute.
5. Section 3 of the NAIC Model Law on Examinations.

The department may also wish to cite the penalties provided for violation of those Acts.
Legislative History (all references are to the Proceedings of the NAIC)

REPORTING REQUIREMENTS FOR LICENSEES SEEKING TO DO BUSINESS WITH CERTAIN UNAUTHORIZED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs)

MODEL REGULATION

The date in parentheses is the effective date of the legislation or regulation, with the latest amendments.

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REPORTING REQUIREMENTS FOR LICENSEES SEEKING TO DO BUSINESS WITH CERTAIN UNAUTHORIZED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs)
MODEL REGULATION
Appendix D – Department of Labor Advisory Opinion Letters

Dear Ms. Mader:

This is in response to your request for an advisory opinion on behalf of the National Automatic Sprinkler Industry Welfare Fund (the Fund) concerning the status of the Fund under the provisions of title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you request an advisory opinion stating that the Fund is an employee welfare benefit plan within the meaning of section 3(1) of title I of ERISA, and you assert that the Fund is not a multiple employer welfare arrangement as described in recently added section 3(40) of title I of ERISA. You state that you are seeking to inform Fund trustees of their responsibilities under state insurance law.

In connection with your request for an advisory opinion you submitted the trust document governing the Fund and a collective bargaining agreement. The collective bargaining agreement dated April 1, 1982 (the CBA) is between the National Automatic Sprinkler and Fire Control Association, Inc. (NASA) and Sprinkler Fitters Local Union No. 669 of the United Association (UA) of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO (Local 669). Article 19 of the Agreement describes the Fund and provides for contributions by contractors on behalf of employees working under the CBA.

The trust document describes the arrangement as follows:

... by and between the National Automatic Sprinkler and Fire Control Association, Inc. (hereinafter referred to as 'NASA') for and on behalf of its contractor members who are bound to a Collective Bargaining Agreement with the Union and other Employers, as defined in Article I, Section 3 of this Trust Agreement, who are contractually obligated to make contributions to the National Automatic Sprinkler Industry Pension Fund and Sprinkler Fitters Union No. 669 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO (hereinafter referred to as 'Union'), and certain individual Trustees ...
Article I, section 3, of the trust document includes among employers eligible to contribute to the Trust the following employers:

... (1) the members of NASA who are bound to a Collective Bargaining Agreement with the Union; (2) members who subsequent to the date of this Agreement authorized NASA to negotiate and execute Collective Bargaining Agreements on their behalf; (3) any employers engaged in the sprinkler or fire control business of installing, servicing and maintaining sprinkler and fire control systems, who are now or may become parties to a Collective Bargaining Agreement with a Local Union affiliated with the United Association, which provides that the Employer party to the Agreement shall contribute to the National Automatic Sprinkler Industry Welfare Fund; (4) employers employing sprinkler fitters of a Sprinkler Local Union affiliated with the United Association who are contractually obligated, by agreements or signed stipulations, to make contributions and do in fact make one or more payments to the National Automatic Sprinkler Industry Welfare Fund; and (5) sprinkler Local Unions affiliated with the United Association who are contractually obligated by a signed stipulation to make contributions on behalf of all paid employees of Sprinkler Local Unions to the National Automatic Sprinkler Industry Welfare Fund and do in fact make one or more such payments...

Local 669 constitution and bylaws and the NASA organizational documents were not included in the materials you submitted; nevertheless, nothing in your correspondence suggests that Local 669 is not a bona fide employee organization or that NASA is not a bona fide employer association within the meaning of sections 3(4) and (5) of Title I of ERISA.* Therefore, for purposes of this opinion, we assume that Local 669 is an employee organization and that NASA is an employer with respect to the Fund. Accordingly, the opinion rendered herein is dependent on the accuracy of the assumption. You describe the Fund

* In a series of advisory opinions, the Department of Labor has discussed a number of factors that should be considered in determining whether an organization is a bona fide employee organization or a bona fide group or association of employers acting for an employer in relation to an employee benefit plan.
as jointly administered by union and employer trustees. Specifically, article III, section 1, of the trust document provides for six Fund trustees. Local 669 appoints two trustees in accordance with Local 669 constitution and bylaws, and the remaining union trustee is appointed by other UA local unions as prescribed by the UA General President. NASA appoints all three employer trustees. According to article III, section 6, the party designating a trustee may also establish the trustee's term of office. You state that you believe the Fund complies with sections of the Taft-Hartley Act identified in your correspondence.

You also state that the Fund became self-insured as of June 1983, with the exception of certain life insurance coverage. The Fund's sole purpose appears to be the provision of medical, surgical, hospital care, sickness, accident, disability, and death benefits.

Section 3(1) of ERISA defines the term "employee welfare benefit plan" as:

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

Based on the information you submitted, the Fund appears to provide benefits among those enumerated in section 3(1) of ERISA and appears to be established and maintained both by employee organizations (Local 669, other UA locals, and UA itself) and by NASA, a group or association of employers meeting the definition of an employer within the meaning of section 3(5) of ERISA, with respect to members' employees and therefore appears to be an employee welfare benefit plan within the meaning of section 3(1) of ERISA.

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) is not subject to state insurance regulation.

You should be aware, however, that if benefits provided by the Fund extend to individuals (other than employees of a UA local) who are not under the jurisdiction of UA's or UA locals' collective bargaining agreements with NASA
(for example, in accordance with unspecified agreements or signed stipulations),
the Department of Labor cannot assure you that the above conclusions concerning
the Fund under title I of ERISA are applicable.

This letter constitutes an advisory opinion under ERISA Procedure 75-1.
Accordingly, this letter is issued subject to the provisions of that procedure,
including section 10 thereof relating to the effect of advisory opinions.

The opinions expressed in this letter relate solely to the legal consequences
of the facts described herein under title I of ERISA. In particular, we express
no opinion regarding the legal consequences of those facts under section 302

Sincerely,

Morton Kleven
Deputy Administrator
Pension and Welfare Benefit Programs
Mr. J. Scott Kyle  
Texas State Board of Insurance  
1110 San Jacinto  
Austin, Texas 78701-1998

Dear Mr. Kyle:

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

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

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

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

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

We hope the following is responsive to your request.

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

Second, it is the view of the Department that Congress, in enacting the MEWA provisions, recognized that the application and enforcement of state insurance laws to ERISA-covered MEWAs 1/ provide both appropriate and necessary protection for the participants and beneficiaries covered by such plans, in addition to those protections afforded by ERISA. For this reason, the Department is of the opinion that in the context of

1/ The principles discussed in this letter apply to those MEWAs which are also title I plans, and, thus, such MEWAs will be referred to as "ERISA-covered MEWAs".
section 514(b)(6)(A)(ii), which, in the case of a MEWA which is not fully insured, saves from ERISA preemption any law of any state which regulates insurance to the extent such law is not inconsistent with the provisions of title I of ERISA, a state law which regulates insurance would be inconsistent with the provisions of title I to the extent that compliance with such law would abolish or abridge an affirmative protection or safeguard otherwise available to plan participants and beneficiaries under title I of ERISA. For example, state insurance law which would require an ERISA-covered MEWA to make imprudent investments would be deemed to be "inconsistent" with the provisions of title I of ERISA because compliance with such a law would "conflict" with the fiduciary responsibility provisions of ERISA section 404, and, as such, would be preempted pursuant to the provisions of ERISA section 514(b)(6)(A)(ii).

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

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

4/ While certain permissive state insurance laws may not be "inconsistent" with the provisions of title I of ERISA as here defined, the behavior permitted under such laws may yet be denied to ERISA-covered MEWAs and their fiduciaries pursuant to ERISA section 514(b)(6)(A)(ii), which applies the provisions of title I as well as state insurance laws which are not inconsistent with the provisions of title I of ERISA to such MEWAs. For example, neither ERISA-covered MEWAs nor their fiduciary managers may take advantage of laws which would permit an ERISA-covered MEWA to engage in transactions which are prohibited under the provisions of ERISA section 406; to effectuate exculpatory provisions relieving a fiduciary from responsibility or liability for any responsibility, obligation, or duty under ERISA; or, to fail to meet the reporting and disclosure requirements contained in part 1 of title I of ERISA.
However, a state insurance law will, generally, not be deemed "inconsistent" with the provisions of title I of ERISA if it requires ERISA-covered MEWAs to meet more stringent standards of conduct, or to provide more or greater protections to plan participants and beneficiaries, than required by ERISA. For example, state insurance laws which would require more informational disclosure to plan participants of an ERISA-covered MEWA will not be deemed by the Department to be "inconsistent" with the provisions of ERISA. Similarly, a state insurance law prohibiting a fiduciary of an ERISA-covered MEWA from availing himself of an ERISA statutory or administratively-granted exemption permitting certain behavior will not be deemed by the Department to be "inconsistent" with the provisions of ERISA.

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

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

Finally, we would note that while section 514(b)(6)(B) of ERISA provides that the Secretary of Labor may prescribe regulations under which the Department may exempt MEWAs from state regulation under section 514(b)(6)(A)(ii), the Department has neither prescribed regulations in this area, nor granted any such exemptions.
This letter constitutes an advisory opinion under ERISA Procedure 76-1.

Sincerely,

Robert J. Doyle
Director of Regulations
and Interpretations
Ms. Christine Phillips  
Investigator  
Oregon Department of Insurance and Finance  
21 Labor and Industries Building, Room 440-2  
Salem, Oregon 97310

Dear Ms. Phillips:

This is in reply to your request for an advisory opinion regarding the applicability of title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically you ask whether the AGC Health Benefit Trust (the Trust) is a multiple employer welfare arrangement (MEWA) within the meaning of section 3(40) of title I of ERISA and therefore subject to the applicable regulatory authority of the State of Oregon and whether the Trust is an employee welfare benefit plan within the meaning of section 3(1) of title I of ERISA or an employee pension benefit plan within the meaning of section 3(2) of that title.

The information you submitted indicated that the Trust was created pursuant to a trust agreement effective January 1, 1971, and amended and restated on January 1, 1986, between the Oregon-Columbia Chapter, The Associated General Contractors of America, Inc. (AGC) on behalf of itself and its employer members as Trustor and four individuals as Trustees. The restated trust agreement states that the purpose of the Trust is to provide health benefits to eligible employees of employers who qualify and elect to make contributions. The term "employer" is defined in Article I, Section 5 as follows:

Subject to approval by Trustees, Trustor, and any other employer who is a member of Trustor, including an affiliate member who is required to make contributions to the Fund, Trustees may adopt uniform rules and regulations for the inclusion of new employers in and the expulsion of current employers from Trust participation based on sound actuarial principles for the funding of Plan benefits. No employee shall be allowed to begin participation or to continue to participate in the Plan and Trust if such participation would cause the Trust to not constitute a voluntary employees' beneficiary association.

Trustees of the Trust serve at the pleasure of AGC. Article 2, Section 2.1 of the Bylaws of the AGC provides for the following classes of membership.

2.1.1 The classes of membership and affiliation in the Association are a) General Contractor Members (voting members); and b) Associates (non-voting affiliates).
2.1.2 General Contractor Member. General Contractor Members (Members) are the members of the association. A Member shall be an individual partnership, corporation, or other business entity that is capable of performing construction work as a contractor with overall responsibility for the satisfactory completion of a project using its own forces to perform or supervise part of the work and who is also in good standing with the Association.

2.1.3 Associate. An Associate shall be an individual, partnership, corporation, or other business entity that is in good standing with the Association and qualifies under any of the following categories:

2.1.3.1 Subcontractor Associate. One who performs construction work as a subcontractor, and does not qualify or elect Member status;

2.1.3.2 Industry Associate. One who serves the construction industry in a trade, fiduciary, or other relationship;

2.1.3.3 Professional Associate. One who provides professional services to the construction industry;

2.1.3.4 Construction Employee Associate. A current employee in the construction industry, or one who is actively seeking employment in the construction industry, who has a recent successful history of employment in the construction industry;

2.1.3.5 Public Employee Associate. A public employee involved in or responsible for public works construction for a federal, state, county, or municipal government or other political subdivision; or

2.1.3.6 Retiree Associate. One who has retired from the construction industry but while working was an owner or manager of a Member or Associate.

2.1.4 An individual, partnership, corporation, or other business entity which would otherwise qualify as an Associate but which performs over 25% of its volume as a general contractor must be a Member.
2.1.5 The Board of Directors is the sole judge of the qualifications and proper classification of a Member or Associate or prospective Member or Associate.

In a telephone conversation with a representative of this Office, you stated that, to your knowledge, the Trust is not maintained under or pursuant to any collective bargaining agreement, the participating employers in the Trust are not a "control group" within the meaning of section 3(40)(B) of title I of ERISA, and there is no rural electric cooperative in any way involved with the Trust.

Section 3(40)(A) of title I of ERISA defines the term "MEWA" to include:

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

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

(ii) by a rural electric cooperative.

Section 3(40)(B) provides in pertinent part:

For purposes of this paragraph --

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

(ii) the term "control group" means a group of trades or businesses under common control, . . .

Based upon the information you submitted, it is the position of the Department of Labor (the Department) that the Trust is a MEWA within the meaning of section 3(40). The Trust covers the employees of two or more separate, independent employers; is not maintained by a rural electric cooperative; and is not maintained under or pursuant to any collective bargaining agreement.

Although section 514(a) of ERISA provides that any state law or regulation which relates to an employee benefit plan covered by ERISA is preempted, section 514(b) of title I of ERISA provides:
(6)(A) Notwithstanding any other provision of this section-- (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides-- (i) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and (ii) provisions to enforce such standards, and (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.

(D) 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.

Although section 514(b)(6)(B) provides that the Secretary of Labor may prescribe regulations under which the Department may exempt MEWAs from state regulation under section 514(b)(5) (A)(ii), the Department has previously stated that it did not see the need to prescribe such regulations. The Department, at this time, has not changed its position. Accordingly, the Department is not exempting MEWAs from state regulation. It is, therefore, the Department's position that the preemption provisions of ERISA do not preclude state regulation of the Trust at least to the extent provided in section 514(b)(6)(A), regardless of whether it is an employee benefit plan covered by
title I of ERISA, because it is a MEWA within the meaning of section 3(40) of that title.

Enclosed for your information is a copy of Opinion 90-18A (issued July 2, 1990) which discusses the scope of the states' authority to regulate pursuant to section 514(b)(6)(A).

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

We found no indications in the information you submitted that the Trust may be fully insured. The fact that the Trust may have obtained stop-loss insurance does not in itself indicate the Trust is fully insured within the meaning of section 514(b)(6)(D). Although the information you submitted did not include a copy of the stop-loss insurance contract, it is the Department's position that such a policy shall be considered to fully insure an arrangement only if the terms of the arrangement provide that the amount of all benefits are guaranteed under the insurance contract or policy. Many stop-loss policies only guarantee benefits above a threshold amount paid through another funding vehicle. Accordingly, based on the information provided, we are unable to conclude that the Trust is fully insured within the meaning of section 514(b)(6)(D) of title I of ERISA.

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

Sincerely,

Robert J. Doyle
Director of Regulations and Interpretations

Enclosure

cc: PWBA/ORI:DOC:JLKeene;mif;523-8521;1/8/91
Control# P-10983AS
Mr. Gerald Grimes  
Oklahoma Insurance Commissioner  
1901 N. Walnut  
P.O. Box 53808  
Oklahoma City, Oklahoma 73158-3408

Dear Commissioner Grimes:

This is in response to the joint request of the Insurance Commissioners of the states of Oklahoma, Texas and California as to whether state regulation of the Diversified Industrial Group (DIG) is preempted under section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

According to the information provided, DIG is a self-insured or partially self-insured trust that provides health care and other benefits to members of the International Union of Petroleum and Industrial Workers (IUPIW). The membership of the IUPIW consists of "Members", who are individuals working in bargaining units represented by the IUPIW in collective bargaining, and "Associate Members", who are not currently part of an organized bargaining unit and with respect to whom the IUPIW has no obligation to collectively bargain. According to an IUPIW "Resolution" (undated), accompanying the request, "Associate" membership is open to any person who is interested in advancing the cause of organized labor but who is not eligible for membership as a member of a bargaining unit represented by the IUPIW for collective bargaining. Also, according to the "Resolution", "Associate Members" are entitled to hold office and to be elected a delegate and are allowed a voice and vote in the internal union affairs of the IUPIW, in the same manner as all other members, under the constitution. "Associate Members" are also entitled, among other things, to participate in the DIG health benefits program. We understand that the number of "Associate Members" may equal or exceed the current number of "Members" participating in the IUPIW and DIG.

According to the provided information, DIG was established and is maintained pursuant to various collective bargaining agreements between the IUPIW and various employers, including the Western Labor Exchange, Inc. According to the Agreement and Declaration of Trust creating DIG, which accompanied the request, DIG is to be administered by a board of four trustees, two of whom are appointed by the IUPIW and two of whom are to be appointed by employers.
Section 514(a) of ERISA generally provides that any state law which relates to an employee benefit plan covered by title I of ERISA is preempted, except to the extent otherwise provided in section 514(b). The only exception in section 514(b) which appears to be relevant to your request is the exception set forth in section 514(b)(6), which excepts from ERISA preemption the application and enforcement of state insurance laws with respect to "multiple employer welfare arrangements." The term "multiple employer welfare arrangement" (MEWA) is defined in ERISA section 3(40)(A) to mean:

an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of providing any benefit described in paragraph (1) [section 3(1)[ to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained --

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

* * *

(Emphasis supplied)

On the basis of the information provided, it appears that DIG is maintained pursuant to one or more collective bargaining agreements between the IUPIW and various employers, albeit all participants covered by the DIG plan are not represented in collective bargaining by the IUPIW. Therefore, assuming that the agreements pursuant to which DIG is maintained are bona fide collective bargaining agreements, it is the view of the Department that DIG does not constitute a MEWA within the meaning of section 3(40)(A). Accordingly, state regulation of DIG is preempted under section 514(a) to the extent that DIG constitutes an "employee welfare benefit plan" within the meaning of ERISA section 3(1).

In the absence of any facts or representations concerning the extent to which the agreements, pursuant to which DIG is maintained, constitute bona fide collective bargaining agreements for purposes of section 3(40)(A)(i), the Department, without making any findings, is assuming, for purposes of this ruling, that the agreements are agreements which the Department would find to be collective bargaining agreements.
Section 3(1) defines the term "employee welfare benefit plan" to include:

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

While DIG appears to provide benefits described in section 3(1), i.e., medical benefits, in order to constitute an "employee welfare benefit plan" covered by title I, DIG must also be established or maintained by an employer, an employee organization, or by both. The term "employee organization" is defined in ERISA section 3(4) 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.

(Emphasis supplied)

On the basis of the information provided, it appears that the "Members" and "Associate Members" of the IUPIW have the right to hold office and vote in the internal affairs of the IUPIW and, therefore, appear to "participate" in the IUPIW. Further, it appears that, as the collective bargaining representative of its "Members", the IUPIW exists, at least "in part", for the purpose of dealing with employers.

Accordingly, it is the view of the Department that the IUPIW is an "employee organization" within the meaning of ERISA section 3(4) with respect to its members. Inasmuch as DIG was established and is maintained by the IUPIW, an "employee organization" within the meaning of section 3(4), in addition to
employers with respect to which the IUPIW has collective bargaining agreements, it is the view of the Department that DIG is an "employee welfare benefit plan" within the meaning of ERISA section 3(40)(A)(i). Thus, as an employee benefit plan covered by ERISA, which also meets the exception of section 3(40)(A)(i) from the definition of "multiple employer welfare arrangement," the application and enforcement of any state laws which "relate to" DIG would be preempted by ERISA section 514(a).

The Department notes, however, that although state law is preempted by section 514(a) of ERISA, the application of other federal laws to ERISA-covered plans is preserved by section 514(d) of ERISA. The legality of employer contributions to DIG is dependent upon compliance with section 302(c)(5) of the Labor-Management Relations Act of 1947 (LMRA) (29 U.S.C. §186(c)(5)), which establishes an exception from a general proscription against payments by an employer to, among others, "any representative of his employees who are employed in an industry affecting commerce, or any labor organization, or any officer or employee thereof, which represents or seeks to represent, or would admit to membership, any of the employees of such employer who are employed in an industry affecting commerce. . . ." The exception in 302(c)(5) of the LMRA applies only --

with respect to money or other thing of value paid to a trust fund established by such representative, for the sole and exclusive benefit of the employees of such employer, and their families and dependents (or of such employees, families, and dependents jointly with employees of other employers making similar payments, and their families and dependents)

29 U.S.C. §186(c)(5)

Moreover, the relevant definition of "employee", found in section 152(3), does not include --

any individual employed as an agricultural laborer, or in the domestic service of any family or person at his home, or any individual employed by his parent or spouse, or any individual having the status of an independent contractor, or any individual employed as a supervisor, or any individual employed by an employer subject to the Railway Labor Act, as amended from time to time, or by any other person who is not an employer as herein defined. (Emphasis Added)

29 U.S.C. §152(3)

The documents submitted with your request indicate that independent contractors may be included as "Associate Members" of the IUPIW. In addition, it appears that employers who have not
signed a collective bargaining agreement with IUPIW are making payments on behalf of their employees into the jointly-trusted DIG, or that employees of such non-signatory employers are making payments on their own behalf into DIG. Accordingly, the Department is referring the material submitted by you to the Department of Justice which has responsibility for the enforcement of section 302 of the LMRA, to determine what, if any, action may be appropriate with respect to the operation of DIG.

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

Sincerely,

Robert J. Doyle
Director of Regulations and Interpretations
AUG 3 1992

Mr. Philip M. Payne  
Division of Legal Services  
Florida Department of Insurance  
412 Larson Building  
Tallahassee, Florida 32399-0300  

RE: United Welfare Fund and Amalgamated  
Local Union 355  

Dear Mr. Payne:

The purpose of this letter is to apprise interested parties of the Department of Labor's (the Department) action with respect to the subject Fund for purposes of section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and to afford the parties an opportunity to submit any additional information or views which they believe relevant to the consideration of this matter.

The issue before the Department is whether, for purposes of the exception from the definition of "multiple employer welfare arrangement" in ERISA section 3(40)(A)(1), the agreements pursuant to which the United Welfare Fund (the UWF) is established or maintained, are collective bargaining agreements. For the reasons discussed below, the Department declines to make a determination for purposes of section 3(40)(A)(1) that the UWF is established or maintained pursuant to agreements which constitute collective bargaining agreements.

Background:

The Department's involvement in this matter arises from litigation brought by the Amalgamated Local Union 355 (the Union) and the UWF seeking to enjoin the Florida Department of Insurance from enforcing certain Florida insurance statutes against them (Amalgamated Local Union No. 355 et al. v. Gallagher, United States District Court, Eastern District of New York, 91-CV-0193). Following an investigation by the Florida Department of Insurance into the UWF's activities in the State of Florida, the Department of Insurance concluded that the UWF appeared to be a "multiple employer welfare arrangement" (MEWA), and, as such, was operating as an unauthorized insurer in violation of Florida statutes. The UWF maintains that it is a collectively bargained multiemployer plan within the meaning of ERISA section 3(37)(A), not a MEWA, and thus exempt from state regulation under ERISA section 514(a). The Florida Department of Insurance contends that the UWF and the Union are actually engaged in the sale of insurance and that the "collective bargaining agreements" referred to by the Union and the UWF are ruses to avoid State insurance regulation. Allyne R. Ross, United States Magistrate, issued a report and
By letter dated November 20, 1991, the Department apprised the State of Florida Insurance Department and Counsel for the Union and UWF (i.e., parties to the litigation) of the Department's decision to make a "finding" as to whether the agreements pursuant to which UWF is maintained constitute "collective bargaining agreements" and invited the parties to submit any documents they believed relevant to the Department's determination under ERISA section 3(40)(A)(i). The letter to the Counsel for the Union and UWF also requested the submission of specific information and documents, including copies of a representative sample of executed collective bargaining agreements pursuant to which the UWF is maintained. Each of the parties submitted information and documents for consideration. Counsel for the Union and UWF submitted, among other things, copies of nine agreements, examples of National Labor Relations Board certifications and a listing of all employers and employee organizations which are parties to agreements under or pursuant to which the UWF is maintained, as well as certain other information relating to the Union and UWF.\(^1\) On January 23, 1991, the Department requested from the Counsel for the Union and UWF additional information concerning the employers participating in the UWF and that information was provided by Counsel.

On February 19, 1992, the Department apprised the parties that, in order to compile a sufficient record upon which to make a determination, the Department determined it necessary to obtain information from contributing employers. Specifically, the parties were apprised that the Department would be conducting

\(^{1}\) Counsel for the Union and UWF submitted on October 8, 1991, prior to the Department's formal request, a letter describing the Union and the UWF, as well as examples of collective bargaining agreements, arbitration awards, National Labor Relations Board representations and certifications, unfair labor practice charges filed by the Union and additional documents relating to the UWF operations and activities of the Union. The October 8, 1991 letter has been included as part of the record of this review, accordingly, interested persons are referred to the record for a complete description of the representations provided in that letter.
interviews of employers who are parties to agreements with the Union to ascertain whether the agreements are the product of good faith bargaining between bona fide employee representatives and participating employers.²

Using information furnished on behalf the Union and the UWF, the Department selected 30 employers which, taking into account a variety of factors, appeared to be a representative sample of the employers identified as currently having collective bargaining agreements with the Union and participating in the UWF. The factors applied in selecting employers were the location and size of the employer, the duration of the relationship between the Union and the employer, the nature of the employer's participation in collective bargaining (i.e., whether participation was direct or through an association of employers). Each selected employer was sent a letter in advance of their interview notifying them of the Department's intention to contact them by telephone for purposes of discussing their participation in the UWF. Of the 30 selected employers, 27 employers were interviewed.³ A summary of the information obtained as a result of these interviews follows.⁴

Results of Interviews:

In brief, the Department found, on the basis of its interviews that, of the 27 participating employers interviewed by the Department, 18 employers indicate employer participation in the UWF in the absence of an agreement which is the product of good faith bargaining and/or the absence of any employee representation by the Union.⁵ One employer interviewed did not

² The Department concluded that, where a controversy exists, establishment of the bona fide of the bargaining process and employee representation by the Union must be based in part on independent factual determinations by the Department and not solely on the basis of the representations of the parties.

³ Despite efforts to the contrary, the Department was unable to arrange interviews with three of the selected employers.

⁴ Interviews were conducted with the owners, officers, or other person represented to be familiar with the company's benefits programs.

⁵ Haber Fabrics (Texas); Turnbull, Wase & Lyons, PA (Maryland); Warren Engineering (Ohio); Artisan Electrical Contractors (Delaware); Imperial Carpet & Textile (Illinois); Gnos Reserve (Louisiana); DeRosa Agency (New York); Precision Chevrolet (Mayslanding location, New Jersey); Interlogic Industries (New York); Management Systems (Arizona); Wichita River Oil Corp. (Colorado); R.J. Imports (Illinois); Nevada
provide sufficient information to reach any conclusion concerning the employer's participation in the UWF. The following discussion focuses on the information obtained from the 18 employers whose participation in the UWF does not appear to be pursuant to such agreements.

Fourteen of these 18 employers indicated they either have not entered into a collective bargaining agreement with the Union or have no recollection of having entered into a collective bargaining agreement with the Union. These 14 employers indicated there was no bargaining or negotiations with the Union. In sum, these employers do not view their companies as parties to a collective bargaining agreement, but merely purchasers of medical coverage from the UWF. Some of these employers indicated that while their employees may have signed union membership cards and pay union dues they do not view their company as unionized. Employee union membership and payment of dues appeared to be a condition to employer participation in the UWF, at least in some instances. Three of the employers, as a result of the Department's interviews, located unexecuted and incomplete applications for membership in an association, which authorizes the association to negotiate with the Union on their behalf. None of these employers had any recollection of having joined an association or authorizing anyone to act on their behalf in negotiations with the Union.

Three of the 18 employers acknowledged entering into an agreement with the Union, but indicated that those agreements were not entered into as the result of bargaining with the Union, but solely to obtain medical coverage. Moreover, there was no indication that such agreements in any way affected the employment relationships beyond providing medical coverage.

In one of the 18 interviews, the president of the company indicated that he represented the company, which includes one other employee, in negotiations with the Union and which resulted in an agreement with Union. In the course of the interview, the president indicated he also serves as the shop steward, which, in the view of the Department, raises serious questions as to the bona fides of the agreement.

Diamond Exchange (Nevada); Alternative Defense Counsel (California); Finkle & Ross (New York); Thomas Kearney Custom Builders (Pennsylvania); American Pipe and Tank Lining (New York); Acme Lawn Sprinklers (New York).

6 Universal Process Equipment (New Jersey).
In addition to the apparent absence of any good faith bargaining by the Union with these employers, the interviews also indicate the absence of any meaningful employee representation by the Union in relation to the UWF or working conditions generally. Based on the interviews, it appears that most of the contacts were with the employers and related solely to the UWF and typically involved individuals described as "insurance agents." It is also noted that, in the case of employees of three employers, the employees never became members of the Union. Six participating employers indicated that no union dues are paid by their employees and three employers indicated they were unsure whether payments to the UWF included union dues.

Questions concerning the bona fides of the Union and the UWF also result from the appearance, if not fact, that participation in the UWF is viewed by a number of participating employers as marketed by individuals who are insurance agents, whether or not such individuals hold themselves out to be acting in another capacity (e.g. labor consultant). Sixteen of the 18 employers indicated they obtained UWF coverage for their employees through insurance agents. The remaining two employers signed up through organizations, which may or may not be insurance agents or brokers. In one case, the employer obtained medical coverage for company employees through Park Services and was unaware prior to the Department's interview that the company was involved with the Union. In the other case, the employer obtained coverage through the H.P. Agency, whose insurance agent apparently received a commission as a result of the employer's participation. The employer thought the Union acted as a third party administrator.

One employer participating in the UWF provided the Department with a copy of a letter it received in connection with a solicitation from WFG Associates, Inc. to participate in the UWF. The letter, dated May 28, 1990, provides, in relevant part, the following information concerning the Fund:

The United Welfare Fund (UWF), otherwise known as Amalgamated Local Union 355, was established approximately 37 years ago as an "employers" union. Unlike a normal union that is set up by employees in order to obtain better working conditions or higher wages, this was structured by the owners of companies in order to establish fringe benefits that they felt were better suited to their needs.

Approximately 3 - 4 years ago the UWF opened up the health plan to companies who wanted to participate only in this area, and not represent them for purposes of collective bargaining. Since the UWF is a legal union, however, every employer and employee must be a member to belong to the
health plan. The only contact that the UWF will have with your employees is to forward them an annual statement which summarizes the contributions and dividends that were deposited on their behalf in the "Security Fund". There is no attempt to organize them or represent them for purposes of collective bargaining. You will be part of their health plan and nothing more.

While the Department does not have information indicating either the Union's or the UWF's endorsement of the above description, the descriptions contained in the letter do appear to present a characterization of the Union and the UWF which is consistent with the information obtained from the above referenced 13 employers identified by the Union and UWF as participating in the UWF.

Since the majority of the interviews indicate a lack of an agreement which is the product of good faith bargaining and/or the absence of union representation, the Department is unable to make a determination with respect to the remaining eight employers. The Department believes that the presence of 18 employers as parties to non-bona fide collective bargaining agreements taints the results of the interviews with the remaining eight employers.

Analysis:

ERISA Section 3(40)(A) defines the term "multiple employer welfare arrangement, in relevant part, to mean:

... an employee welfare benefit plan or any other arrangement (other than an employee welfare benefit plan) which is established or maintained for purposes of offering or providing any benefit described in paragraph (1) to employees of two or more employers . . . , except that such term does not include any plan or other arrangement which is established or maintained --

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

*    *    *

As indicated above, the issue before the Department is whether, for purposes of this exception to the MEWA definition, the UWF is a plan established or maintained pursuant to one or more collective bargaining agreements. For purposes of the MEWA exception in section 3(40)(A)(i), the Department has indicated that "an employee benefit plan will generally be considered to be
established or maintained "under or pursuant to a collective bargaining agreement" if the agreement is a bona fide collective bargaining agreement and the agreement provides, directly or indirectly, for establishment or maintenance of a plan for the benefit of employees represented by a union in the collective bargaining process. 7 The Department also indicated that "[w]hile no one item is determinative, factors generally indicative of a bona fide collective bargaining agreement may, among other things, include: the agreement provides for wages, benefits, working conditions or resolution of grievances; the agreement is executed by representatives of a labor organization/union which is either certified by the National Labor Relations Board or is elected by a majority of employees or signatory employers as the exclusive bargaining representative of the employees; neither the agreement nor the labor organization/union was promoted by the employer(s); and the agreement is the product of good faith bargaining." 8

On the basis of the Department's interviews, it is clear that at least 18 employers, identified from information furnished on behalf of the Union and UWF as participating in the UWF pursuant to collective bargaining agreements, do not participate pursuant to agreements which have any meaningful effect on the employment relationship (wages, working conditions, resolution of grievances), beyond participation in the UWF. It also appears clear from the interviews that the terms of employee participation in the UWF, and in some instances the Union, were promoted by the employers. Finally, it is clear from the interviews that employers are participating in the UWF pursuant to terms or agreements which are not the product of good faith bargaining between the employers and the Union, as a bona fide representative of the employers' employees. These employers, therefore, cannot be found to be participating in the UWF pursuant to bona fide collective bargaining agreements.

The language of section 3(40)(A)(i), by reference to a finding by the Secretary of Labor (the Secretary), clearly vests in the Department the authority to determine, in the event of a controversy, the bona fides of a purported collectively bargained plan by reference to the agreement or agreements under or pursuant to which the plan is established or maintained. However, where, the plan does not appear to be maintained pursuant to agreements which constitute bona fide collective bargaining agreements, the Department believes that consideration


8 Id. at 35.
also must be given to the statutory context and purpose of the exception in 3(40)(A)(i). In the case of section 3(40)(A)(i), the applicability of the exception serves to define which plans are MEWAs, and thereby subject to applicable state insurance laws, and which plans are not.

The information obtained by the Department, as described above, indicates that the Union, in connection with the UWF, has engaged in a pervasive practice of soliciting employers through the use of individuals and organizations, described by employers as insurance agents, to participate in the UWF under the guise of collective bargaining agreements and union membership. It is the view of the Department that this type of activity is indicative of a MEWA-insurance enterprise, which Congress intended to be subject to state insurance regulation, rather than a bona fide collectively bargained employee welfare benefit plan, which Congress intended to be exempt from state regulation. Given the extensive documentation of clearly non-bona fide arrangements revealed by our sample, we have concluded that the entire enterprise is sufficiently tainted by evidence of systematic fraud that the Secretary will decline to find any of the agreements entered into by Local Union 355 to be a bona fide collective bargaining agreement. To find such an arrangement to be excepted from MEWA status would, in the Department’s view, not only invite the improper exploitation of the collectively bargained plan exception in section 3(40)(A)(i) but also encourage the exploitation of bona fide collectively bargained plans.

Conclusion:

Given the pattern of the non-bona fide nature of the agreements and/or the majority of agreements examined for which there has been no bargaining, the Secretary declines to make a finding that any of the agreements are bona fide collective bargaining agreements. This represents a tentative letter by the Department on this matter.

The Department further notes that on the basis of the interviews, certain individuals covered by the UWF do not participate either on the basis of being bargaining unit employees or as members of Local 355. This raises questions concerning the status of the UWF as an employee welfare benefit plan described in ERISA section 3(1). Although our view with respect to the status of the collective bargaining agreements should resolve the issue of whether the State of Florida may enforce its laws against this arrangement, the Secretary would be prepared to file an amicus brief addressing the arrangement’s status under section 3(1) of ERISA, should the Court deem it relevant.
The Department hereby affords the parties the opportunity to submit information and views which they believe may be relevant to the Department's consideration of this matter. Submissions to the Department are requested no later than September 30, 1992. All submissions will be included as part of the public record. The parties should also be aware that reports of interviews with employers and documents provided to the Department in connection with those interviews are part of the record and available for inspection.

Questions concerning this matter may be directed to Mary C. McCarron at (202) 523-8671.

Sincerely,

ROBERT J. DOYLE
Director of Regulations and Interpretations
Ms. Lois A. Sherwood
Multiple Employer Welfare
Arrangement Section
Michigan Insurance Bureau
P.O. Box 30220
Lansing, Michigan 48909

Dear Ms. Sherwood:

This responds to your request for an advisory opinion regarding application of section 514(b)(6)(D) of the Employee Retirement Income Security Act of 1974 ("ERISA") to the Associated Builders and Contractors, Inc. of Michigan Employee Benefit Plan (the "Plan"). Specifically, you ask whether the Plan would be "fully insured" within the meaning of section 514(b)(6)(D) of ERISA if the Associated Builders and Contractors, Inc. of Michigan ("ABC") enters into a proposed contractual arrangement (described below) with First Security Health and Life Assurance Company ("FSL") with respect to payment of benefits under the Plan.

The following facts and representations have been furnished by the Michigan Insurance Bureau and by ABC. ABC is the Michigan chapter of a national trade association whose members are "merit shop" contractors and suppliers. ABC has for a long time made a group health insurance program available to its members. Benefits under this program originally were provided through insurance, but in 1981, ABC established the Plan on a "self-insured" basis. From that time forward, ABC members who participate in the Plan have paid premiums to a trust (the "Trust") established under a trust agreement between ABC and Old Kent Bank and Trust Company. Benefit claims are processed by a third-party administrator, and benefits have always been paid directly from the Trust. The Trust has purchased "stop-loss" insurance to protect the Trust against losses due to large claims.

Following enactment in 1983 of certain amendments to ERISA that modified the scope of ERISA's preemption of state law to permit application of certain state insurance laws to employee welfare benefit plans that are "multiple employer welfare arrangements" ("MEWAs"), ABC entered into a contractual arrangement with FSL (then called National Retirement Insurance Company) that ABC intended would cause the Plan to be considered "fully insured" within the meaning of section 514(b)(6)(D), while retaining as many elements of self-insurance as possible. This contractual arrangement, as originally entered into, was composed
of two parts: a "group health insurance policy" (the "Policy")\(^1\) and a "Security and Reimbursement Agreement" (the "SR Agreement")\(^2\) that, by its terms, was made part of the Policy.

Following discussions with the Michigan Insurance Bureau over the SR Agreement, ABC negotiated a proposed "minimum premium insurance agreement" (the "MPI Agreement") with FSL. The MPI Agreement is intended to replace the SR Agreement and to result in the Plan's being considered "fully insured" within the meaning of section 514(b)(6)(D).

If executed, the MPI Agreement would become a rider to the Policy, and all other agreements between ABC and FSL, including the SR Agreement and an existing excess-loss insurance policy, would terminate as of the MPI Agreement's effective date. The MPI Agreement would provide that all benefits under the Policy will be paid by FSL. It would further require ABC to designate the Trust as the "claims fund" for the purpose of funding benefit

\(^1\) The use of the term "group health insurance policy" in describing the Policy is based on the representations made by ABC and does not reflect any view of the State of Michigan or the Department of Labor concerning how the existing or proposed contractual arrangement between ABC and FSL would be characterized under Michigan insurance law.

\(^2\) The SR Agreement, which is currently in effect, provides that Plan benefits (which are those benefits provided under the Policy) are to be paid from the Trust. It obligates FSL to pay such benefits only if the Trust first fails to pay them. The SR Agreement specifically provides that payment by FSL of any such benefit will not alter the Trust's primary obligation to pay the benefit. ABC is obligated to obtain a stop-loss policy providing specific and aggregate limits acceptable to the FSL and to designate a certain sum from the assets of the Trust from which FSL has the right to draw to reimburse itself for any benefits it pays that are not reimbursed by the Trust or the stop-loss insurer. The SR Agreement further provides that the Trust will pay FSL a premium for the Policy in the amount of two percent of paid claims.

The SR Agreement provides that either party may terminate the agreement upon written notice to the other party or upon certain events. Termination of the SR Agreement and the Policy for any reason, however, will not terminate the application of their provisions with respect to benefits that have "become due" prior to the date of termination. It is further provided that, for purposes of the SR Agreement, "benefits become due upon receipt by the third-party administrator or [FSL] of sufficient proof in substantiation of a valid claim for such benefits".
payments under the Policy. The MPI Agreement would require the Trust to reimburse FSL, each business day, by wire transfer of funds, for all benefit claims paid by FSL under the Policy. It would further require ABC to fund the Trust sufficiently to permit these reimbursements and to provide FSL, upon request, with confirmation of the balance in the Trust. FSL would be permitted to audit the records of the Trust upon reasonable notice to ABC. The MPI Agreement would further provide that the Trust is the sole entity responsible for making payments to FSL. Neither ABC, nor its individual employer members, their employees, or their dependents are to have any liability of any type to FSL.

The MPI Agreement would set a maximum amount for which the Trust will be liable to FSL for reimbursement of claims actually paid in a contract year. The MPI Agreement also would set a maximum amount, called the "Maximum Liability Upon Termination," for which the Trust will be liable to FSL upon termination of the MPI Agreement for claims incurred but not paid during the period in which the MPI Agreement is in effect. ABC would be required to maintain, during a specific portion of each month, a balance in the Trust at least equal to the Maximum Liability Upon Termination.¹

The MPI Agreement would further require ABC to pay FSL a monthly premium. This monthly premium would be experience-rated, which means that each contract year's monthly premium would be set by taking into account the Plan's actual claims experience during the previous contract year and that ABC could receive an experience-rated premium refund at the end of each contract year, if actual claims during the year are lower than expected.⁴ ABC would be permitted to choose whether to receive the premium refund in cash or in the form of a credit applied toward future monthly premium payments. Before the beginning of each month during a contract year, FSL and ABC would determine the list of eligible participants for that month and, therefore, the number of participants for which the monthly premium would be due.

¹ ABC represents that the "Maximum Liability Upon Termination" is not defined in the MPI Agreement, but that the parties contemplate that it will be equal to the estimated claims for the next three months.

⁴ ABC represents that FSL currently has no experience-rated arrangements, but that the parties to the MPI Agreement intend to negotiate rules and guidelines to govern the experience-rated premium refund in advance and anticipate that such rules and guidelines will be incorporated into the MPI Agreement by reference.
The MPI Agreement further calls for ABC and FSL to set a per-participant "medical pooling point" for each contract year. If any participant's claims during the year exceed the medical pooling point, the excess would not be treated as part of the year's experience in setting the next year's premiums and would increase ABC's experience-rated premium refund for that year. ABC represents that although the Trust will be obligated to reimburse FSL for its payments in excess of the medical pooling point, ABC will in turn be reimbursed by FSL for such "excess" payments through the experience-rated refund at the end of the contract year.

The MPI Agreement would provide that it will terminate either on the date the Policy terminates or upon the written agreement of the parties. Alternatively, either party would be permitted to terminate the MPI Agreement immediately if the other party ceased doing business or became insolvent. FSL would further be permitted to terminate the MPI Agreement immediately if ABC fails to pay any monthly premium within 30 days after it is due, if FSL is not timely reimbursed for claims paid by it, if the Trust is not adequately funded to permit such reimbursement, or if the Trust is not adequately funded to maintain the Maximum Liability Upon Termination balance within ten days after the specified period in each month.

With respect to payment of incurred claims if the MPI Agreement terminates, Section XIII of the MPI Agreement would provide:

If this Agreement is terminated, FSL shall continue to pay claims incurred (whether or not reported) before the termination and shall be reimbursed from the Trust for claims actually paid and for administrative expenses, up to the Maximum Liability Upon Termination . . . However, if the Trust fails to contain sufficient assets to reimburse FSL, FSL shall be solely liable for the payment of any excess amount.

The only issue on which the Department's views are sought in this case is whether the Plan would be "fully insured" within the meaning of section 514(b)(6)(D) of ERISA, if the parties enter into the MPI Agreement described above. Section 514(b)(5)(D) provides that, for purposes of section 514(b)(5)(A) of ERISA, "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 [of Labor] determines

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5 ABC represents that, although it is not specifically stated in the MPI Agreement, it is the intent of the parties that FSL's liability be backed by its general assets.
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."

For purposes of this letter, it is assumed that the benefits to be provided by the Plan consist solely of the benefits provided under the Policy. It is further assumed that FSL is and will continue to be an insurance company, insurance service, or insurance organization qualified to conduct business in a state. The MPI Agreement obligates FSL to pay participants and beneficiaries of the Plan, directly or through its agent, and in a timely manner, all of the benefits under the Plan. FSL's obligation to pay benefits directly to participants and beneficiaries, which is backed by FSL's general assets, is not conditioned on whether FSL receives reimbursements from the Trust, and FSL's obligation to pay benefits will survive termination of the MPI Agreement with respect to all claims for benefits incurred prior to termination, whether such claims have been reported or not. Although the MPI Agreement limits FSL's actual risk of loss in various ways, such as by providing that FSL will be reimbursed by the Trust on a daily basis for its benefit payments, by requiring ABC to maintain a substantial balance in the Trust, and further by permitting FSL to terminate the MPI Agreement unilaterally if these conditions are not met, FSL nonetheless will be unconditionally liable to the participants and beneficiaries for payment of all claims for benefits incurred while the MPI Agreement is in effect.

Inasmuch as its views on the matter were not sought by the parties, the Department does not opine in this letter on whether the Plan is an "employee welfare benefit plan" as that term is defined by section 3(1) of ERISA.

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6 Whether any specific insurance company, insurance service, or insurance organization is in fact qualified to conduct business in a particular state is a determination that must be made under the applicable laws of that state.

7 The Department offers no view in this letter concerning whether the Plan as currently in effect under the Policy and the SR Agreement would be considered "fully insured" within the meaning of section 514(b)(6)(D) of ERISA.
Finally, we wish to note that decisions regarding the method through which benefits are to be paid under an employee welfare benefit plan, including the selection of an insurer and the negotiation of the terms of any contractual arrangement obligating the plan, are matters that generally are subject to the fiduciary responsibility provisions of Title I of ERISA.

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

Sincerely,

ROBERT J. DOYLE  
Director of Regulations and Interpretations
Advisory Opinion

Mr. Alfred W. Gross
Deputy Commissioner
Virginia Bureau of Insurance
Box 1157
Richmond, Virginia 23209

Dear Mr. Gross:
This is in reply to your request for an advisory opinion regarding the applicability of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you ask whether a health benefit program (the ERM Program) offered by Employers Resource Management Company, Inc. (ERM) is a multiple employer welfare arrangement (MEWA) within the meaning of ERISA section 3(40).

The following facts and representations are contained in materials submitted by your office. ERM is an employee leasing firm that markets certain services relating to employees of client companies. A client company (the Client) retains ERM by executing a "Service Agreement" that specifies the terms and conditions of the services to be provided and the fees payable for those services. The "Services" section of the Service Agreement states that ERM is an independent contractor providing "management services to Client for certain of Client's employer responsibilities." It provides that ERM is responsible for "payment of employer federal, state and local taxes, those various employee benefits which may be specified, and all required federal, state and local
employee payments or withholdings from wages." It also provides that ERM has sole discretion to establish and maintain an employee welfare benefit plan as defined in ERISA and that ERM agrees to hold harmless and indemnify the Client for any failure to pay any required benefit or other specified payment. The "Administration" section of the Service Agreement generally provides that ERM may exercise the right to direct other aspects of management not designated to the Client. The management functions that may be exercised by ERM are described to include, but are not limited to, recruiting, determining qualifications, hiring, training, evaluation, supervision, discipline, replacement, and termination of employees.

The "Administration" section also imposes specific administrative duties on the Client. These duties include periodically reviewing and evaluating employee performance and wages; recommending adjustments to employee wages, titles and functions; verifying employee time submission; and assisting ERM with administering unemployment claims and labor complaints. The Client also agrees to indemnify and hold harmless ERM for claims arising out of specific conduct of employees who are made available to the Client by ERM.

The "Insurance" section of the Service Agreement gives ERM the option either to maintain workers compensation insurance covering the employees with respect to whom it provides services, or to provide occupational accident and disease benefits under the ERM Program.

The information you have submitted indicates the ERM offers the ERM Program as an optional part of its services. If a Client contracts for this service, the ERM Program provides health benefits to employees with respect to whom ERM provides management services.

ERM maintains that it acts as a "fiscal employer" or "co-employer" of employees with respect to whom it provides management services. All of the documents submitted indicate that employer responsibilities with respect to the employees covered by the ERM program are expected to be divided between ERM and the Client.
For example, section 5.04 of the summary plan description for the ERM Program and section 3.01(e) of the trust agreement for the ERM Program both define the term "Co-Employer" to mean "any client company of E.R.M.'s which enters into a Contract with E.R.M. whereby such client company and E.R.M. act as Employers of such client companies' [sic] Employees." These documents define "Employer" to mean "both E.R.M. and its Co-Employers." Further, marketing information disseminated by ERM (which you supplied to us) describes "co-employment" as . . . a business arrangement between your company and [ERM] to share employer responsibilities. As the managing employer, you retain the responsibilities of hiring, firing, and supervising your employees. You're still the boss, just like in the past, and you continue to run your business, making all the management decisions. [ERM] becomes the administrative employer; handling the "paperwork" side of your business -- payroll, personnel and benefits administration.

The term "multiple employer welfare arrangement" is defined in ERISA section 3(40) (A) 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, except that such term does not include any such plan or other arrangement which is established or maintained --

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

(ii) by a rural electric cooperative, or

(iii) by a rural telephone cooperative association.

The only issue relating to the ERM Program's status as a MEWA presented by this case is whether the Program provides health benefits "to the employees of
two or more employer." 1 This issue must be resolved by determining whether, for purposes of ERISA section 3(40 (A), the employees who participate in the ERM Program are exclusively employees of a single employer, or are, rather, employees of more than one employer. Section 3(6) of ERISA defines "employee" as "any individual employed by an employer." Section 3(5) of ERISA defines "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 any employer in such capacity."

In order for an individual covered by a plan to be considered an "employee" of an "employer" for purpose of section 3(6), an employer-employee relationship must exist between the employer and the individual. The Department has taken the position that, for purposes of section 3(6), such determinations must be made by applying common law of agency principles. 2 In applying common law principles, consideration must be given to, among other things, whether the person for whom services are being performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work, but also as to the details and means by which the result is to be accomplished; whether the person for whom services are being performed has the right to discharge the individual performing the services; and whether the individual performing the services is as a matter of economic reality dependent upon the business to which he or she renders service. In general, whether an employer-employee relationship exists is a question that must be determined on the basis of the facts and circumstances involved. In this regard, payment of wages; payment of federal, state, and local employment taxes; and the provision of health or pension benefits (or both) are not the sole determinants of an employee-employer relationship. Moreover, a contract purporting to create an employer-employee relationship surrounding the contract.

ERM maintains that the ERM Program is a single-employer plan exempt from state insurance regulation under ERISA because ERM is the "co-employer" of all
of the employees covered under the ERM Program. However, the Service Agreement and the other documents concerning the ERM Program clearly contemplate that Clients of ERM will, in many instances, retain significant employer functions.

Specifically, the Service Agreement's characterization of ERM as an "independent contractor" providing "management services" to Clients who may exercise significant employer functions, and the acknowledgements in the summary plan description and the trust agreement of the employer status of Clients indicate that Clients are expected in specific contractual arrangements to retain and exercise employer authority and control. In addition, ERM's marketing information emphasizes that its services are intended to be largely administrative in nature.

Any Client that in fact exercises employer control and authority over employees covered under the ERM Program would be an "employer" with respect to such employees for purposes of ERISA section 3(6). Your submission indicates that in at least one instance a Client in fact retained just such powers.

Therefore, in the absence of any indication that ERM and its Clients constitute a "control group" within the meaning of section 3(40)(B)(i) of ERISA, it is the view of the Department that the ERM Program is an arrangement providing benefits to the employees of two or more employers and is, therefore, a multiple employer welfare arrangement (MEWA) within the meaning of section 3(40)(A).

Accordingly, the preemption provisions of ERISA would not preclude state regulation of the ERM Program to the extent provided in ERISA section 514(b)(6)(A). In this regard, we are enclosing, for your information, a copy of Opinion 90-18A (dated July 2, 1990), which discusses the scope of the states' authority to regulate MEWAs pursuant to section 514(a)(6)(A) of ERISA.

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

Sincerely,
Robert J. Doyle
Director of Interpretations

and Regulations

There is no indication in the materials submitted that the ERM Program is established or
maintained under or pursuant to one or more collective bargaining agreements, by a rural electric
cooperative, or by a rural telephone cooperative association.

While the principles of the common law of agency typically have been applied to determine
whether a person is an employee or an independent contractor, such common law principles are
equally applicable to determining by whom an individual is employed. See Professional &
Executive Leasing, Inc. v. Commissioner, 89 T.C. 225 (1987), aff'd 862 F.2d 751 (9th Cir. U.S.
Mr. Robert R. Googins  
Commissioner of Insurance  
P.O. Box 816  
Hartford, CT 06142-0816

Dear Commissioner Googins:

This responds to your request for an advisory opinion regarding the applicability of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) to an employee benefit arrangement sponsored by the United Service Association for Health Care (USA). Specifically, you asked whether seven trusts established under the arrangement constitute "employee welfare benefit plans" within the meaning of section 3(1) of ERISA and whether they are "fully insured" within the meaning of section 514(b)(6)(D) of ERISA. Subsequent to your request, USA advised the Department of Labor (Department) that it has determined to restructure the arrangement by consolidating the seven trusts into a single trust, described below. Because your request for an opinion was concerned primarily with the status that the USA benefit arrangement will have under Connecticut's insurance laws on an ongoing basis, this letter will address the arrangement only as to its restructured form.

The facts and representations before the Department in this matter, as furnished with your request or separately by USA, include the following. USA represents that it is a non-profit trade association of small employers that was founded in 1983 under the name "American Tax Reform Committee." The association's original purpose was to promote equitable tax policy for its members. By 1988, the focus of the association shifted to other concerns of small employers that included health care concerns in particular, and the association adopted its present name at that time to reflect the interests of its membership. USA further represents that it has a current membership of approximately 130,000 small employers located throughout the United States. In addition to offering the health benefit arrangement at issue here, USA provides certain services to its members that include access to legal counsel at reduced fees through a network of 3,500 law firms, a magazine and other publications providing information and advice on employment issues.

1 A copy of USA's correspondence in this regard is enclosed.
matters, a telephone 800 number service to answer questions from members, and a computer system that allows members to communicate with each other on matters of common concern.

The Articles of Incorporation (Articles) under which USA is organized, as amended in October 1992, state that USA "shall have, as its members, small business employers (including persons who are self-employed), who are interested in and supportive of the purposes for which [USA] was organized . . . ." The Articles state further that "[t]he business of [USA] shall be carried on through its Board of Directors; the manner of their election and/or appointment shall be as provided in the Bylaws of [USA]." Bylaws of USA adopted in October 1992 (the Bylaws) similarly provide that USA "shall have one (1) class of members, consisting of small business employers and persons who are self-employed . . . ." and that "[t]he business and affairs of [USA] and all corporate powers shall be managed by the Board of Directors . . . ." (Art. 2.1 and 4.1).

The Bylaws require the holding of annual meetings of USA members at which the members elect the Board of Directors (Art. 3.1). Each member is entitled to one vote and voting may be in person or by proxy (Art. 3.6). A quorum of members consists of the lesser of 100 members or members holding 5 percent of the votes that may be cast (Art. 3.5). The Board is to be composed of three to nine directors, as determined by the Board, and each director serves until his or her successor is elected and qualified (Art. 4.2). Candidates for the Board are to be nominated by existing directors (Art. 4.3). Directors may be elected to succeed themselves (Art. 4.4). The Bylaws further provide that officers of USA are to be elected by the Board of Directors and may be removed by the Board at any time with or without cause (Art. 6.1 and 6.2). The Bylaws may be amended by the Board of Directors, subject to repeal or change by action of the members (Art. 8.4).

USA established an arrangement in 1992 to provide health care benefits for its employer members, their employees, and eligible dependents. The arrangement was structured under seven benefit trusts, each of which provides for participation by employers engaged in a particular industry group. The seven trusts are now being consolidated into a single trust (the "Trust") pursuant to a restated trust instrument entitled "Restatement of Agreement and Declaration of Trust/USA for Health Care Benefit Trust" (the "Trust Agreement"). The Trust is treated hereafter in this letter as though it has been fully effectuated.

Under the Trust Agreement, participation in the Trust is limited to employers that are members of USA, agree to be bound by the terms and conditions of the Trust, and meet the underwriting standards of the Trust (Trust Agreement §§ 1.02,
1.03 and 26.01). A bank serves as custodial trustee and control over the management and administration of the Trust is placed in a Benefits Review Committee (BRC) composed of the Board of Directors of USA. The BRC or the trustee may propose amendments to the Trust Agreement for adoption by a majority vote of the BRC or of the participating employers (Trust Agreement § 29.02). The Trust may be terminated by the BRC (Trust Agreement § 29.04).\textsuperscript{2}

For the reasons discussed below, the Department is unable to find on the basis of the information presented that USA is a bona fide group or association of employers within the meaning of section 3(5) of ERISA and, accordingly, is unable to conclude that the USA for Health Care Benefit Trust (referred to herein as the "Trust") is an employee welfare benefit plan for purposes of Title I of ERISA. Moreover, as also discussed below, even if the Trust were found to be an ERISA-covered employee welfare benefit plan, the Department is unable to find that the Trust would, under the contractual agreements presented, be "fully insured" within the meaning of ERISA section 514(b)(6)(D).

The term "employee welfare benefit plan" is defined in section 3(1) of Title I of ERISA to include:

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

Although the Trust is established for the purpose of providing benefits among those identified in section 3(1) of ERISA, in order to be an employee welfare benefit plan, the Trust must, among other criteria, be established or maintained by an

\textsuperscript{2} The Trust Agreement, at section 1.08, establishes seven sub-trusts, which USA represents are only for the purpose of underwriting and rating participants according to industry groups.
employer, an employee organization, or both. Since there is no indication that an employee organization within the meaning of section 3(4) of ERISA is in any way involved in the Trust, this letter will address only the issue of whether the Trust is established or maintained by an employer.

The term "employer" is defined in section 3(5) of ERISA to include "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." The definitional provisions of ERISA recognize that a single employee welfare benefit plan might be established or maintained by a cognizable, bona fide group or association of employers, within the meaning of section 3(5), acting in the interests of its employer members to provide benefits to their employees. On the other hand, where several unrelated employers merely execute participation agreements or similar documents as a means to fund benefits, in the absence of any genuine organizational relationship between the employers, no employer association can be recognized.

A determination whether a purported group or association of employers is a bona fide employer group or association must be made on the basis of all the facts and circumstances involved. Among the factors considered are the following: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers; and who actually controls and directs the activities and operations of the benefit program. In the view of the Department, the employers that participate in a benefit program must, either directly or indirectly, exercise control over that program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the program.

Based on the documents and representations presented, the Department cannot conclude that USA is a bona fide group or association of employers within the meaning of section 3(5) of ERISA. In particular, we note the following. First, although USA represents that its membership is composed of employers, the Articles and Bylaws indicate that USA's membership class includes self-employed persons. Because self-employed persons are not necessarily employers of common-law employees, it appears that membership eligibility in USA is not limited to "employers." Second, the Articles and Bylaws do not appear to place control over USA in its membership. Although the Bylaws provide that USA's members elect directors who serve on the Board of Directors, which has the power to conduct the business and affairs of USA, the Bylaws provide that only directors may
nominate persons to be directors. In addition, directors may be reelected indefinitely. It thus appears that the Board may be a self-perpetuating body that is insulated from any control by the members of USA. Moreover, the Bylaws place the power to amend the Bylaws primarily in the Board of Directors and the Trust Agreement provides that only the BRC or the trustee may propose amendments to that document. Thus, the role of USA’s members appears to be limited to rejecting or modifying amendments adopted by the Board, the BRC or the trustee. Members, therefore, appear to have no meaningful method under the Bylaws or the Trust Agreement to propose amendments. It thus appears that USA’s governing documents provide no effective way for members to affect the Board or operations of USA, including the Trust.¹

The information provided further indicates that USA may lack the commonality of interest that forms the basis for sponsorship of an employee welfare benefit plan. "The definition of an employee welfare benefit plan is grounded on the premise that the entity that maintains the plan and the individuals that benefit from the plan are tied by a common economic or representation interest, unrelated to the provision of benefits." *Wisconsin Education Association Insurance Trust v. Iowa State Board of Public Instruction*, 804 F.2d 1059, 1063 (8th Cir. 1986).¹ USA has numerous members spread across the country who are engaged in operating small businesses. The activities of USA appear to consist primarily of offering its members services or programs of a consumer nature, among which the opportunity to purchase health care benefits may be the most significant. None of the information furnished points to a common economic or representation interest linking employees of USA’s members to USA that is unrelated to their obtaining benefits.

Because we cannot conclude that USA is a bona fide group or association of employers within the meaning of ERISA section 3(5), we are unable to find that the Trust constitutes an ERISA-covered "employee welfare benefit plan." With regard to your inquiry concerning whether the Trust would constitute a

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¹ Because the Board, in its capacity as the BRC, controls the Trust, members of USA also have no effective way to exercise control over the benefit program.

² See also Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) (en banc); Matthew 25 Ministries, Inc. v. Corcoran, 771 F.2d 21 (2d Cir. 1985); Wayne Chemical, Inc. v. Columbus Agency Service, 567 F.2d 622 (7th Cir. 1977); Bell v. Employee Security Benefit Association, 437 F. Supp. 382 (D. Kan. 1977); Credit Managers Ass’n v. Kennesaw Life & Accident Ins. Co., 809 F.2d 617 (9th Cir. 1987); MD Physicians & Associates Inc. v. Texas Board of Insurance, 957 F.2d 178 (5th Cir. 1992).
"multiple employer welfare arrangement" (MEWA) that is "fully insured" within the meaning of ERISA section 514(b)(6)(D), we note the following.

The question whether a MEWA is fully insured arises only if the arrangement constitutes an "employee welfare benefit plan" covered by ERISA. Although, as indicated above, we cannot find that the Trust is an employee welfare benefit plan, we note that the Trust is a MEWA within the meaning of section 3(40) of ERISA. Pursuant to section 514(b)(6)(D) of ERISA, a MEWA "shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary [of Labor] determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State."

According to the facts and representations provided, the Trust receives contributions from the participating employers and benefit claims are paid from the Trust. The Trust, acting through its BRC, has entered into a contract, called a "quota share reinsurance agreement" (the Agreement), with National Health Insurance Company (NHIC). NHIC is an insurance company licensed in the District of Columbia and in all states except New York.

Under the Agreement, as described by USA, NHIC is obligated to pay to the Trust 90 percent of the amount of liabilities that the Trust incurs under its benefit plan, up to a per-claim limit

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5 Section 3(40)(A) of ERISA provides that, subject to certain exceptions not relevant here, a MEWA is an employee welfare benefit plan or other arrangement that provides any benefit described in section 3(1) of ERISA to the employees of two or more employers. Section 514(b)(6)(A) of ERISA permits the application of state insurance law, otherwise preempted under section 514(a) of ERISA, to an employee welfare benefit plan that is a MEWA, as follows: If the MEWA is "fully insured" within the meaning of section 514(b)(6)(D) of ERISA, state insurance law may apply to the extent it provides standards requiring the maintenance of specified levels of reserves and contributions, and provisions to enforce such standards (See section 514(b)(6)(A)(i)). If the MEWA is not fully insured, any law of any state that regulates insurance may apply to the extent not inconsistent with Title I of ERISA (See 514(b)(6)(A)(ii)).

6 The Department expresses no view in this letter concerning how the Agreement would be characterized under the insurance law of Connecticut or any other state.
of $10 million (Art. 6.01). The Trust retains responsibility for the remaining 10 percent of the liabilities (Art. 6.02), except under certain conditions described below. The Trust is obligated to pay to NHIC 90 percent of the amount of contributions received from participating employers (Art. 7.01), and NHIC is obligated to pay to the Trust a "commission" specified in the Agreement to cover acquisition costs and issuing fees, taxes, and other costs (Art. 7.03). The Trust retains 10 percent of the contributions for payment of its share of the liabilities and maintaining a reserve thereon, and for its administrative expenses.

The Agreement provides further that NHIC guarantees payment to the Trust of the Trust's retained portion of the liabilities in the event the Trust is unable to fund that portion (Art. 6.03). NHIC's obligation for both the 90 percent portion and the 10 percent portion of the liabilities is payable to the Trust notwithstanding insolvency of the Trust or failure of the Trust's liquidator, receiver, or statutory successor to pay the claims (Art. 12.01). In addition, under a proposed amendment to the Agreement (proposed new Art. 6.05), NHIC will undertake a further obligation in the event the Trust is unable to fund its retained portion of the liabilities. Specifically, NHIC agrees, notwithstanding any other provision of the Agreement, that if the Trust remains unable to fund the full amount of benefits after NHIC has made the full 100 percent payment to the Trust, NHIC will pay the remaining claims directly to the plan participants. USA represents, and the proposed amendment provides, that payments under this provision would be made for the benefit of the Trust pursuant to the reinsurance relationship between NHIC.

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7 In addition to the per-claim limit, the Agreement limits or circumscribes NHIC's liability in several ways. For example, Article III contains exclusions relating to, inter alia, claims arising from the Trust's participation in any insolvency fund and losses attributable to inability of the Trust to collect from any other reinsurer; Article IV provides a territorial limitation; and Article X specifies the extent to which the Agreement includes "excess limits judgments."

8 The Agreement also provides that, as a condition precedent to NHIC's obligation upon the trust's insolvency, the liquidator, receiver, or statutory successor will give written notice of any claim against the trust filed in the insolvency proceeding (Art. 12.02).

9 USA represents that NHIC has agreed to this additional obligation. A copy of the amendment that the Trust and NHIC propose to execute has been submitted by USA to the Department of Labor and to the Connecticut Insurance Department.
and the Trust, and that this obligation would not create a direct contractual relationship between NHIC and the plan participants.

The Agreement provides that it may be cancelled by either party by giving 90 days' advance notice in writing (Art. 5.01). The Agreement also provides that the Trust's insolvency, defined by the Agreement as inability of the Trust to fund its retained portion of the losses, will be deemed termination of the Agreement to be effective the first day of the following month (Art. 5.03).

Based on the representations concerning the nature of the Agreement that have been submitted, it is the opinion of the Department that the Agreement, including the proposed amendment, would not cause the Trust to be "fully insured" within the meaning of section 514(b)(6)(D) of ERISA. At all times that the Agreement would be in effect, plan participants would be required to present benefit claims to the Trust, and benefit payments would be made solely by or on behalf of the Trust. Although NHIC would promise under the proposed amendment to the Agreement to pay remaining unpaid claims directly to plan participants, NHIC and the Trust intend that the obligation to make those payments would not create any direct contractual relationship between NHIC and plan participants. Because participants do not appear to have contractual rights against the insurance company, there is, in the view of the Department, a serious question as to whether plan participants could in any manner enforce the provisions of the amendment against NHIC. In addition, because the obligation of NHIC with respect to the 10 percent portion of the liabilities is conditioned on the Trust's inability to fund that portion, and is not triggered by the mere failure of the Trust to pay the full amount of benefits due, NHIC's obligation does not, in the view of the Department, constitute a guarantee of the full amount of the benefits for purposes of section 514(b)(6)(D) of ERISA. Whether the failure of the Trust to pay a valid claim for benefits is due to an inability to pay could become a matter of dispute and require a determination of facts not readily ascertained by the affected participant. Further, due to provisions in the Agreement limiting NHIC's liability in certain circumstances (notes 7 and 8 supra), it is questionable whether NHIC's liability would extend to all benefit claims that could be valid under the Trust. For these reasons, the contractual arrangement between the Trust and NHIC does not, in the view of the Department, appear to provide the certainty of benefit protection contemplated by section 514(b)(6)(D).
This letter constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of that procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

ROBERT J. DÖYLE
Director of Regulations and Interpretations

Enclosure
Mr. Kevin W. Ahern  
McLaughlin & Ahern, P.C.  
202 Cherry Street  
Milford, Connecticut 06460

Dear Mr. Ahern:

This is in reply to your request for an advisory opinion regarding the applicability of Title I of the Employee Retirement Income Act of 1974 (ERISA). Specifically, you ask whether the Employee Staffing of America, Inc.’s Employee Benefit Plan (the ESA Program) is an employee welfare benefit plan maintained by a single employer within the meaning of section 3(1) of Title I of ERISA.

You represent that Employee Staffing of America, Inc. (ESA) is in the business of “employee leasing.” An employer retains ESA to provide human resource management, administration and staffing services by executing an “Employee Staffing Agreement” (the Agreement), a copy of which was enclosed with your submission. Section 2(a) of the Agreement provides that all persons listed on “Schedule A” of the Agreement are “deemed” to be employees of ESA.1 Sections 2(b) and 3 provide that ESA is responsible for all administrative functions of the employer including the payment of all payroll taxes and workers compensation insurance, and for determining personnel policies, procedures, and administration, including hiring, termination, vacations, and wage administration. Sections 6 and 7 delineate certain financial responsibilities of the employer to ESA with respect to the employees leased from ESA. Your cover letter indicates that the relationship between ESA and an employer who executes the Agreement is that of "co-employers" and that such an employer is a "co-employer client of ESA (also referred to herein as a "client employer").

Section 3 of the Agreement also provides that ESA and the client employer shall be considered an "affiliated service group." You assert that ESA and its client employers are "a trade or business under common control and thus the ESA Program is a single-employer plan.

1 We are unable to determine from your submission whether the persons listed on Schedule A of the Agreement and "deemed" to be employees of ESA are persons who have a common-law employer-employee relationship with ESA or with the client employer.

Working for America’s Workforce
You represent that, in addition to providing the services to client employers as outlined in the Agreement, ESA established the ESA Program, effective June 1, 1989, as a self-insured stop-loss benefit plan, to provide, at the client employer’s option, health insurance for employees that ESA leases to the client employer. The Agreement itself does not refer to the ESA Program. Although you indicate that it client employers who contribute financially to the ESA Program and whose contributions are held in a separate trust for payment of benefits under the ESA Program. The client employer, apparently, may determine the level at which employees must contribute, and the maximum level of the employee’s contribution is set at $500 per employee. Under the ESA Program, ESA pays the first $20,000 of any benefits due to an employee under the program directly out of its trust fund. All medical expenses in excess of $20,000 per employer are covered under a stop-loss insurance policy issued by the Safeco Life Insurance Company.

The term "employee welfare benefit plan" is defined in section 3(1) of Title I of ERISA to include:

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

Thus, to be an employee welfare benefit plan, an entity must not only provide benefits among those described in section 3(1) but also, among other criteria, be established or maintained by an employer, an employee organization, or both. There is no indication in your request that an employee organization is in any way involved in the ESA Program. Accordingly, this letter examines only whether the ESA Program was established or is maintained by an employer.
The term "employer" is defined in section 3(5) of ERISA to include "any person acting directly as an employer or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." The term "employer," for purposes of Title I of ERISA, thus encompasses not only persons with respect to whom the individuals covered under the plan (i.e., persons acting directly as an employer), but also certain persons, group and associations that, while acting indirectly in the interest of or for an employer in relation to an employee benefit plan, have no direct employer-employee relationship with the individuals covered under the plan. Therefore, merely because a person, group or association may be determined to act as an "employer" within the meaning of ERISA section 3(5) does not mean that the individuals covered under the plan with respect to which the person, group or association acts an "employer" are "employees" of that employer. From the information submitted with your request, it appears that the ESA Program was created, and is maintained, by ESA for "employees," including those individuals for whom it is a "co-employer," and with respect to whom, under the Agreement, ESA performs tasks that the common-law employer of the "employees" would perform. There is no indication that any entity other than ESA has control over the ESA Program, although day-to-day operations of the ESA Program are supervised by Robert S. Weiss & Company. Accordingly, based on your representations, it is the position of the Department of Labor (the Department) that ESA is acting either directly or indirectly in the interest of an "employer" in establishing and maintaining the ESA Program, which therefore is one or more employee welfare benefit plans within the meaning of section 3(1) of Title I of ERISA.

You are specifically interested in whether the ESA Program is a single-employer welfare plan or a multiple employer welfare arrangement (MEWA) within the meaning of section 3(40) of Title I of ERISA. Thus, the issue is whether the ESA Program covers employees of a single employer or two or more employers for which it provides benefits as described in ERISA section 3(1). Section 3(40)(A) defines the term "MEWA" to include:

an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained --
(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,
(ii) by a rural electric cooperative, or
(iii) by a rural telephone cooperative association.

Section 3(40)(B) provides, in pertinent part:

For purposes of this paragraph --
(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,
(ii) the term "control group" means a group of trades or businesses under common control,
(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether the employees of two or trades or business are treated as employed by a single employer under section 4001(b), except that, for the purposes of this paragraph, common control shall not be based on an interest of less than 25 percent . . .

Section 4001(b) of ERISA provides that determinations of whether employees of trades or business that are under common control shall be treated as employees of a single employer shall be made in a manner consistent with regulations issued under section 414(c) of the Internal Revenue Code (the Code).

Although the Agreement states that the client employers and ESA shall be considered an affiliated service group, there is nothing in your submission to support that claim. Nor have you submitted any evidence that ESA and any of its client employers share ownership interests in such a way as to be within the same control group as provided in section 3(40)(B)(ii). Accordingly, the Department is unable to conclude that ESA and any of its client employers represent a control group within the meaning of section 3(40)(B) of Title I of ERISA.

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

We are unable to determine with any degree of certainty based on the Agreement and your representations, the relationship of the individuals covered by the Agreement or by the ESA Program, or both, to ESA and its client employers. It is not clear from your submission whether the ESA Program is limited solely to persons who have a common-law relationship with ESA or whether it also includes persons who have such a relationship with one or more client employers. Although the Agreement outlines ESA's responsibilities with respect to persons listed on Schedule A that are "deemed" under section 2(a) to be employees of ESA, it is silent as to the client employer's responsibilities other than the responsibility to maintain a safe workplace. You represent that the client employer has the power to elect whether to provide coverage under the ESA Program to the employees "leased" to it and to determine the amount of employee contributions. Accordingly, it is the view of the Department that the documents and your representations do not provide a basis for determining whether the client employers or ESA, or both, in fact have an employer-employee relationship with the "leased employees" and whether ESA or the client employers are the employers of the individuals covered by the ESA Program. Moreover, the Department does not consider the Agreement's characterization of the parties' relationship to be dispositive as to the actual nature of the relations between them, which must be determined in light of the actual facts and circumstances of that relationship.

Further, there is no indication in the information you submitted that the ESA Program was established or is maintained pursuant to any collective bargaining agreement or by a rural electric cooperative or a rural telephone cooperative association. Accordingly, inasmuch as we cannot conclude that ESA and the client employers constitute a "control group" within the meaning of section 3(40)(B) of Title I of ERISA or that the covered employees are common law employees of ESA, it is the view of the Department that the ESA Program is an arrangement providing benefits to the employees of two or more employers and is, therefore, a MEWA within the meaning of section 3(40)(A) of Title I of ERISA.²

² It is the Department's position that where the employees participating in the plan of an employee leasing organization
Although section 514(a) of ERISA provides that any state law or regulation that relates to an employee benefit plan covered by Title I of ERISA is generally preempted, section 514(b) provides:

(6)(A) Notwithstanding any other provision of this section--
(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--
(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.

Based on the assumptions outlined above, the preemption provisions of ERISA would not preclude state regulation of the ESA Program, to the extent provided in ERISA section 514(b)(6)(A), because the ESA Program constitutes a MEWA. However, if further facts demonstrated that ESA and its client employers actually constituted a "control group," or if all the individuals covered by the ESA Program were, in fact, shown to be include employees of two or more client (or recipient) employers, or employees of the leasing organization and at least one client employer, the plan of the leasing organization would, by definition, constitute a MEWA because the plan would be providing benefits to the employees of two or more employers.
exclusively the common-law employees of ESA, the preemption provisions of ERISA would preclude state regulation of the ESA Program because it would constitute an employee welfare benefit plan within the meaning of section 3(1) of Title I of ERISA established and maintained by a single employer and not a MEWA within the meaning of section 3(40)(A). We emphasize, however, that the Agreement itself and the representations set forth herein provide no basis for reaching such conclusions.

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

Sincerely,

Robert J. Doyle
Director of Regulations and Interpretations
LEXSEE 463 US 85

SHAW, ACTING COMMISSIONER, NEW YORK STATE DIVISION OF HUMAN RIGHTS, ET AL. v. DELTA AIR LINES, INC., ET AL.

No. 81-1578

SUPREME COURT OF THE UNITED STATES


January 10, 1983, Argued
June 24, 1983, Decided *

* Together with Shaw, Acting Commissioner, New York State Division of Human Rights v. Burroughs Corp.; and Shaw, Acting Commissioner, New York State Division of Human Rights, et al. v. Metropolitan Life Insurance Co., also on appeal from the same court (see this Court's Rule 10.6).

PRIOR HISTORY:

APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT.

DISPOSITION:

650 F.2d 1287 and 666 F.2d 21; and 666 F.2d 27 and 666 F.2d 26, affirmed in part, vacated in part, and remanded.

CASE SUMMARY:

PROCEDURAL POSTURE: Appellant state agencies challenged the judgment of the United States Court of Appeals for the Second Circuit in favor of appellee employers, holding that the New York Human Rights Law, N.Y. Exec. Law § § 290-301 (1982), and the Disability Benefits Law, N.Y. Workers' Comp. Law § § 200-242 (1965), were preempted by ERISA insofar as they required benefits to be provided to employees disabled by pregnancy. The court affirmed in part, holding that for purposes of preemption the state laws "related to" employee benefit plans under 514(a) of ERISA because they had a connection with or reference to such plans. The state laws were pre-empted to the extent that they prohibited practices that were lawful under federal law. The court further held that § 4(b)(3) of ERISA excluded "plans," not parts of plans, from ERISA coverage. Thus, the parts of one employer's multi-benefit plans that were maintained to comply with the Disability Benefits Law were not exempt from preemption by ERISA, contrary to the appellate court's ruling. The employer's entire plan had to be maintained for the purpose of complying with an applicable state disability insurance law in order to claim an exemption to ERISA preemption under § 4(b)(3).

OUTCOME: The court affirmed the judgment holding that the Human Rights Law provision was pre-empted by ERISA insofar as the state law prohibited practices that were lawful under ERISA. The court reversed the judgment that the portions of one employer's multi-

OVERVIEW: The employers provided their employees with medical and disability benefits through plans subject to ERISA. They alleged that the New York Human Rights Law, N.Y. Exec. Law § § 290-301 (1982), and the Disability Benefits Law, N.Y. Workers' Comp. Law § § 200-242 (1965), were preempted by ERISA insofar as they required benefits to be provided to employees disabled by pregnancy. The court affirmed in part, holding that for purposes of preemption the state laws "related to" employee benefit plans under 514(a) of ERISA because they had a connection with or reference to such plans. The state laws were pre-empted to the extent that they prohibited practices that were lawful under federal law. The court further held that § 4(b)(3) of ERISA excluded "plans," not parts of plans, from ERISA coverage. Thus, the parts of one employer's multi-benefit plans that were maintained to comply with the Disability Benefits Law were not exempt from preemption by ERISA, contrary to the appellate court's ruling. The employer's entire plan had to be maintained for the purpose of complying with an applicable state disability insurance law in order to claim an exemption to ERISA preemption under § 4(b)(3).
benefit plan, which were maintained to comply with the Disability Benefits Law, were exempt from ERISA preemption.

**LexisNexis(R) Headnotes**

**SYLLABUS:**

New York's Human Rights Law forbids discrimination in employee benefit plans on the basis of pregnancy, and its Disability Benefits Law requires employers to pay sick-leave benefits to employees unable to work because of pregnancy. Section 514(a) of the federal Employee Retirement Income Security Act of 1974 (ERISA) provides, with enumerated exceptions, that ERISA shall supersede "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits. Prior to the effective date of the Pregnancy Discrimination Act of 1978 (PDA), which made discrimination based on pregnancy unlawful under Title VII of the Civil Rights Act of 1964, appellee employers had welfare benefit plans subject to ERISA that did not provide benefits to employees disabled by pregnancy. Appellees brought three separate declaratory judgment actions in Federal District Court, alleging that the Human Rights Law was pre-empted by ERISA. Appellee airlines also alleged that the Disability Benefits Law was pre-empted. The District Court in each case held that the Human Rights Law was pre-empted, at least insofar as it required the provision of pregnancy benefits prior to the effective date of the PDA. As to appellee airlines' challenge to the Disability Benefits Law, the District Court construed § 4(b)(3) of ERISA as exempting from ERISA coverage those provisions of an employee benefit plan maintained to comply with state disability insurance laws, and, because it concluded that appellees would have provided pregnancy benefits solely to comply with the Disability Benefits Law, the court dismissed the portion of the complaint seeking relief from that law. The Court of Appeals affirmed as to the Human Rights Law. With respect to the Disability Benefits Law, the Court of Appeals held that § 4(b)(3)'s exemption from pre-emption applied only when a benefit plan, "as an integral unit," is maintained solely to comply with the disability law. The Court of Appeals remanded for a determination whether appellee airlines provided benefits through such plans, in which event the Disability Benefits Law would be enforceable, or through portions of comprehensive plans, in which case ERISA regulation would be exclusive.

**Held:**

1. Given § 514(a)'s plain language, and ERISA's structure and legislative history, both the Human Rights Law and the Disability Benefits Law "relate to any employee benefit plan" within the meaning of § 514(a). Pp. 95-100.

2. The Human Rights Law is pre-empted with respect to ERISA benefit plans only insofar as it prohibits practices that are lawful under federal law. Pp. 100-106.

(a) Section 514(d) of ERISA provides that § 514(a) shall not "be construed to . . . modify [or] impair . . . any law of the United States." To the extent that the Human Rights Law provides a means of enforcing Title VII's commands, pre-emption of the Human Rights Law would modify and impair federal law within the meaning of § 514(d). State fair employment laws and administrative remedies play a significant role in the federal enforcement scheme under Title VII. If ERISA were interpreted to pre-empt the Human Rights Law entirely with respect to covered benefit plans, the State no longer could prohibit employment practices relating to such plans and the state agency no longer would be authorized to grant relief. The Equal Employment Opportunity Commission thus would be unable to refer claims involving covered plans to the state agency. This would frustrate the goal of encouraging joint state/federal enforcement of Title VII. Pp. 100-102.

(b) Insofar as state laws prohibit employment practices that are lawful under Title VII, however, pre-emption would not impair Title VII within the meaning of § 514(d). While § 514(d) may operate to exempt state laws upon which federal laws, such as Title VII, depend for their enforcement, the combination of Congress' enactment of § 514(a)'s all-inclusive pre-emption provision and its enumeration of narrow, specific exceptions to that provision militate against expanding § 514(d) into a more general saving clause. Section 514(d)'s limited legislative history is entirely consistent with Congress' goal of ensuring that employers would not face conflicting or inconsistent state and local regulation of employee benefit plans. Pp. 103-106.

3. The Disability Benefits Law is not pre-empted by ERISA. Pp. 106-108.

(a) Section 4(b)(3) of ERISA, which exempts from ERISA coverage "any employee benefit plan . . . maintained solely for the purpose of complying with applicable . . . disability insurance laws," excludes "plans," not portions of plans, from ERISA coverage. Hence, those portions of appellee airlines' multibenefit plans maintained to comply with the Disability Benefits Law are not exempt from ERISA and are not subject to state regulation. Section 4(b)(3)'s use of the word
"solely" demonstrates that the purpose of the entire plan must be to comply with an applicable disability insurance law. Thus, only separately administered disability plans maintained solely to comply with the Disability Benefits Law are exempt from ERISA coverage under § 4(b)(3). Pp. 106-108.

(b) A State may require an employer to maintain a separate disability plan, but the fact that state law permits employers to meet their state-law obligations by including disability benefits in a multibenefit ERISA plan does not make the state law wholly unenforceable as to employers who choose that option. P. 108.

COUNSEL:

Deborah Bachrach, Assistant Attorney General of New York, argued the cause for appellants. With her on the briefs were Robert Abrams, Attorney General, and Peter Bienstock, Robert Hermann, Peter H. Schiff, and Daniel Berger, Assistant Attorneys General.

Gordon Dean Booth, Jr., argued the cause for appellees. With him on the brief for appellees Delta Air Lines, Inc., et al. was William H. Boice. Robert C. Bernius, William E. McKnight, and Robb M. Jones filed a brief for appellee Burroughs Corp. Edward Silver, Sara S. Portnoy, and Jeffrey A. Mishkin filed a brief for appellee Metropolitan Life Insurance Co.+

Briefs of amici curiae urging reversal were filed by LeRoy S. Zimmerman, Attorney General, and Ellen M. Doyle for the Commonwealth of Pennsylvania et al.; by Mary L. Heen, Joan E. Bertin, and Isabelle Katz Pinzler for the American Civil Liberties Union et al.; and by J. Albert Woll, Marsha Berzon, Laurence Gold, and John Fillion for the American Federation of Labor and Congress of Industrial Organizations et al.

Briefs of amici curiae urging affirmance were filed by Solicitor General Lee, Stuart A. Smith, T. Timothy Ryan, Jr., Kerry L. Adams, and John A. Bryson for the United States; by Eugene B. Granof and George J. Pantos for the ERISA Industry Committee et al.; and by Walter P. DeForest and Stuart I. Saltman for Westinghouse Electric Corp.

JUDGES:

BLACKMUN, J., delivered the opinion for a unanimous Court.
"(a) For an employer or licensing agency, because of the age, race, creed, color, national origin, sex, or disability, or marital status of any individual, to refuse to hire or employ or to bar or to discharge from employment such individual or to discriminate against such individual in compensation or in terms, conditions or privileges of employment."

n2 The New York court in *Brooklyn Union Gas* noted the *Gilbert* decision, but declined to follow it in interpreting the analogous provision of the Human Rights Law. 41 N. Y. 2d, at 86, n. 1, 359 N. E. 2d, at 395, n. 1. Most state courts have done the same. See *Minnesota Mining & Manufacturing Co. v. State*, 289 N. W. 2d 396, 399, n. 2 (Minn. 1979) (collecting cases), appeal dismissed, 444 U. S. 1041 (1980).

n3 Subsection (k) provides in relevant part:

"The terms 'because of sex' or 'on the basis of sex' include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 703(h) of this title shall be interpreted to permit otherwise." "

**B**


n5 ERISA § 3(3), 29 U. S. C. § 1002(3). An "employee pension benefit plan" provides income deferral or retirement income. § 3(2), 29 U. S. C. § 1002(2). An "employee welfare benefit plan" includes any program that provides benefits for contingencies such as illness, accident, disability, death, or unemployment. § 3(1), 29 U. S. C. § 1002(1).

Section 514(a) of ERISA, 29 U. S. C. § 1144(a), pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. n6 State laws regulating insurance, banking, or securities are exempt from this pre-emption provision, as are generally applicable state criminal laws. §§ 514(b)(2)(A) and (b)(4), 29 U. S. C. §§ 1144(b)(2)(A) and (b)(4). Section 514(d), 29 U. S. C. § 1144(d), moreover, provides that "[nothing] in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law." And § 4(b)(3) [*92] of [***498] ERISA, 29 U. S. C. § 1003(b)(3), exempts from ERISA coverage employee benefit plans that are "maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws."

n6 Section 514(a) provides:

"Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b)."

The term "State law" includes "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." § 514(c)(1), 29 U. S. C. § 1144(c)(1). The term "State" includes "a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title." § 514(c)(2), 29 U. S. C. § 1144(c)(2).

II

Appellees in this litigation, Delta Air Lines, Inc., and other airlines (Airlines), Burroughs Corporation (Burroughs), and Metropolitan Life Insurance Company (Metropolitan), provided their employees with various medical and disability benefits through welfare plans subject to ERISA. These plans, prior to the effective date of the Pregnancy Discrimination Act, did not provide benefits to employees disabled by pregnancy as required by the New York Human Rights Law and the State's Disability Benefits Law. Appellees brought three separate federal declaratory judgment actions against appellant state agencies and officials, n7 alleging that the Human Rights Law was pre-empted by ERISA. The Airlines in their action alleged that the Disability Benefits Law was similarly pre-empted. n8

n7 The Airlines brought their action in the United States District Court for the Southern District of New York and named as defendants the New York State Division of Human Rights, the Division's Commissioner, the Division's General Counsel, the New York State Workmen's Compensation Board, and the Board's Chairman. App. 28. Burroughs brought its action in the Western District of New York against only the Commissioner of the Division of Human Rights. Id., at 81. Metropolitan, suing in the Southern District of New York, named the Commissioner, the Division, and the New York State Human Rights Appeal Board. Id., at 88.

n8 The Airlines also contended that the Human Rights Law and Disability Benefits Law were pre-empted by the Railway Labor Act, 45 U. S. C. § 151 et seq.; the Equal Pay Act, 29 U. S. C. § 206(d); Exec. Order No. 11246, 3 CFR 339 (1964-1965 Comp.); and Title VII. These claims were resolved against the Airlines, see Delta Air Lines, Inc. v. Kramarsky, 666 F.2d 21, 26, n. 2 (CA2 1981); Delta Air Lines, Inc. v. Kramarsky, 650 F.2d 1287, 1296-1302 (CA2 1981), and are not before us.
respect [***499] to the Airlines' [**2898] challenge to the Disability Benefits Law, the District Court construed § 4(b)(3) of ERISA as exempting from the federal statute "those provisions of an employee plan which are maintained to comply with" state disability insurance laws. Delta Air Lines, Inc. v. Kramarsky, 485 F.Supp. 300, 307 (SDNY 1980). Because it concluded that the Airlines would have provided pregnancy benefits solely to comply with the Disability Benefits Law, the court dismissed the portion of their complaint seeking relief from that law.

n9 The opinion in the Airlines' case is reported as Delta Air Lines, Inc. v. Kramarsky, 485 F.Supp. 300 (SDNY 1980); the District Court opinions in the two other cases are not reported. In the Airlines' case, the District Court enjoined appellants from enforcing the Human Rights Law against the Airlines' benefit plans with respect to the period from December 20, 1976 (the date of the New York Court of Appeals' decision in Brooklyn Union Gas) to April 29, 1979 (the effective date of the federal Pregnancy Discrimination Act). See App. to Juris. Statement A75. As of the latter date, the court held, the Airlines' claims for relief were moot because federal law required the Airlines to include pregnancy disabilities in their employee benefit plans. 485 F.Supp., at 302.

In Burroughs' case, the District Court enjoined prosecution of Burroughs for its refusal to compensate New York employees for pregnancy-related disability claims between January 1, 1975 (the effective date of ERISA) and April 1, 1979 (which the court mistakenly believed to be the effective date of the Pregnancy Discrimination Act). App. to Juris. Statement A103-A104. In Metropolitan's case, the District Court enjoined enforcement of the Human Rights Law with respect to employee benefit plans subject to ERISA. The court's order was not limited to pregnancy benefits and did not refer specifically to any time period. Id., at A119-A120.

[***LedHR3B] [3B]The cases, of course, are not moot with respect to the period before the effective date of the Pregnancy Discrimination Act, since enforcement of the Human Rights Law would subject appellees to liability.

The United States Court of Appeals for the Second Circuit affirmed as to the Human Rights Law. Delta Air Lines, Inc. v. Kramarsky, 666 F.2d 21 (1981);

Metropolitan Life [*94] Insurance Co. v. Kramarsky, 666 F.2d 26 (1981); Burroughs Corp. v. Kramarsky, 666 F.2d 27 (1981). n10 Relying on this Court's decision in Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981), and on its own ruling in Pervel Industries, Inc. v. Connecticut Commission on Human Rights & Opportunities, 603 F.2d 214 (1979), order aff'd 468 F.Supp. 490 (Conn. 1978), cert. denied, 444 U.S. 1031 (1980), the court held that § 514(a) of ERISA operated to pre-empt the Human Rights Law, and that § 514(d) did not save that law from pre-emption. n11 With respect to the Disability Benefits Law, the Court of Appeals had concluded earlier that § 4(b)(3)'s exemption from pre-emption applied only when a benefit plan, "as [***95] an integral unit," is maintained solely to comply with a disability law. Delta Air Lines, Inc. v. Kramarsky, 665 F.2d 1287, 1304 (1981). The court remedied for inquiries into whether the Airlines provided disability benefits through plans constituting separate administrative [**2899] units, in which event the Disability Benefits Law would be enforceable, or through portions of comprehensive benefit plans, in which case ERISA regulation would be exclusive.

n10 The three cases were not consolidated on appeal, but were argued the same day. The court treated the Airlines' appeal as the "lead" case.

n11 Initially, the Court of Appeals had reversed the District Courts' holdings that ERISA pre-empted the Human Rights Law. Delta Air Lines, Inc. v. Kramarsky, 650 F.2d 1287 (1981); Burroughs Corp. v. Kramarsky, 650 F.2d 1308 (1981); Metropolitan Life Insurance Co. v. Kramarsky, 650 F.2d 1309 (1981). Although Pervel ordinarily would have been controlling, the court concluded that it was bound by this Court's dismissals, for want of a substantial federal question, of the appeals in Minnesota Mining & Manufacturing Co. v. State, 289 N.W. 2d 396 (Minn. 1979), appeal dism'd, 444 U.S. 1041 (1980), and Mountain States Telephone & Telegraph Co. v. Commissioner of Labor & Industry, 187 Mont. 22, 608 P. 2d 1047 (1979), appeal dism'd, 445 U.S. 921 (1980). In those cases the state courts had determined that state fair employment laws similar to the Human Rights Law were not pre-empted by ERISA.

The Court of Appeals observed that this Court had denied certiorari in Pervel, which reached the opposite result, only a week before dismissing the appeal in Minnesota Mining. Understandably viewing this sequence of events as "rather mystifying," 650 F.2d, at 1296, the
court noted that dismissals of appeals are binding precedents for the lower courts, see Hicks v. Miranda, 422 U.S. 332, 343-345, and n. 14 (1975), while denials of certiorari have no precedential force. After this Court's decision in Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981), the Court of Appeals granted rehearing and returned to its Per vel reasoning, holding that Alessi was a "doctrinal development," see Hicks v. Miranda, 422 U.S., at 344-345, that warranted departure from the precedent set by the Court's summary dispositions. 666 F.2d, at 25-26.

[***LEdHR4A] [4A]Because courts have disagreed [***500] about the scope of ERISA's pre-emption provisions, n12 and because of the continuing importance of the issues presented, n13 we noted probable jurisdiction in all three cases. 456 U.S. 924 (1982).

n12 See Minnesota Mining & Manufacturing Co. v. State, supra; Mountain States Telephone & Telegraph Co. v. Commissioner of Labor & Industry, supra; see also Bucyrus-Erie Co. v. Department of Industry, Labor & Human Relations, 599 F.2d 205 (CA7 1979), cert. denied, 444 U.S. 1031 (1980).

n13

[***LEdHR4B] [4B]Under the Pregnancy Discrimination Act, the kind of discrimination at issue here is now unlawful regardless of state law. The controversy about the Human Rights Law has not thereby become less significant, however; the Human Rights Law and other state fair employment laws may contain proscriptions broader than Title VII in other respects, see, e. g., N. Y. Exec. Law. § 296.1(a) (McKinney 1982) (prohibiting discrimination in employment based on marital status), and there is uncertainty about whether state fair employment laws may be enforced to the extent they prohibit the same practices as Title VII.

III

[***LEdHR5] [5] [***LEdHR6A] [6A]

[***LEdHR7A] [7A]In deciding whether a federal law pre-empts a state statute, our task is to ascertain Congress' intent in enacting the federal statute at issue. "Pre-emption may be either express or implied, and 'is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose.' Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977)." Fidelity Federal Savings & Loan Assn. v. De la Cuesta, 458 U.S. 141, 152-153 (1982). See Exxon Corp. v. Eagerton, 462 U.S. 176, 180-182 (1983); [*96] Pacific Gas & Electric Co. v. State Energy Resources Conservation and Development Comm'n, 461 U.S. 190, 203-204 (1983). In these cases, we address the scope of several provisions of ERISA that speak expressly to the question of pre-emption. The issues are whether the Human Rights Law and Disability Benefits Law "relate to" employee benefit plans within the meaning of § 514(a), see n. 6, supra, and, if so, whether any exception in ERISA saves them from pre-emption. n14

n14 The Court's decision today in Franchise Tax Board v. Construction Laborers Vacation Trust, ante, p. 1, does not call into question the lower courts' jurisdiction to decide these cases. Franchise Tax Board was an action seeking a declaration that state laws were not pre-empted by ERISA. Here, in contrast, companies subject to ERISA regulation seek injunctions against enforcement of state laws they claim are pre-empted by ERISA, as well as declarations that those laws are pre-empted.

[***LEdHR6B] [6B] [***LEdHR7B] [7B]It is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights. See Ex parte Young, 209 U.S. 123, 160-162 (1908). A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U. S. C. § 1331 to resolve. See Smith v. Kansas City Title & Trust Co., 255 U.S. 180, 199-200 (1921); Louisville & Nashville R. Co. v. Mottley, 211 U.S. 149, 152 (1908); see also Franchise Tax Board, ante, at 19-22, and n. 20; Note, Federal Jurisdiction over Declaratory Suits Challenging State Action, 79 Colum. L. Rev. 983, 996-1000 (1979). This Court, of course, frequently has resolved pre-emption disputes in a similar jurisdictional posture. See, e. g., Ray v. Atlantic Richfield Co., 435 U.S. 151 (1978); Jones v. Rath Packing Co., 430 U.S. 519 (1977); Florida Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132 (1963); Hines v. Davidowitz, 312 U.S. 52 (1941).
"relate to" employee benefit plans.  The breadth of § 514(a)'s pre-emptive reach is apparent from that section's language. n15 A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.

n16 Employing this definition, the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly "relate to" benefit plans. n17 We must give effect to this plain language unless there is good reason to believe Congress intended the language to have some more restrictive meaning. Consumer Product Safety Comm'n v. GTE Sylvania, Inc., 447 U.S. 102, 108 (1980); see North Dakota v. United States, 460 U.S. 300, 312 [*98] (1983); Dickerson v. New Banner Institute, Inc., 460 U.S. 103, 110 (1983).

n15 The Court recently considered § 514(a) in Alessi, supra. In that case, a New Jersey statute prohibited a method of computing pension benefits which, the Court found, Congress intended to permit when it enacted ERISA. Finding that Congress "meant to establish pension plan regulation as exclusively a federal concern," 451 U.S., at 523, and that the New Jersey law "eliminates one method for calculating pension benefits -- integration -- that is permitted by federal law," id., at 524, the Court held that the law was pre-empted. The Court relied not on § 514(a)'s language and legislative history, but on the state law's frustration of congressional intent. That kind of tension is not present in these cases; while federal law did not prohibit pregnancy discrimination during the relevant period, Congress, in enacting ERISA, demonstrated no desire to permit it. Alessi's recognition of the exclusive federal role in regulating benefit plans, therefore, is instructive but not dispositive. See also Franchise Tax Board v. Construction Laborers Vacation Trust, ante, at 24, n. 26 (describing § 514(a) as a "virtually unique pre-emption provision"); Allied Structural Steel Co. v. Spannaus, 438 U.S. 234, 248, n. 21 (1978) (dictum).

n16 See Black's Law Dictionary 1158 (5th ed. 1979) ("Relate. To stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with"). See also Sinclair Refining Co. v. Jenkins Petroleum Process Co., 289 U.S. 689, 695 (1933).


n11 In fact, however, Congress used the words "relate to" in § 514(a) in their broad sense. To interpret § 514(a) to pre-empt only state laws specifically designed to affect employee benefit plans would be to ignore the remainder of § 514. It would have been unnecessary to exempt generally applicable state criminal statutes from pre-emption in § 514(b), for example, if § 514(a) applied only to state laws dealing specifically with ERISA plans.

Nor, given the legislative history, can § 514(a) be interpreted to pre-empt only state laws dealing with the subject matters covered by ERISA -- reporting, disclosure, fiduciary responsibility, and the like. The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. n18 The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's pre-emptive scope was as broad as its language. See H. R. Conf. Rep. No. 93-1280, p. 383 (1974); S. Conf. Rep. No. 93-1090, p. 383 (1974). n19 Statements by the bill's [*99] sponsors during the subsequent debates stressed the breadth of federal pre-emption. Representative Dent, for example, stated:

"Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent..."

Senator Williams echoed these sentiments:

"It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preemp the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law." 1d., at 29933. n20

n18 The bill that passed the House, H. R. 2, 93d Cong., 2d Sess., § 514(a) (1974), 3 Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print compiled by the Senate Committee on Labor and Public Welfare), pp. 4057-4058 (1976) (Legislative History), provided that ERISA would supersede state laws "[relating] to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies." The bill that passed the Senate, H. R. 2, 93d Cong, 2d Sess., § 699(a) (1974), 3 Legislative History 3820, provided for pre-emption of state laws "[relating] to the subject matters regulated by this Act or the Welfare and Pension Plans Disclosure Act."

n19 In deciding to pre-empt state laws relating to benefit plans, rather than those laws relating to subjects covered by ERISA, the Conference Committee rejected a much narrower administration proposal. The administration's recommendations to the conferees described the pre-emption provision of the House and Senate bills as "extremely vague" and "too broad," respectively, and suggested language making explicit the areas of state law to be pre-empted. Administration Recommendations to the House and Senate Conference on H. R. 2 to Provide for Pension Reform 107-108, 3 Legislative History 5145-5146. The version of § 514(a) that emerged from Conference bore no resemblance to the administration proposal. See Hutchinson & Ifshin, Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974, 46 U. Chi. L. Rev. 23, 39-40, and n. 121 (1978).


"Both [original] House and Senate bills provided for preemption of State law, but -- with one major exception appearing in the House bill - - defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme.

"Although the desirability of further regulation -- at either the State or Federal level -- undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required -- but for certain exceptions -- the displacement of State action in the field of private employee benefit programs."

Senator Javits noted that the conferees had assigned the Congressional Pension Task Force the responsibility of studying and evaluating ERISA pre-emption in order to determine whether modifications in the pre-emption policy would be necessary. Ibid. See ERISA §§ 3021, 3022(a)(4), 88 Stat. 999 (formerly codified as 29 U. S. C. §§ 1221, 1222(a)(5)). After a period of monitoring by the Task Force, and hearings by the Subcommittee on Labor Standards of the House Committee on Education and Labor, a Report was issued evaluating ERISA's pre-emption provisions. The Report expressed approval of ERISA's broad pre-emption of state law, explaining that "the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded." H. R. Rep. No. 94-1785, p. 47 (1977). The Report recommended only that the exceptions described in § 514(b) be narrowed still further. Ibid.
the Act, and its legislative history, we hold that the Human Rights Law and the Disability Benefits Law "relate to any employee benefit plan" within the meaning of ERISA's § 514(a).

n21 Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan. Cf. American Telephone and Telegraph Co. v. Merry, 592 F.2d 118, 121 (CA2 1979) (state garnishment of a spouse's pension income to enforce alimony and support orders is not pre-empted). The present litigation plainly does not present a borderline question, and we express no views about where it would be appropriate to draw the line.

[**2902] IV

We next consider whether any of the narrow exceptions to § 514(a) saves these laws from pre-emption.

A

Appellants argue that the Human Rights Law is exempt from pre-emption by § 514(d), which provides that § 514(a) [*101] shall not "be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States." According to appellants, pre-emption of state fair employment laws would impair and modify Title VII because it would change the means by which it is enforced.

[***LEdHR12A] [12A]State laws obviously play a significant role in the enforcement of Title VII. See, e. g., Kremer v. Chemical Construction Corp., 456 U.S. 461, 468-469, 472, 477 (1982); id., at 504 (dissenting opinion); New York Gaslight Club, Inc. v. Carey, 447 U.S. 54, 63-65 (1980). Title VII expressly preserves nonconflicting state laws in its § 708:

"Nothing in this title shall be deemed to exempt or relieve any person from any liability, duty, penalty, or punishment provided by any present or future law of any State or political subdivision of a State, other than any such law which purports to require or permit the doing of any act which would be an unlawful employment practice under this title." 78 Stat. 262, 42 U. S. C. § 2000e-7. n22

[***504] Moreover, Title VII requires recourse to available state administrative remedies. When an employment practice prohibited by Title VII is alleged to have occurred in a State or locality which prohibits the practice and has established an [*102] agency to enforce that prohibition, the Equal Employment Opportunity Commission (EEOC) refers the charges to the state agency. The EEOC may not actively process the charges "before the expiration of sixty days after proceedings have been commenced under the State or local law, unless such proceedings have been earlier terminated." § 706(c), 86 Stat. 104, 42 U. S. C. § 2000e-5(c); see Love v. Pullman Co., 404 U.S. 522 (1972). In its subsequent proceedings, the EEOC accords "substantial weight" to the state administrative determination. § 706(b), 86 Stat. 104, 42 U. S. C. § 2000e-5(b).

n22

[***LEdHR12B] [12B]See also § 1104, 78 Stat. 268, 42 U. S. C. § 2000h-4. The Court of Appeals properly rejected the simplistic "double saving clause" argument -- that because ERISA does not pre-empt Title VII, and Title VII does not pre-empt state fair employment laws, ERISA does not pre-empt such laws. 666 F.2d, at 25-26. Title VII does not transform state fair employment laws into federal laws that § 514(d) saves from ERISA pre-emption. Furthermore, since Title VII's saving clause applies to all state laws with which it is not in conflict, rather than just to nondiscrimination laws, and since many federal laws contain nonpre-emption provisions, the double saving clause argument, taken to its logical extreme, would save almost all state laws from pre-emption. The question whether pre-emption of state fair employment laws would "impair" Title VII, in light of Title VII's reliance on state laws and agencies, is the more difficult question we address in the text.

Given the importance of state fair employment laws to the federal enforcement scheme, pre-emption of the Human Rights Law would impair Title VII to the extent that the Human Rights Law provides a means of enforcing Title VII's commands. Before the enactment of ERISA, an employee claiming discrimination in connection with a benefit plan would have had his complaint referred to the New York State Division of Human Rights. If ERISA were interpreted to pre-empt the Human Rights Law entirely with respect to covered benefit plans, the State no longer could prohibit the challenged employment practice and the state agency no longer would be authorized to grant relief. The EEOC thus would be unable to refer the claim to the state agency. This would frustrate the goal of encouraging joint state/federal enforcement of Title VII; an employee's only remedies for discrimination [**2903]
prohibited by Title VII in ERISA plans would be federal ones. Such a disruption of the enforcement scheme contemplated by Title VII would, in the words of § 514(d), "modify" and "impair" federal law. n23

n23 Pre-emption of this sort not only would eliminate a forum for resolving disputes that, in certain situations, may be more convenient than the EEOC, but also would substantially increase the EEOC's workload. Because the EEOC would be unable to refer claims to state agencies for initial processing, those claims that would have been settled at the state level would require the EEOC's attention. Claims that would not have been settled at the state level, but would have produced an administrative record, would come to the EEOC without such a record. The EEOC's options for coping with this added burden, barring discoveries of reserves in the agency budget, would be to devote less time to each individual case or to accept longer delays in handling cases. The inevitable result of complete pre-emption, in short, would be less effective enforcement of Title VII.

[*103]

[***LEdHR13] [13] Insofar as state laws prohibit employment practices that are lawful under Title VII, however, pre-emption would not impair Title VII within the meaning of § 514(d). Although Title VII does not itself prevent [*505] States from extending their nondiscrimination laws to areas not covered by Title VII, see § 708, 78 Stat. 262, 42 U. S. C. § 2000e-7, it in no way depends on such extensions for its enforcement. Title VII would prohibit precisely the same employment practices, and be enforced in precisely the same manner, even if no State made additional employment practices unlawful. Quite simply, Title VII is neutral on the subject of all employment practices it does not prohibit. n24 We fail to see how federal [*104] law would be impaired by pre-emption of a state law prohibiting conduct that federal law permitted.

n24 Appellants argue that pre-emption of the Human Rights Law's prohibition of pregnancy discrimination would impair Title VII because that law encourages States to enact fair employment laws providing greater substantive protection than Title VII. See, e. g., Tr. of Oral Arg 6-7, 11. We have found no statutory language or legislative history suggesting that the federal interest in state fair employment laws extends any farther than saving such laws from pre-emption by Title VII itself. As the court stated in Pervel, 468 F.Supp., at 493, "Title VII did not create new authority for state antidiscrimination laws; it simply left them where they were before the enactment of Title VII."

The legislative history of the Pregnancy Discrimination Act does not assist appellants. Although the House Report observed that many employers already were subject to state laws prohibiting pregnancy discrimination, H. R. Rep. No. 95-948, pp. 9-11 (1978); see S. Rep. No. 95-331, pp. 10-11 (1977), this observation subsequent to ERISA's enactment conveys no information about the intent of the Congress that passed ERISA. The conferees did not even mention ERISA; evidently, they simply failed to consider whether ERISA plans were subject to state laws prohibiting pregnancy discrimination. ERISA's structure and legislative history, while not particularly illuminating with respect to § 514(d), caution against applying it too expansively. As we have detailed above, Congress applied the principle of pre-emption "in its broadest sense to foreclose any non-Federal regulation of employee benefit plans," creating only very limited exceptions to pre-emption. 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent); see id., at 29933 (remarks of Sen. Williams). Sections 4(b)(3) and 514(b), which list specific exceptions, do not refer to state fair employment laws. While § 514(d) may operate to exempt provisions of state laws upon which federal laws depend for their enforcement, the combination of Congress' enactment of an all-inclusive pre-emption provision and its enumeration of narrow, specific exceptions to that provision makes us reluctant to expand § 514(d) into a more general saving clause.

The references to employment discrimination in the legislative history of ERISA provide no basis for an expansive construction of § 514(d). During floor debates, Senator Mondale questioned whether the Senate bill should be amended to require nondiscrimination in ERISA plans. Senator Williams replied that no such amendment was necessary or desirable. He noted that Title VII already prohibited discrimination in benefit plans, and stated: "I believe that the thrust toward centralized administration [*2904] of nondiscrimination in employment must be maintained. And I believe this can be done by the Equal Employment Opportunity Commission under terms of existing law."

119 Cong. Rec. 30409 (1973). Senator Mondale, "with the understanding that nondiscrimination in pension and profit-sharing plans is fully required under the Equal Employment Opportunity Act," id., at [***506] 30410,
chose not to offer a nondiscrimination amendment. This colloquy was repeated on the floor of the House by Representatives Abzug and Dent. 120 Cong. Rec. 4726 (1974).

[*105] These exchanges demonstrate only the obvious: that § 514(d) does not pre-empt federal law. The speakers referred to federal law, the EEOC, and the need for centralized enforcement. The limited legislative history dealing with § 514(d) is entirely consistent with Congress' goal of ensuring that employers would not face "conflicting or inconsistent State and local regulation of employee benefit plans," 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams). Congress might well have believed, had it considered the precise issue before us, that ERISA plans should be subject only to the nondiscrimination provisions of Title VII, and not also to state laws prohibiting other forms of discrimination. By establishing benefit plan regulation "as exclusively a federal concern," Alessi v. Raybestos-Manhattan, Inc., 451 U.S., at 523, Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees. n25

We recognize that our interpretation of § 514(d) as requiring partial pre-emption of state fair employment laws may cause certain practical problems. Courts and state agencies, rather than considering whether employment practices are unlawful under a broad state law, will have to determine whether they are prohibited by Title VII. If they are not, the state law will be superseded and the agency will lack authority to act. It seems more than likely, however, that state agencies and courts are sufficiently familiar with Title VII to apply it in their adjudicative processes. Many States look to Title VII law as a matter of course in defining the scope of their own laws. n26 In any event, these minor practical difficulties do not represent the kind of "impairment" or "modification" of federal law that can save a state law from pre-emption under § 514(d). To the extent that our construction of ERISA causes any problems in the administration of state fair employment laws, those problems are the result [***507] of congressional choice and should be addressed by congressional action. To give § 514(d) the broad construction advocated by appellants would defeat [**2905] the intent of Congress to provide comprehensive pre-emption of state law.

n25 An employer with employees in many States might find that the most efficient way to provide benefits to those employees is through a single employee benefit plan. Obligating the employer to satisfy the varied and perhaps conflicting requirements of particular state fair employment laws, as well as the requirements of Title VII, would make the administration of a uniform nationwide plan more difficult. The employer might choose to offer a number of plans, each tailored to the laws of particular States; the inefficiency of such a system presumably would be paid for by lowering benefit levels. Alternatively, assuming that the state laws were not in conflict, the employer could comply with the laws of all States in a uniform plan. To offset the additional expenses, the employer presumably would reduce wages or eliminate those benefits not required by any State. Another means by which the employer could retain its uniform nationwide plan would be by eliminating classes of benefits that are subject to state requirements with which the employer is unwilling to comply. ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.

B

The Disability Benefits Law presents a different problem. Section 514(a) of ERISA pre-empts state laws that relate to benefit plans "described in section 4(a) and not exempt under section 4(b)." Consequently, while the Disability Benefits Law plainly is a state law relating to employee benefit plans, it is not pre-empted if the plans to which it relates are exempt from ERISA under § 4(b). Section 4(b)(3) exempts "any employee benefit plan . . . maintained solely for the purpose of complying with applicable . . . disability insurance laws." The Disability Benefits Law is a "disability insurance law," of course; the difficulty is that at least some of the benefit [*107] plans offered by the Airlines provide benefits not required by that law. The question is whether, with respect to those among the Airlines using multibenefit plans, the Disability Benefits Law's requirement that employers provide particular benefits remains enforceable.
As the Court of Appeals recognized, § 4(b)(3) excludes "plans," not portions of plans, from ERISA coverage; those portions of the Airlines' multibenefit plans maintained to comply with the Disability Benefits Law, therefore, are not exempt from ERISA and are not subject to state regulation. There is no reason to believe that Congress used the word "plan" in § 4(b) to refer to individual benefits offered by an employee benefit plan. To the contrary, § 4(b)(3)'s use of the word "solely" demonstrates that the purpose of the entire plan must be to comply with an applicable disability insurance law. As the Court noted in *Alessi*, plans that not only provide benefits required by such a law, but also "more broadly serve employee needs as a result of collective bargaining," are not exempt. 451 U.S., at 523, n. 20. The test is not one of the employer's motive -- any employer could claim that it provided disability benefits altruistically, to attract good employees, or to increase employee productivity, as well as to obey state law -- but whether the plan, as an administrative unit, provides only those benefits required by the applicable state law.

Any other rule, it seems to us, would make little sense. Under the District Court's approach, for which appellants argue here, one portion of a multibenefit plan would be subject only to state regulation, while other portions would be exclusively within the federal domain. An employer with employees in several States would find its plan subject to a different jurisdictional pattern of regulation in each State, depending on what benefits the State mandated under disability, workmen's compensation, and unemployment compensation laws. The administrative impracticality of permitting mutually exclusive pockets of federal and state [*108] jurisdiction within a plan is apparent. We see no reason to torture the plain language of § 4(b)(3) to achieve this result. Only separately administered disability plans maintained solely to comply with the Disability Benefits Law are exempt from ERISA coverage under § 4(b)(3).

This is not to say, however, that the Airlines are completely free to circumvent the Disability Benefits Law by adopting plans that combine disability benefits inferior to those required by that law with other types of benefits. Congress surely did not intend, at the same time it preserved the role of state disability laws, to make enforcement of those laws impossible. A State may require an employer to maintain a disability plan complying with state law as a separate administrative unit. Such a plan would be exempt under § 4(b)(3). The fact that state law permits employers to meet their state-law obligations by including disability insurance benefits in a multibenefit ERISA plan, see N. Y. Work. Comp. Law App. § 355.6 (McKinney [*2906] Supp. 1982-1983), does not make the state law wholly unenforceable as to employers who choose that option.

In other words, while the State may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan. If the State is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply. The Court of Appeals erred, therefore, in holding that appellants are not at all free to enforce the Disability Benefits Law against those appellees that provide disability benefits as part of multibenefit plans.
Annotation References:

What circumstances render civil case, or issues arising therein, moot so as to preclude Supreme Court's consideration of their merits. 44 L Ed 2d 745.

Pregnancy leave or maternity leave policy, or lack thereof, as unlawful employment practice violative of Title VII of the Civil Rights Act of 1964 (42 USCS 2000e et seq.). 27 ALR Fed 537.
LEXSEE 471 US 724

METROPOLITAN LIFE INSURANCE CO. v. MASSACHUSETTS

No. 84-325

SUPREME COURT OF THE UNITED STATES


February 26, 1985, Argued
June 3, 1985, Decided *

* Together with No. 84-356, Travelers Insurance Co. v. Massachusetts, also on appeal from the same court.

Prior History:

APPEAL FROM THE SUPREME JUDICIAL COURT OF MASSACHUSETTS.

Disposition:

391 Mass. 730, 463 N. E. 2d 548, affirmed.

Case Summary:

Procedural Posture: On remand, the Supreme Judicial Court of Massachusetts affirmed a trial court order for a permanent injunction requiring appellant insurers to comply with a state benefits law, Mass. Gen. Laws Ann. ch. 175, § 47(B), holding that the statute was not preempted by § 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1144(a), or by the NLRA, 29 U.S.C.S. § 151 et seq. On further appeal, the Supreme Court affirmed, holding that the statute avoided preemption because it regulated insurance within the meaning of ERISA's savings clause, § 514(b)(2)(A), 29 U.S.C.S. § 1144(b)(2)(A), and because benefit plans were not deemed insurance companies under § 514(b)(2)(B) of ERISA, 29 U.S.C.S. § 1144(b)(2)(B).

Further, the mandated benefit law was a state regulation of the insurance business protected by the McCarran-Ferguson Act, 15 U.S.C.S. § 1011 et seq. The court also found no preemption under the NLRA because state laws that imposed minimum requirements for contract terms did not limit protected rights of self-organization or collective bargaining.

Outcome: The court affirmed the judgment requiring the insurers to comply with the state benefits law.

LexisNexis(R) Headnotes

Syllabus:

A Massachusetts statute (§ 47B) requires that certain minimum mental-health-care benefits be provided a Massachusetts resident who is insured under a general health insurance policy or an employee health-care plan insurer in No. 84-325 contends that § 47B, as applied to insurance policies purchased by employee health-care
plans regulated by the federal Employee Retirement Income Security Act of 1974 (ERISA), is pre-empted by that Act. Section 514(a) of ERISA provides that the statute shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." But § 514(b)(2)(A) provides that, with one exception, nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance." The one exception is found in § 514(b)(2)(B), which states that no employee-benefit 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." Appellant insurer in No. 84-356 contends that § 47B, as applied to insurance policies purchased pursuant to collective-bargaining agreements subject to a collective-bargaining agreement, is pre-empted by that Act, because it effectively imposes a contract term on the parties that otherwise would be a mandatory subject of collective bargaining.

Massachusetts brought an action in Massachusetts Superior Court to enforce § 47B against appellant insurers, and that court issued an injunction requiring the insurers to provide the coverage mandated by § 47B. The Massachusetts Supreme Judicial Court affirmed, finding no pre-emption under either ERISA or the NLRA.

**Held:**

1. Section 47B, as applied, is a law "which regulates insurance" within the meaning of § 514(b)(2)(A), and therefore is not pre-empted by § 514(a) as it applies to insurance contracts purchased for plans subject to ERISA. Section 514(b)(2)(A)'s plain language, its relationship to the other ERISA pre-emption provisions, and the traditional understanding of insurance regulations, all lead to the conclusion that mandated-benefit laws such as § 47B are saved from pre-emption by the operation of § 514(b)(2)(A). Nothing in ERISA's legislative history suggests a different result. Pp. 739-747.

2. Nor is § 47B, as applied to a plan negotiated pursuant to a collective-bargaining agreement subject to the NLRA, pre-empted by the NLRA. Pp. 747-758.

(a) The NLRA pre-emption involved here is the one that protects against state interference with policies implicated by the structure of the NLRA itself, by pre-empting state law and state causes of action concerning conduct that Congress intended to be unregulated. Pp. 747-751.

(b) Such pre-emption rests on a sound understanding of the NLRA's purpose and operation that is incompatible with the view that the NLRA pre-empts any state attempt to impose minimum-benefit terms on the parties to a collective-bargaining agreement. Pp. 751-753.

(c) Minimum state labor standards affect union and nonunion employees equally and neither encourage nor discourage the collective-bargaining processes that are the subject of the NLRA. Nor do they have any but the most indirect effect on the right of self-organization established in the NLRA. Unlike the NLRA, mandated-benefit laws, such as § 47B, are not designed to encourage or discourage employees in the promotion of their interests collectively; rather, they are in part designed to give minimum protections to individual employees and to ensure that each employee covered by the NLRA receives mandated health insurance coverage. These laws are minimum standards independent of the collective-bargaining process. Pp. 753-756.

(d) There is no suggestion in the NLRA's legislative history that Congress intended to disturb the state laws that set minimum labor standards but were unrelated to the collective-bargaining or self-organization processes. To the contrary, Congress in the NLRA developed the framework for self-organization and collective bargaining within the larger body of state law promoting public health and safety. When a state law establishes a minimal employment standard not inconsistent with the NLRA's general goals, it conflicts with none of the NLRA's purposes. Section 47B is an insurance regulation designed to implement the Commonwealth's policy on mental-health care, and as such is a valid and unexceptional exercise of the Commonwealth's police power. Though § 47B potentially limits any employee's right to choose one thing by requiring that he be provided with something else, it does not limit the right of self-organization or collective bargaining protected by the NLRA. Pp. 756-758.

**COUNSEL:**

Jay Greenfield argued the cause for appellant in No. 84-325. With him on the briefs was Peter Buscemi. Lane McGovern argued the cause for appellant in No. 84-356. With him on the brief was Steven A. Kaufman.

Sally A. Kelly, Assistant Attorney General of Massachusetts, argued the cause for appellee in both cases. With her on the brief were Francis X. Bellotti, Attorney General, and Susan M. Roberts, Assistant Attorney General. +

+ Briefs of amici curiae urging reversal were filed for the American Federation of Labor and Congress of Industrial Organizations by David M. Silberman, Marsha Berzon, and Laurence...
Gold; for the Blue Cross and Blue Shield Association by Philip S. Neal; for the ERISA Industry Committee by John M. Vine and Arvid E. Roach II; for the Health Insurance Association of America by Roger D. Redden and John P. Dineen; for the International Brotherhood of Electrical Workers Local 421 Health and Welfare Fund et al. by David L. Nixon; for the National Coordinating Committee for Multiemployer Plans by Gerald M. Feder; and for Milton R. Hill et al. by James H. Clarke.


JUDGES:
BLACKMUN, J., delivered the opinion of the Court, in which all other Members joined, except POWELL, J., who took no part in the decision of the cases.

OPINIONBY:
BLACKMUN

OPINION:

[*727] [***732] [**2382] JUSTICE BLACKMUN delivered the opinion of the Court.

[***LEdHR1A] [1A] [***LEdHR2A] [2A]A Massachusetts statute requires that specified minimum mental-health-care benefits [*2383] be provided a Massachusetts resident who is insured under a general insurance policy, an accident or sickness insurance policy, or an employee health-care plan that covers hospital and surgical expenses. The first question before us in these cases is whether the state statute, as applied to insurance policies purchased by employee health-care plans regulated by the federal Employee Retirement Income Security Act of 1974, is pre-empted by that Act. The second question is whether the state statute, as applied to insurance policies purchased pursuant to negotiated collective-bargaining agreements regulated by the National Labor Relations Act, is pre-empted by the labor Act.

I

A

General health insurance typically is sold as group insurance to an employer or other group. n1 Group insurance presently is subject to extensive state regulation, including [*728] regulation [***733] of the carrier, regulation of the sale and advertising of the insurance, and regulation of the content of the contracts. n2 Mandated-benefit laws, that require an insurer to provide a certain kind of benefit to cover a specified illness or procedure whenever someone purchases a certain kind of insurance, are a subclass of such content regulation.

n1 See Health Insurance Association of America, 1982-1983 Source Book of Health Insurance Data 4-7 (1984 Update). Group health insurance is provided either by commercial insurance companies or service corporations such as Blue Cross-Blue Shield. Ibid.
n2 Laws regulating the insurer include, for example, those governing solvency or the qualification of management. Laws regulating aspects of transacting the business of group insurance include, for example, those regulating claims practices or rates. Finally, laws regulating the content of group policies include, in addition to the mandated-benefit statutes under consideration here, those requiring the policies to provide grace periods and conversion privileges. See Brummond, Federal Preemption of State Insurance Regulation Under ERISA, 62 Iowa L. Rev. 57, 81-84, 101 (1976). All three varieties of regulation are common. Ibid.

While mandated-benefit statutes are a relatively recent phenomenon, n3 statutes regulating the substantive terms of insurance contracts have become commonplace in all 50 States over the last 30 years. n4 Perhaps the most familiar are those regulating the content of automobile insurance policies. n5


n4 See Brummond, 62 Iowa L. Rev., at 82-84, 101. In particular, there are a wide variety of longstanding statutes that mandate that insurance contracts contain certain provisions. See, e.g., New York Life Ins. Co. v. Hardison, 199 Mass. 190, 85 N. E. 410 (1908) (upholding statute prescribing provisions); Md. Ann. Code, Art. 48A, § 410(a)(5) (1979) (law enacted in 1956 mandating the inclusion of a clause in a life insurance policy that limits the exclusion from coverage for death by suicide to that occurring within two years of the issuance of the policy).

n5 See, e.g., California Automobile Assn. Inter-Insurance Bureau v. Maloney, 341 U.S. 105 (1951) (upholding state statute requiring insurers to participate in a mandatory assigned-risk pool to assure the availability of automobile insurance). Like most States, Massachusetts at present mandates both the kinds of automobile policies insurers must offer to sell and the kinds of coverage insureds may purchase. See Mass. Gen. Laws Ann., ch. 175, § 113A et seq. (West 1972 and Supp. 1985).


n7 See App. to APHA brief 1A-6A (listing statutes).

n8 There are approximately 50 such laws in over 20 States. See App. to Brief for Health Insurance Association of America as Amicus Curiae in Support of Juris. Statements 1a-2a (listing statutes).

n9 For example, a majority of States require that coverage for services offered by an optometrist be either mandated or at least offered in a health-insurance plan. See id., at 4a (listing statutes).

Mandated-benefit statutes, then, are only one variety of a matrix of state laws that regulate the substantive content of health-insurance policies to further state health policy. Massachusetts Gen. Laws Ann., ch. 175, § 47B (West Supp. 1985), is typical of mandated-benefit laws currently in place in the majority of States. n10 With respect to a Massachusetts [*730] resident, it requires any general health-insurance policy that provides hospital and surgical coverage, or any benefit plan that has such coverage, to provide as well a certain minimum
of mental-health protection. In particular, § 47B requires that a health-insurance policy provide 60 days of coverage for confinement in a mental hospital, coverage for confinement in a general hospital equal to that provided by the policy for nonmental illness, and certain minimum outpatient benefits. n11

n10 According to the Health Insurance Association of America, 26 States have promulgated 69 mandated-benefit laws. See id., at 1a-2a; see also Wayne Chemical, Inc. v. Columbus Agency Service Corp., 426 F.Supp. 316, 324, n. 8 (ND Ill.) (citing statutes in 26 States), aff’d as modified, 567 F.2d 692 (CA7 1977).


n11 Section 47B reads:

"(a) In the case of benefits based upon confinement as an inpatient in a mental hospital . . . the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year . . . .

(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

"(c) In the case of out-patient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) or subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions . . . ."

[*731]  Section 47B was designed to address problems encountered in treating mental illness in Massachusetts. The Commonwealth determined that its working people needed to be protected against the high cost of treatment for such illness. It also believed that, without insurance, mentally ill workers were often institutionalized in large state mental hospitals, and that mandatory insurance would lead to a higher incidence of more effective treatment in private community mental-health centers. See Massachusetts General Court, Joint [*2385] Committee on Insurance, Advances in Health Insurance in Massachusetts (1974), reprinted in App. 426, 430-432.

In addition, the Commonwealth concluded that the voluntary insurance market was not adequately providing mental-health coverage, because of "adverse selection" in mental-health insurance: good insurance risks were not purchasing coverage, and this drove up the price of coverage for those who otherwise might purchase mental-health insurance. The legislature believed that the public interest required that it correct the insurance market in the Commonwealth by mandating minimum-coverage levels, effectively forcing the good-risk individuals to become part of the risk pool, and enabling insurers to price the insurance at an average market rather than a market retracted due to adverse selection. See Findings of Fact of the Superior Court, App. to Juris. Statement in No. 84-325, pp. 50a-53a. Section 47B, then, was intended to help safeguard the public against the high costs of comprehensive inpatient and outpatient mental-health care, reduce nonpsychiatric medical-care expenditures for mentally related illness, shift the delivery of treatment from inpatient to outpatient services, and relieve the Commonwealth of some of the financial burden it otherwise would encounter with respect to mental-health problems. Ibid.

[*732]  It is our task in these cases to decide whether such insurance regulation violates or is inconsistent with federal law.
B

The federal Employee Retirement Income Security Act of 1974, 88 Stat. 829, as amended, 29 U. S. C. § 1001 et seq. (ERISA), comprehensively regulates employee pension and welfare plans. An employee welfare-benefit plan or welfare plan is defined as one which provides to employees "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death," whether these benefits are provided "through the purchase of insurance or otherwise." § 3(1), 29 U. S. C. § 1002(1). Plans may self-insure or they may purchase insurance for their participants. Plans that purchase insurance -- so-called "insured plans" -- are directly affected by state laws that regulate the insurance industry.


ERISA thus contains almost no federal regulation of the terms of benefit plans. It does, however, contain a broad pre-emption provision declaring that the statute shall "supersede any and all State laws insofar as they may now or hereafter relate to [***736] any employee benefit plan." § 514(a), 29 U. S. C. § 1144(a). Appellant Metropolitan in No. 84-325 argues that ERISA pre-empted Massachusetts' mandated-benefit law insofar as § 47B restricts the kinds of insurance policies that benefit plans may purchase.

[***733] While § 514(a) of ERISA broadly pre-empts state laws that relate to an employee-benefit plan, that pre-emption is substantially qualified by an "insurance saving clause," § 514(b)(2)(A), 29 U. S. C. § 1144(b)(2)(A), which broadly states that, with one exception, nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." The specified exception to the saving clause is found in § 514(b)(2)(B), 29 U. S. C. § 1144(b)(2)(B), the so-called "deemer clause," which states that no employee-benefit plan, with certain exceptions not relevant here, "shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or [**2386] to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

Massachusetts argues that its mandated-benefit law, as applied to insurance companies that sell insurance to benefit plans, is a "law which regulates insurance," and therefore is saved from the effect of the general pre-emption clause of ERISA.

Wholly apart from the question whether Massachusetts' mandated-benefit law is pre-empted by ERISA, appellant Travelers in No. 84-356 argues that as applied to benefit plans negotiated pursuant to collective-bargaining agreements, § 47B is pre-empted by the National Labor Relations Act, 49 Stat. 449, as amended, 29 U. S. C. § 151 et seq. (NLRA), because it effectively imposes a contract term on the parties that otherwise would be a mandatory subject of collective bargaining. Unlike ERISA, the NLRA contains no statutory provision indicating the extent to which it was intended to pre-empt state law. Resolution of the NLRA pre-emption question, therefore, requires us to discern legislative intent from the general purpose of the NLRA, and not from any particular statutory language.

[*734] II

Appellants are Metropolitan Life Insurance Company and Travelers Insurance Company (insurers) who are located in New York and Connecticut respectively and who issue group-health policies providing hospital and surgical coverage to plans, or to employers or unions that employ or represent employees residing in Massachusetts. Under the terms of § 47B, both appellants are required to provide minimal mental-health benefits in policies issued to cover Commonwealth residents.

In 1979, the Attorney General of Massachusetts brought suit in Massachusetts Superior Court for declaratory and injunctive relief to enforce § 47B. The Commonwealth asserted that since January 1, 1976, the effective date of § 47B, the insurers had issued policies to group policyholders situated outside Massachusetts that provided for hospital and surgical coverage for certain residents of the Commonwealth. App. 8-9. It further asserted that those policies failed to [***737] provide Massachusetts-resident beneficiaries the mental-health coverage mandated by § 47B, and that the insurers intended to issue more such policies, believing themselves not bound by § 47B for policies issued outside the Commonwealth. In their answer, the insurers admitted these allegations. n12

n12 See Answer paras. 8-14, App. 51-52. See also Stipulation paras. 1-11, App. 459-462.

The complaint further asserted that the insurers had amended a number of policies in effect prior to January
1, 1976, but had failed to include the benefits mandated by § 47B in the amended policies, in violation of the law. App. 9-10. Finally, the Commonwealth asserted that the insurers refused to provide the mandated benefits in part on the ground that they believed ERISA and the NLRA pre-empted § 47B. App. 10. Though the insurers had not actually refused to provide the mandated benefits in any policy issued after January 1, 1976, within the Commonwealth, the insurers preserved their right to challenge the applicability of § 47B [*735] to any policy issued to an ERISA plan within the Commonwealth. n13 The Commonwealth accordingly requested broad preliminary and permanent injunctive relief, asking the court to require the insurers to provide the mandated benefits to all covered residents of the Commonwealth subject to the terms of § 47B, regardless of when their policies were issued or whether they were presently receiving such benefits. App. 11-12.

n13 See Answer to the Complaint, Second and Third Defenses, App. 53-54. See also Stipulation para. 9, App. 461-462.

The Superior Court issued a preliminary injunction requiring the insurers to provide the coverage mandated by § 47B. App. 57-59. After trial, a different judge issued a permanent injunction to the same effect, [**2387] see App. to Juris. Statement in No. 84-325, pp. 67a-70a, making extensive findings of fact concerning the cost, nature, purpose, and effect of the mandated-benefit law. See id., at 36a-62a. The Supreme Judicial Court of Massachusetts granted the insurers' application for direct appellate review and affirmed the judgment of the Superior Court. Attorney General v. Travelers Ins. Co., 385 Mass. 598, 433 N. E. 2d 1223 (1982).

Addressing first the ERISA pre-emption question, the court recognized that § 47B is a law that "relates to' benefit plans," and so would be pre-empted unless it fell within one of the exceptions to the pre-emption clause of ERISA. 385 Mass., at 605, 433 N. E. 2d, at 1227. The court went on to hold, however, that § 47B is a law "which regulates insurance," as understood by the ERISA saving clause, § 514(b)(2)(A), 29 U. S. C. § 1144(b)(2)(A), and therefore is not pre-empted by ERISA. 385 Mass., at 606-609, 433 N. E. 2d, at 1228-1230. n14 It [***738] rejected appellants' claim that [*736] the saving clause was designed to save only "traditional" insurance laws rather than those that are designed to promote public health, finding no such limitation in the statutory language of ERISA. The court nonetheless was wary of a literal reading of the statute, lest the saving clause give the States unintended authority to regulate in areas otherwise governed by ERISA. It therefore understood the saving clause to save only state laws that were unrelated to the substantive provisions of ERISA. Since nothing in ERISA regulates the content of welfare plans, state regulation of insurance that indirectly affects the content of welfare plans is not pre-empted by ERISA. 385 Mass., at 606-607, 609, 433 N. E. 2d, at 1228-1229.

n14 Section 47B also requires benefit plans that are self-insured to provide the mandated mental-health benefits. In light of ERISA's "deemer clause," § 514(b)(2)(B), 29 U. S. C. § 1144(b)(2)(B), which states that a benefit plan shall not "be deemed an insurance company" for purposes of the insurance saving clause, Massachusetts has never tried to enforce § 47B as applied to benefit plans directly, effectively conceding that such an application of § 47B would be pre-empted by ERISA's pre-emption clause, § 514(a), 29 U. S. C. § 1144(a). See Stipulation para. 12, App. 462. In a part of its decision that is not challenged here, the Supreme Judicial Court held that that part of § 47B which applies to insurers is severable from the pre-empted provisions pertaining directly to benefit plans. See 385 Mass., at 601-602, 433 N. E. 2d, at 1225.

The court then went on to conclude that the NLRA does not pre-empt § 47B. Although § 47B regulates health benefits, a subject of mandatory collective bargaining, the NLRA does not pre-empt all local regulation affecting employment relations. A public health statute, § 47B does not regulate labor-management relations as such or affect the free play of economic forces between labor and management. "It is unlikely that Congress intended, by enacting the NLRA, to bind the hands of State Legislatures with respect to problems such as mental health." 385 Mass., at 613, 433 N. E. 2d, at 1232.

Moreover, the court pointed out, Congress has indicated in the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U. S. C. § 1011 et seq., that federal laws should not be construed to supersede state laws "regulating the business of insurance." § 1012(b). Section 47B operates upon insurance and insurance policies. The McCarran-Ferguson Act [*737] contains no limiting definition of the term "business of insurance" that would suggest a narrow reading excluding § 47B from its protection. 385 Mass., at 613-614, 433 N. E. 2d, at 1232. The court therefore found no pre-emption under either ERISA or the NLRA.
that decision, the Supreme Judicial Court, 463 U.S. 85 (1983). Appropriately refocusing on the judgment.

remanded the cases for further consideration in light of the intervening decision in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). Appropriately refocusing on the ERISA pre-emption provisions that were the subject of that decision, the Supreme Court,held that ERISA's broad pre-emption provision was intended to pre-empt any state law that "[related] to" an employee-benefit plan, not merely those state laws that directly conflicted with a substantive provision in the federal statute. Though the Court thus had rejected a conflict-based analysis of the broadly phrased pre-emption clause as being too narrow an interpretation of that provision, it did not follow that the conflict-based limitation on the saving clause imposed by the Supreme Judicial Court similarly should be rejected.

The dissenting justice felt that the *Shaw* Court had made clear that the exemptions and exceptions to ERISA's pre-emption clause should be read narrowly in order to preserve nationwide uniformity in the administration of welfare plans. [*738] Reading the insurance saving clause narrowly, § 47B should not be understood as a statute that regulates insurance. As applied, § 47B concerns health benefits that an employer must provide, and only incidentally regulates insurance. *Shaw* established that it is "irrelevant whether State law dictating plan benefits conflicts with the substantive policies of ERISA." 391 Mass., at 736, 463 N. E. 2d, at 552.

The insurers once again appealed pursuant to 28 U. S. C. § 1257(2), and we noted probable jurisdiction. 469 U.S. 929 (1984).

III

Section 47B clearly "[relates] to" welfare plans governed by ERISA so as to fall within the reach of ERISA's pre-emption provision, § 514(a). The broad scope of the pre-emption clause was noted recently in *Shaw v. Delta Air Lines, Inc.*, supra, where [*740] we held that the New York Human Rights Law and the State's Disability Benefits [*2389] Law "[related] to" welfare plans governed by ERISA. The phrase "relate to" was given its broad common-sense meaning, such that a state law "[relates] to" a benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." 463 U.S., at 97. The pre-emption provision was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements. *Id.*, at 98-99. "[Even] indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).
Though § 47B is not denominated a benefit-plan law, it bears indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy. The Commonwealth does not argue that § 47B as applied to policies purchased by benefit plans does not relate to those plans, and we agree with the Supreme Judicial Court that the mandated-benefit law as applied relates to ERISA plans and thus is covered by ERISA’s broad pre-emption provision set forth in § 514(a).

Nonetheless, the sphere in which § 514(a) operates was explicitly limited by § 514(b)(2). The insurance saving clause preserves any state law "which regulates insurance, banking, or securities." The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly [*740] pre-empts state law, the saving clause appears broadly to preserve the States’ lawmakers’ power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time. n16


Fully aware of this statutory complexity, we still have no choice but to "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." Park ‘N Fly, Inc. v. Dollar Park and Fly, Inc., 469 U.S. 189, 194 (1985). We also must presume that Congress did not intend to pre-empt areas of traditional state regulation. See Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977).

[***741] To state the obvious, § 47B regulates the terms of certain insurance contracts, and so seems to be saved from pre-emption by the saving clause as a law "which regulates insurance." This common-sense view of the matter, moreover, is reinforced by the language of the subsequent subsection of ERISA, the "deemer clause," which states that an employee-benefit plan shall not be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, [*741] or investment companies." § 514(b)(2)(B), 29 U. S. C. § 1144(b)(2)(B) (emphasis added). By exempting from the saving clause laws regulating insurance [*740] contracts that apply directly to benefit plans, the deemer clause makes explicit Congress’ intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.

The insurers nonetheless argue that § 47B is in reality a health law that merely operates on insurance contracts to accomplish its end, and that it is not the kind of traditional insurance law intended to be saved by § 514(b)(2)(A). We find this argument unpersuasive.

Initially, nothing in § 514(b)(2)(A), or in the "deemer clause" which modifies it, purports to distinguish between traditional and innovative insurance laws. The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind.

Appellants assert that state laws that directly regulate the insurer, and laws that regulate such matters as the way in which insurance may be sold, are traditional laws subject to the clause, while laws that regulate the substantive terms of insurance contracts are recent innovations more properly seen as health laws rather than as insurance laws, which § 514(b)(2)(A) does not save. This distinction reads the saving clause out of ERISA entirely, because laws that regulate only the insurer, or the way in which it may sell insurance, do not "relate to" benefit plans in the first instance. Because
they would not be pre-empted by § 514(a), they do not need to be "saved" by § 514(b)(2)(A). There is no indication that Congress could have intended the saving clause to operate [*742] only to guard against too expansive readings of the general pre-emption clause that might have included laws wholly unrelated to plans. n17 Appellants' construction, in our view, violates the plain meaning of the statutory language and renders redundant both the saving clause it is construing, as well as the deemer clause which it precedes, [***742] and accordingly has little to recommend it. n18

n17 In light of the fact that the saving clause was in place well before the general pre-emption clause was amended to pre-empt broadly all laws that relate to plans, such an explanation is unacceptable. See n. 23, infra.


Moreover, it is both historically and conceptually inaccurate to assert that mandated-benefit laws are not traditional insurance laws. As we have indicated, state laws regulating the substantive terms of insurance contracts were commonplace well before the mid-70's, when Congress considered ERISA. n19 The case law concerning the meaning of the phrase "business of insurance" in the McCarran-Ferguson Act, 15 U. S. C. § 1011 et seq., also [**2391] strongly supports the conclusion that regulation regarding the substantive terms of [*743] insurance contracts falls squarely within the saving clause as laws "which regulate insurance."

Cases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within that Act's reference to the "business of insurance": "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982) (emphasis in original). See also Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979). Application of these principles suggests that mandated-benefit laws are state regulation of the "business of insurance."

Section 47B obviously regulates the spreading of risk: as we have indicated, it was intended to effectuate the legislative judgment that the risk of mental-health care should be shared. See Findings of Fact of the Superior Court, App. to Juris. Statement in No. 84-325, pp. 50a-51a. It is also evident that mandated-benefit laws directly regulate an integral part of the relationship between the insurer and the policyholder by limiting the type of insurance that an insurer may sell to the policyholder. Finally, the third criterion is present here, for mandated-benefit statutes impose requirements only on insurers, with the intent of affecting the [***743] relationship between the insurer and the policyholder. Section 47B, then, is the very kind of regulation that this Court has identified as a law that relates to the regulation of the business of insurance as defined in the McCarran-Ferguson Act: n20

"Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers [*744] around the contract of insurance . . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement -- these were the core of the 'business of insurance.' [The] focus [of the statutory term] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws

n20 See also 91 Cong. Rec. 480 (1945) (remarks of Sen. Ferguson) ("A state law relating to . . . the fixing of the terms of a contract of insurance . . . would be permitted [under the McCarran-Ferguson Act]").

n21 That mandated-benefit laws fall within the terms of the definition of insurance in the McCarran-Ferguson Act is directly relevant in another sense as well. Congress' "primary concern" in enacting McCarran-Ferguson was to "ensure that the States would continue to have the ability to tax and regulate the business of insurance." Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 217-218 (1979). That Act provides: "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." 59 Stat. 34, 15 U. S. C. § 1012(a). The ERISA saving clause, with its similarly worded protection of "any law of any State which regulates insurance," appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States. Moreover, § 514(d) of ERISA, 29 U. S. C. § 1144(d), explicitly states in part: "Nothing in [ERISA] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States." Thus application of the McCarran-Ferguson Act lends further support to our ruling that Congress did not intend mandated-benefit laws to be pre-empted by ERISA.


The Conference Committee that was convened to work out differences between the Senate and House versions of ERISA broadened
the general pre-emption provision from one that pre-empted state laws only insofar as they regulated the same areas explicitly regulated by ERISA, to one that pre-empted all state laws unless otherwise saved. See H. R. Conf. Rep. No. 93-1280, p. 383 (1974). The change gave the insurance saving clause a much more significant role, as a provision that saved an entire body of law from the sweeping general pre-emption clause. There were no comments on the floor of either Chamber specifically concerning the insurance saving clause, and hardly any concerning the exceptions to the pre-emption clause in general. See n. 24, infra.

The change in the pre-emption provision was not disclosed until the Report was filed with Congress 10 days before final action was taken on ERISA. The House conferees filed their Report, H. R. Conf. Rep. No. 93-1280, on August 12, 1974, while the Senate conferees filed their Report, S. Conf. Rep. No. 93-1090, the following day. 30 Cong. Q. Almanac 252 (1974). ERISA was passed by the House on August 20, and by the Senate on August 22. 120 Cong. Rec. 29215-29216, 29963 (1974). n24 See id., at 29197 (remarks of Rep. Dent) ("narrow exceptions specifically enumerated"); id., at 29933 (remarks of Sen. Williams) ("narrow exceptions specified in the bill . . . eliminating the threat of conflicting or inconsistent State and local regulation"). See also id., at 29942 (remarks of Sen. Javits) (avoiding danger of "potentially conflicting State laws hastily contrived"). We have previously made reference to these comments in Shaw v. Delta Air Lines, Inc., 463 U.S., at 99, 105, finding them "not particularly illuminating," but lending support to our conclusion that the exception in § 514(d) should not be given an artificially broad construction. 463 U.S., at 104. We agree with the Supreme Judicial Court that our understanding of § 514(d) in Shaw is of little help in analyzing § 514(b)(2)(A), for, unlike § 514(d), the saving clause is broad on its face and specific in its reference.

We therefore decline to impose any limitation on the saving clause beyond **2393 those Congress imposed in the clause itself and in the "deemer clause" which modifies it. If a state law "regulates insurance," as mandated-benefit laws do, it is not pre-empted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause, whether it be the Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions [*747] [***745] of ERISA, or the insurers' more speculative attempt to read the saving clause out of the statute.

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. n25 We also are aware that appellants' construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress.

n25 A 1977 Activity Report of the House Committee on Education and Labor recognized the difference in treatment between insured and uninsured plans: "To the extent that [certain programs selling insurance policies] fail to meet the definition of an 'employee benefit plan' [subject to the "deemer clause"], state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these 'products.'" H. R. Rep. No. 94-1785, p. 48. A bill to amend the saving clause to specify that mandated-benefit laws are pre-empted by ERISA was reported to the Senate in 1981 but was not acted upon. See n. 16, supra.

IV

A

[***LEdHR4] [4]Unlike ERISA, the NLRA contains no statutory pre-emption provision. Still, as in any pre-emption analysis, "'[t]he purpose of Congress is the ultimate touchstone.'" Malone v. White Motor Corp., 435 U.S. 497, 504 (1978), quoting Retail Clerks v. Schermerhorn, 375 U.S. 96, 103 (1963). Where the preemptive effect of federal enactments is not explicit, "courts sustain a local regulation 'unless it conflicts with federal law or would frustrate the federal scheme, or unless the courts discern from the totality of the circumstances [*748] that Congress sought to occupy the field to the exclusion of the States.'" Allis-Chalmers
Appellants contend first that because mandated-benefit laws require benefit plans whose terms are arrived at through collective bargaining to purchase certain benefits the parties may not have wished to purchase, such laws in effect mandate terms of collective-bargaining agreements. The Supreme Judicial Court of Massachusetts correctly found that "[because] a plan that purchases insurance has no choice but to provide mental health care benefits, the insurance provisions of § 47B effectively control the content of insured welfare benefit plans." 385 Mass., at 605, 433 N.E. 2d, at 1227. More precisely, faced with § 47B, parties to a collective-bargaining agreement providing for health insurance are forced to make a choice: either they must purchase the mandated benefit, decide not to provide health coverage at all, or decide to become self-insured, assuming they are in a financial position to make that choice.

The question then becomes [***746] whether this kind of interference with collective bargaining is forbidden by federal law. Appellants argue that because Congress intended to leave the choice of terms in collective-bargaining agreements to the free play of economic forces, not subject either to state law or to the control of the National Labor Relations Board (NLRB), mandated-benefit laws should be pre-empted by the NLRA.

The Court has articulated two distinct NLRA pre-emption principles. The so-called Garmon rule, see San Diego Building Trades Council v. Garmon, 359 U.S. 236 (1959), protects the primary jurisdiction of the NLRB to determine in the first instance what kind of conduct is either prohibited or protected by the NLRA. n26 There is no claim here that [*749] Massachusetts has sought to regulate or prohibit any conduct subject to the regulatory jurisdiction of the NLRB, since the Act is silent as to the substantive provisions of welfare-benefit plans.

n26 See Belknap, Inc. v. Hale, 463 U.S. 491, 498-499 (1983). Garmon pre-emption involves balancing the State's interest in controlling or remedying the effects of the conduct in question against the interference with the Board's ability to adjudicate controversies committed to it by the Act, and the risk that the State will sanction conduct that the Act protects. Ibid. Garmon pre-emption accomplishes Congress' purpose of creating an administrative agency in charge of creating detailed rules to implement the Act, rather than having the Act enforced and interpreted by the state or federal courts. San Diego Building Trades Council v. Garmon, 359 U.S., at 241-245.

A second pre-emption doctrine protects against state interference with policies implicated by the structure of the Act itself, by pre-empting state law and state causes of action concerning conduct that Congress intended to be unregulated. The doctrine was designed, at least initially, to govern pre-emption questions that arose concerning activity that was neither arguably protected against employer interference by § § 7 and 8(a)(1) of the NLRA, nor arguably prohibited as an unfair labor practice by § 8(b) of that Act. 29 U.S. C. § § 157, 158(a)(1) and (b). Such action falls outside the reach of Garmon pre-emption. See New York Telephone Co. v. New York Labor Dept., 440 U.S. 519, 529-531 (1979) (plurality opinion). n27

n27 Such analysis initially had been used to determine whether certain weapons of bargaining neither protected by § 7 nor forbidden by § 8(b) could be subject to state regulation. See, e.g., Belknap, Inc. v. Hale, supra (power to terminate replacements hired during a strike); Machinists v. Wisconsin Employment Relations Comm'n, 427 U.S. 132 (1976) (concerted refusal to work overtime). It has been used more recently to determine the validity of state rules of general application that affect the right to bargain or to self-organization. See New York Telephone Co. v. New York Labor Dept., 440 U.S., at 539-540 (plurality opinion) (state unemployment compensation laws).

Such pre-emption does not involve in the first instance a balancing of state and federal interests, see Brown v. Hotel Employees, 468 U.S. 491, 502-503 (1984), but an analysis of the structure of the federal labor law to determine whether certain conduct was meant to be unregulated. An appreciation of the State's interest in regulating a certain kind of conduct may still be relevant in determining whether Congress in fact intended the conduct to be unregulated. See New York Telephone Co. v. New York Labor Dept., 440 U.S., at 539-540.

[*750] In Teamsters v. Morton, 377 U.S. 252 (1964), the Court struck down an [***747] Ohio labor law that prohibited a type of secondary boycott neither prohibited nor protected under the NLRA. The Court ruled that if state law were allowed to deprive the union of a self-help weapon permitted under federal law, "the inevitable result would be to frustrate the congressional
determination to leave this weapon of self-help available, and to upset the balance of power between labor and management expressed in our national labor policy." Id., at 260. Similarly, in Machinists v. Wisconsin Employment Relations Comm'n, 427 U.S. 132 (1976), the Court ruled that a State may not penalize a concerted refusal to work overtime that was neither prohibited nor protected under the NLRA, for "Congress intended that the conduct involved be unregulated because left 'to be controlled by the free play of economic forces.'" Id., at 140, quoting NLRB v. Nash-Finch [*2395] Co., 404 U.S. 138, 144 (1971).

More recently, a divided Court struggled with a feature of New York's unemployment-insurance law that provided certain unemployment-insurance payments to striking workers. New York Telephone Co. v. New York Labor Dept., supra. As in Machinists and Morton, the state law "altered the economic balance between labor and management." 440 U.S., at 532 (plurality opinion). A majority of the Justices nonetheless found the state law not pre-empted, on the ground that the legislative history of the Social Security Act of 1935, along with other federal legislation, suggested that Congress had decided to permit a State to pay unemployment benefits to strikers. n28

A plurality opinion affirmed the state-court decision finding no pre-emption in part on the ground that the 1935 Congress intended to permit the States to make these payments, and in part on the ground that the unemployment insurance statute was a law of general application designed to insure employment security in the State, and not to regulate the bargaining relationship between management and labor. Id., at 532-533. Two opinions concurring in the result agreed with the plurality on only the legislative history ground. See id., at 546 and 547.

[*751] These cases rely on the understanding that in providing in the NLRA a framework for self-organization and collective bargaining, Congress determined both how much the conduct of unions and employers should be regulated, and how much it should be left unregulated:

"The States have no more authority than the Board to upset the balance that Congress has struck between labor and management in the collective-bargaining relationship. "For a state to impinge on the area of labor combat designed to be free is quite as much an obstruction of federal policy as if the state were to declare picketing free for purposes or by methods which the federal Act prohibits." New York Telephone Co. v. New York Labor Dept., 440 U.S., at 554 (dissenting opinion), quoting Garner v. Teamsters, 346 U.S. 485, 500 (1953).

All parties correctly understand this case to involve Machinists pre-emption.

B

Here, however, appellants do not suggest that § 47B alters the balance of power between the parties to the labor contract. Instead, appellants argue that, not only did Congress establish a balance of bargaining power between labor and management in the Act, but it also intended to prevent the States from establishing minimum employment standards that labor and management would otherwise have been required to negotiate from their federally protected bargaining positions, and would otherwise have been permitted to set at a lower level than that mandated by state law. Appellants assert that such state regulation is permissible only when Congress has authorized its enactment. Because welfare benefits are a mandatory subject of bargaining under the [*752] labor law, see Chemical & Alkali Workers v. Pittsburgh Plate Glass Co., 404 U.S. 157, 159, and n. 1 (1971), and because Congress has never given States the authority to enact health regulations that affect the terms of bargaining agreements, appellants urge that the NLRA pre-empts any state attempt to impose minimum-benefit terms on the parties. n29

n28 A plurality opinion affirmed the state-court decision finding no pre-emption in part on the ground that the 1935 Congress intended to permit the States to make these payments, and in part on the ground that the unemployment insurance statute was a law of general application designed to insure employment security in the State, and not to regulate the bargaining relationship between management and labor. Id., at 532-533. Two opinions concurring in the result agreed with the plurality on only the legislative history ground. See id., at 546 and 547.

n29 Even if we were to accept appellants' argument that state laws mandating contract terms on collectively bargained contracts are pre-empted unless Congress authorizes their imposition, we would still find § 47B not pre-empted here. For mandated-benefit laws are laws "regulating the business of insurance," see n. 21, supra, and Congress in the McCarran-Ferguson Act expressly left to the States the power to enact such regulation. 15 U. S. C. § 1012(a). That Act states: "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." § 1012(b). Appellants argue that § 1012(a) does not apply to the NLRA because of § 1014, which states: "Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the ... National Labor Relations Act." The federal laws excepted from the operation of § 1012(b), however, are listed in that subsection itself. Section § 1014 was meant, instead, to codify this Court's decision in Polish
Appellants assume that Congress’ ultimate concern in the NLRA was in leaving the parties free to reach agreement about contract terms. The framework established in the NLRA was merely a means to allow the parties to reach such agreement fairly. A law that interferes with the end result of bargaining is, therefore, even worse than a law that interferes with the bargaining process. Thus, it is argued, this case is a fortiori to cases like Morton, Machinists, and New York Telephone.

The question has been before the Court in the past, see Algoma Plywood Co. v. Wisconsin Board, 336 U.S. 301, 312 (1949), and there is a surface plausibility to appellants’ argument, which finds support in dicta in some prior Court decisions. See Teamsters v. Oliver, 358 U.S. 283, 295-296 (1959); Alessi v. Raybestos-Manhattan, Inc., 451 U.S., at 525-526. Upon close analysis, however, we find that Morton, Machinists, and New York Telephone all rest on a sound understanding of the purpose and operation of the Act that is incompatible with appellants’ position here.

C

Congress apparently did not consider the question whether state laws of general application affecting terms of collective-bargaining agreements subject to mandatory bargaining were to be pre-empted. That being so, "the Court must construe the Act and determine its impact on state law in light of the wider contours of federal labor policy." Belknap, Inc. v. Hale, 463 U.S. 491, 520, n. 4 (1983) (opinion concurring in judgment).

The NLRA is concerned primarily with establishing an equitable process for determining terms and conditions of employment, and not with particular substantive terms of the bargain that is struck when the parties are negotiating from relatively equal positions. See Cox, Recent Developments in Federal Labor Law Preemption, 41 Ohio St. L. J. 277, 297 (1980). The NLRA’s declared purpose is to remedy "[the] inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers who are organized in the corporate or other forms of ownership association." § 1, 29 U. S. C. § 151. The same section notes the desirability of "restoring equality of bargaining power," among other ways, "by encouraging the practice and procedure of collective bargaining and by protecting the exercise by workers of full freedom of association, self-organization, and designation of representatives of their own choosing, for the purpose of negotiating the terms and conditions of their employment or other mutual aid or protection."

One of the ultimate goals of the Act was the resolution of the problem of "[depressed] wage rates and the purchasing power of wage earners in industry." 29 U. S. C. § 151, and "the widening gap between wages and profits," 79 Cong. Rec. 2371 (1935) (remarks of Sen. Wagner), thought to be the cause of economic decline and depression. Congress hoped to accomplish this by establishing procedures for more equitable private bargaining.

n31 "It is well recognized today that the failure to spread adequate purchasing power among the vast masses of the consuming public disrupts the continuity of business operations and causes everyone to suffer. The piling up of excess capital reserves and plant capacities is a dead weight upon the whole economic structure. . . .

"[Under the new program] [employees] were guaranteed protection in their cooperative efforts, in order that they might help the Government to insure a sufficient flow of purchasing power through adequate wages." Hearings on S. 1958 before the Senate Committee on Education and Labor, 74th Cong., 1st Sess., 34-35 (1935) (statement of Sen. Wagner).
The evil Congress was addressing thus was entirely unrelated to local or federal regulation establishing minimum terms of employment. Neither inequality of bargaining power nor the resultant depressed wage rates were thought to result from the choice between having terms of employment set by public law or having them set by private agreement. No incompatibility exists, therefore, between federal rules designed [*750] to restore the equality of bargaining power, and state or federal legislation that imposes minimal substantive requirements on contract terms negotiated between parties to labor agreements, at least so long as the purpose of [*755] the state legislation is not incompatible with these general goals of the NLRA.

Accordingly, it never has been argued successfully that minimal labor standards imposed by other federal laws were not to apply to unionized employers and employees. See, e. g., Barrentine v. Arkansas-Best Freight System, Inc., 450 U.S. 728, 737, 739 (1981). Cf. Alexander v. Gardner-Denver Co., 415 U.S. 36, 51 (1974). Nor has Congress ever seen fit to exclude unionized workers and employers from laws establishing federal minimal employment standards. We see no reason to believe that for this purpose Congress intended state minimum labor standards to be treated differently from minimum federal standards.

Minimum state labor standards affect union and nonunion employees equally, and neither encourage nor discourage the collective-bargaining processes that are the subject of the NLRA. Nor do they have any but the most indirect effect on the right of self-organization established in the Act. Unlike the NLRA, mandated-benefit laws are not laws designed to encourage or discourage employees in the promotion of their interests collectively; rather, they are in part "designed to give specific minimum protections to individual workers and to ensure that each employee covered by the Act would receive" the mandated health insurance coverage. Barrentine, 450 U.S., at 739 (emphasis in original). Nor do these laws even inadvertently affect these interests implicated in the NLRA. Rather, they are minimum standards "independent of the collective-bargaining process [that] devolve on [employees] as individual workers, not as members of a collective organization." Id., at 745.

It would further few of the purposes of the Act to allow unions and employers to bargain for terms of employment that state law forbids employers to establish unilaterally. "Such a rule of law would delegate to unions and unionized employers the power to exempt themselves from whatever state labor standards they disfavored." Allis-Chalmers [*756] Corp. v. Lueck, ante, at 212. It would turn the policy that animated the Wagner Act on its head to understand it to have penalized workers who have chosen to join a union by preventing them from benefiting from state labor regulations imposing minimal standards on nonunion employers.

D

Most significantly, there is no suggestion in the legislative history of the Act that Congress intended to disturb the myriad state laws then in existence that set minimum labor standards, but were unrelated in any way to the processes of bargaining or self-organization. To the contrary, we [*2398] believe that Congress developed the framework for self-organization [*751] and collective bargaining of the NLRA within the larger body of state law promoting public health and safety. The States traditionally have had great latitude under their police powers to legislate as "to the protection of the lives, limbs, health, comfort, and quiet of all persons." Slaughter-House Cases, 16 Wall. 36, 62 (1873), quoting Thorpe v. Rutland & Burlington R. Co., 27 Vt. 140, 149 (1855). "States possess broad authority under their police powers to regulate the employment relationship to protect workers within the State. Child labor laws, minimum and other wage laws, laws affecting occupational health and safety . . . are only a few examples." De Canas v. Bica, 424 U.S. 351, 356 (1976). State laws requiring that employers contribute to unemployment and workmen's compensation funds, laws prescribing mandatory state holidays, and those dictating payment to employees for time spent at the polls or on jury duty all have withstood scrutiny. See, e. g., Day-Brite Lighting, Inc. v. Missouri, 342 U.S. 421 (1952).

Federal labor law in this sense is interstitial, supplementing state law where compatible, and supplanting it only when it prevents the accomplishment of the purposes of the federal Act. Hines v. Davidowitz, 312 U.S. 52, 67, n. 20 (1941); Electrical Workers v. Wisconsin Employment Relations [*757] Bd., 315 U.S. 740, 749-751 (1942); Malone v. White Motor Corp., 435 U.S., at 504. Thus the Court has recognized that it "cannot declare pre-empted all local regulation that touches or concerns in any way the complex interrelationships between employees, employers, and unions; obviously, much of this is left to the States." Motor Coach Employees v. Lockridge, 403 U.S. 274, 289 (1971). When a state law establishes a minimal employment standard not inconsistent with the general legislative goals of the NLRA, it conflicts with none of the purposes of the Act. "A holding that the States were precluded from acting would remove the backdrop of state law that provided the basis of congressional action . . . and would thereby artificially create a no-law area." Taggart v. Weinacker's, Inc., 397 U.S. 223, 228 (1970) (concurring opinion) (emphasis in original).
Thus, in *Malone v. White Motor Corp.*, supra, the Court rejected a similar challenge to a pre-ERISA state pension Act which established minimum funding and vesting levels for employee pension plans. The Court found the law not pre-empted by the NLRA, in part for reasons relevant here:

"There is little doubt that under the federal statutes governing labor-management relations, an employer must bargain about wages, hours, and working conditions and that pension benefits are proper subjects of compulsory bargaining. But there is nothing in the NLRA . . . which expressly forecloses all state regulatory power with respect to those issues, such as pension plans, that may be the subject of collective bargaining." 435 U.S., at 504-505. n32

n32 The Court previously has addressed this same issue in the related context of the Railway Labor Act, 44 Stat. 577, as amended, 45 U. S. C. § 151 et seq.:

"The Railway Labor Act, like the National Labor Relations Act, does not undertake governmental regulation of wages, hours, or working conditions. Instead it seeks to provide a means by which agreement may be reached with respect to them. The national interest expressed by those Acts is not primarily in the working conditions as such. . . .

"State laws have long regulated a great variety of conditions in transportation and industry . . . . But it cannot be that the minimum requirements laid down by state authority are all set aside. We hold that the enactment by Congress of the Railway Labor Act was not a preemption of the field of regulating working conditions themselves and did not preclude the State . . . from making the order in question." *Terminal Railroad Assn. v. Railroad Trainmen*, 318 U.S. 1, 6-7 (1943) (footnote omitted).

[*758] [***752]

[***LEdHR1C] [1C] [***LEdHR2C] [2C] We hold that Massachusetts' mandated-benefit law is a "law which regulates insurance" and so is not pre-empted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA. We further hold that the mandated-benefit law as applied to a plan negotiated pursuant to a collective-bargaining agreement subject to the NLRA is not pre-empted by federal labor law.

The judgment of the Supreme Judicial Court of Massachusetts is therefore affirmed.

It is so ordered.

JUSTICE POWELL took no part in the decision of these cases.

REFERENCES: Return To Full Text Opinion Go To Oral Argument Transcript Go To Supreme Court Brief(s) Go To Supreme Court Brief(s)

16 Am Jur 2d, Constitutional Law 288-293; 43 Am Jur 2d, Insurance 26
29 USCS 151 et seq.; 29 USCS 1144
US L Ed Digest, Insurance 308; States, Territories, and Possessions 21, 22, 33
L Ed Index to Anns, Insurance; Labor and Employment; Pre-emption; States
ALR Quick Index, Health and Accident Insurance Policies and Provisions; Hospital Insurance; Insurance; Labor and Labor Unions; Pre-emption and Pre-emptive Rights
Federal Quick Index, Health and Accident Insurance; Insurance; Labor and Employment; Supremacy Clause

Annotation References:

Federal question jurisdiction in declaratory judgment suit challenging state statute or regulation on grounds of federal pre-emption. 69 ALR Fed 753.
LexisNexis(R) Headnotes

SYLLABUS:

The "pre-emption clause" (§ 514(a)) of the Employee Retirement Income Security Act of 1974 (ERISA) provides that ERISA supersedes all state laws insofar as they "relate to any employee benefit plan," but ERISA's "saving clause" (§ 514(b)(2)(A)) excepts from the pre-emption clause any state law that "regulates insurance." ERISA's "deemer clause" (§ 514(b)(2)(B)) provides that no employee benefit plan shall be deemed to be an insurance company for purposes of any state law "purporting to regulate insurance." On the basis of a work-related injury occurring in Mississippi in 1975, respondent began receiving permanent disability benefits.

LEXSEE 481 US 41

PILOT LIFE INSURANCE CO. v. DEDEAUX

No. 85-1043

SUPREME COURT OF THE UNITED STATES

481 U.S. 41; 107 S. Ct. 1549; 95 L. Ed. 2d 39; 1987 U.S. LEXIS 1512; 55 U.S.L.W. 4471; 8 Employee Benefits Cas. (BNA) 1409

January 21, 1987, Argued
April 6, 1987, Decided

PRIOR HISTORY:
CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT.

DISPOSITION:
770 F.2d 1311, reversed.

CASE SUMMARY:

PROCEDURAL POSTURE: The Court granted certiorari to review the holding of the United States Court of Appeals for the Fifth Circuit that respondent employee's state common law claims based on petitioner insurer's failure to pay disability insurance benefits were not pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1001 et seq.

OVERVIEW: Respondent employee was injured at work and sought permanent disability benefits under a policy purchased from petitioner insurance company. After termination of his benefits, respondent sued petitioner on various state law counts related to insurer good faith. The circuit court of appeals reversed the district court's holding that respondent's common law claims were preempted by ERISA. The Court granted certiorari and reversed. It held that respondent's common law causes of action were preempted because they did not fall under the exemption for law that "regulated insurance" for purposes of the exemption under its common sense meaning, and because it did not define the terms of the relationship between insurer and insured. The Court held further that the language, structure, and legislative history of ERISA required the conclusion that its civil enforcement provisions were meant to establish an exclusive remedy for violations related to employee benefit plans.

OUTCOME: The Court reversed. It held that respondent's common law causes of action were preempted because they did not fall under the statutory exemption for law which "regulates insurance" and because the language, structure, and legislative history of ERISA required the conclusion that its civil enforcement provisions were meant to establish an exclusive remedy for violations related to employee benefit plans.

LexisNexis(R) Headnotes

SYLLABUS:

The "pre-emption clause" (§ 514(a)) of the Employee Retirement Income Security Act of 1974 (ERISA) provides that ERISA supersedes all state laws insofar as they "relate to any employee benefit plan," but ERISA's "saving clause" (§ 514(b)(2)(A)) excepts from the pre-emption clause any state law that "regulates insurance." ERISA's "deemer clause" (§ 514(b)(2)(B)) provides that no employee benefit plan shall be deemed to be an insurance company for purposes of any state law "purporting to regulate insurance." On the basis of a work-related injury occurring in Mississippi in 1975, respondent began receiving permanent disability benefits.
under his employer's ERISA-regulated welfare benefit plan, under which claims were handled by petitioner, the employer's insurer. However, after two years petitioner terminated respondent's benefits, and during the following three years his benefits were reinstated and terminated by petitioner several times. Respondent ultimately instituted a diversity action against petitioner in Federal District Court, alleging tort and breach of contract claims under Mississippi common law for petitioner's failure to pay benefits under the insurance policy. The court granted summary judgment for petitioner, finding that respondent's common law claims were pre-empted by ERISA. The Court of Appeals reversed.

Held: ERISA pre-empts respondent's suit under state common law for alleged improper processing of his claim for benefits under the ERISA-regulated benefit plan. Pp. 44-57.

(a) The common law causes of action asserted in respondent's complaint, each based on alleged improper processing of a benefit claim under an employee benefit plan, "relate to" an employee benefit plan and therefore fall under ERISA's pre-emption clause. Cf. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739; Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-100. The pre-emption clause is not limited to state laws specifically designed to affect employee benefit plans. Pp. 47-48.

(b) Under the guidelines set forth in Metropolitan Life, respondent's causes of action under state decisional common law -- particularly the cause, presently asserted, based on the Mississippi law of bad faith -- do not fall under ERISA's saving clause, and thus are not excepted from pre-emption. A common-sense understanding of the language of the saving clause excepting from pre-emption a state law that "regulates insurance" does not support the argument that the Mississippi law of bad faith falls under the clause. To "regulate" insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Mississippi Supreme Court decisions establish that its law of bad faith applies to any breach of contract, not merely a breach of an insurance contract. Neither do the factors for interpreting the phrase "business of insurance" under the McCarran-Ferguson Act (which factors are appropriate for consideration here) support the assertion that the Mississippi law of bad faith "regulates insurance" for purposes of ERISA's saving clause. Pp. 48-51.

(c) Moreover, interpretation of the saving clause must be informed by the legislative intent concerning ERISA's civil enforcement provisions. The language and structure of those provisions support the conclusion that they were intended to provide exclusive remedies for ERISA-plan participants and beneficiaries asserting improper processing of benefit claims. ERISA's detailed provisions set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The conclusion that ERISA's civil enforcement provisions were intended to be exclusive is also confirmed by the legislative history of those provisions, particularly the history demonstrating that the pre-emptive force of ERISA's enforcement provisions was modeled after the powerful pre-emptive force of § 301 of the Labor Management Relations Act, 1947. Pp. 51-56.

COUNSEL:

John E. Nolan, Jr., argued the cause for petitioner. With him on the briefs were Paul J. Ondrasik, Jr., Antonia B. Ianniello, George F. Woodliff III, and David L. Bacon.

William C. Walker, Jr., argued the cause for respondent. With him on the brief was William L. Denton. *

* Erwin N. Griswold, Jack H. Blaine, Phillip E. Stano, and John P. Dineen filed a brief for the American Council of Life Insurance et al. as amici curiae urging reversal.

Solicitor General Fried, Deputy Solicitor General Kuhl, Christopher J. Wright, George R. Salem, and Allen H. Feldman filed a brief for the United States as amicus curiae.

JUDGES:

O'Connor, J., delivered the opinion for a unanimous Court.

OPINIONBY:

O'CONNOR

OPINION:

[*43] [***45] [**1550] JUSTICE O'CONNOR delivered the opinion of the Court.
[***LEdHR1A] [1A]This case presents the question whether the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U. S. C. § 1001 et seq., pre-empts state common law tort and contract actions asserting improper processing of a claim for benefits under an insured employee benefit plan.

[**1551] 1

In March 1975, in Gulfport, Mississippi, respondent Everate W. Dedeaux injured his back in an accident related to his employment for Entex, Inc. (Entex). Entex had at this time a long term disability employee benefit plan established by purchasing a group insurance policy from petitioner, Pilot Life Insurance Co. (Pilot Life). Entex collected and matched its employees' contributions to the plan and forwarded those funds to Pilot Life; the employer also provided forms to its employees for processing disability claims, and forwarded completed forms to Pilot Life. Pilot Life bore the responsibility of determining who would receive disability benefits. Although Dedeaux sought permanent disability benefits following the 1975 accident, Pilot Life terminated his benefits after two years. During the following three years Dedeaux's benefits were reinstated and terminated by Pilot Life several times.

In 1980, Dedeaux instituted a diversity action against Pilot Life in the United States District Court for the Southern District of Mississippi. Dedeaux's complaint contained three counts: "Tortious Breach of Contract"; "Breach of Fiduciary Duties"; and "Fraud in the Inducement." App. 18-23. Dedeaux sought "damages for failure to provide benefits under the insurance policy in a sum to be determined at the time of trial," "general damages for mental and emotional distress and other incidental damages in the sum of $250,000.00," and "punitive and exemplary damages in the sum of $500,000.00." Id., at 23-24. Dedeaux did not assert any of the several causes of action available to him under ERISA, see infra, at 53.

At the close of discovery, Pilot Life moved for summary judgment, arguing that ERISA pre-empted Dedeaux's common law claim for failure to pay benefits on the group insurance policy. The District Court granted Pilot Life summary judgment, finding all Dedeaux's claims pre-empted. App. to Pet. Cert. 16a.


II

In ERISA, Congress set out to "protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation [***46] for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." § 2, as set forth in 29 U. S. C. § 1001(b).

ERISA comprehensively regulates, among other things, employee welfare benefit plans that, "through the purchase of insurance or otherwise," provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. § 3(1), 29 U. S. C. § 1002(1).

Congress capped off the massive undertaking of ERISA with three provisions relating to the pre-emptive effect of the federal legislation:

"Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and [*45] subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .  " § 514(a), as set forth in 29 U. S. C. § 1144(a) (pre-emption clause).

"Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 514(b)(2)(A), as set forth in 29 U. S. C. § 1144(b)(2)(A) (saving clause).

[**1552] "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." § 514(b)(2)(B), 29 U. S. C. § 1144(b)(2)(B) (deemer clause).

To summarize the pure mechanics of the provisions quoted above: If a state law "relate[s] to . . . employee benefit plan[s]," it is pre-empted. § 514(a). The saving clause excepts from the pre-emption clause laws that "regulate[e] insurance." § 514(b)(2)(A). The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).

[***LEdHR2] [2] [***LEdHR3A] [3A]"The question whether a certain state action is pre-empted by federal law is one of congressional intent. ""The purpose of Congress is the ultimate touchstone."" *Allis-Chalmers

"The bill that became ERISA originally [*47] contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H. R. Conf. Rep. No. 93-1280, p. 383 (1974); S. Conf. Rep. No. 93-1090, p. 383 (1974)."

[***LEdHR3B] [3B]The House and Senate sponsors emphasized both the breadth and importance of the pre-emption provisions. Representative Dent described the "reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans" as ERISA's "crowning achievement." 120 Cong. Rec. 29197 (1974). Senator Williams said:

"It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to pre-empt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law." Id., at 29933.


In Metropolitan Life, this Court, noting that the pre-emption and saving clauses "perhaps are not a model of legislative drafting," 471 U.S., at 739, interpreted these clauses in relation to a Massachusetts statute that required minimum [*47] mental health care benefits to be provided Massachusetts residents covered by general health insurance policies. The appellants in Metropolitan Life argued that the state statute, as applied to insurance policies purchased by employee health care plans regulated by ERISA, was pre-empted.

The Court concluded, first, that the Massachusetts statute did "relate to . . . employee benefit plan[s]," thus placing the state statute within the broad sweep of the pre-emption clause, § 514(a). Metropolitan Life, supra, at 739. [**1553] However, the Court held that, because the state statute was one that "regulate[d] insurance," the saving clause prevented the state law from being pre-empted. In determining whether the Massachusetts statute regulated insurance, the Court was guided by case law interpreting the phrase "business of insurance" in the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U. S. C. § 1011 et seq.

Given the "statutory complexity" of ERISA's three pre-emption provisions, Metropolitan Life, supra, at 740, as well as the wide variety of state statutory and decisional law arguably affected by the federal pre-emption provisions, it is not surprising that we are again called on to interpret these provisions.

III

[*48] [1B] [***LEdHR4] [4] [***LEdHR5] [5] There is no dispute that the common law causes of action asserted in Dedeaux's complaint "relate to" an employee benefit plan [*48] and therefore fall under ERISA's express pre-emption clause, § 514(a). In both Metropolitan Life, supra, and Shaw v. Delta Air Lines, Inc., supra, at 96-100, we noted the expansive sweep of the pre-emption clause. In both cases "the phrase 'relate to' was given its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" Metropolitan Life, supra, at 739, quoting Shaw v. Delta Air Lines, supra, at 97. In particular we have emphasized that the pre-emption clause is not limited to "state laws specifically designed [*48] to affect employee benefit plans." Shaw v. Delta Air Lines, supra, at 98. The common law causes of action raised in Dedeaux's complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a).

[***LEdHR1C] [1C] Unless these common law causes of action fall under an exception to § 514(a), therefore, they are expressly pre-empted. Although Dedeaux's complaint pleaded several state common law causes of action, before this Court Dedeaux has described only one of the three counts -- called "tortious breach of contract" in the complaint, and "the Mississippi law of bad faith" in respondent's brief -- as protected from the pre-emptive effect of § 514(a). The Mississippi law of bad faith, Dedeaux argues, is a law "which regulates insurance," and thus is saved from pre-emption by § 514(b)(2)(A). n1

n1 Decisional law that "regulates insurance" may fall under the saving clause. The saving clause, § 514(b)(2)(A), covers "any law of any
State." For purposes of § 514, "the term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U. S. C. § § 1144(c)(1) and (2).

n2 The McCarran-Ferguson Act provides, in relevant part: "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." 15 U. S. C. § 1012(a).

[***LEdHR1E] [1E] In the present case, the considerations [***49] weighed in Metropolitan Life argue against the assertion that the Mississippi law of bad faith is a state law that "regulates insurance."

As early as 1915 the Mississippi Supreme Court had recognized that punitive damages were available in a contract case when "the act or omission constituting the breach of the contract amounts also to the commission of a tort." See Hood v. Moffett, 109 Miss. 757, 767, 69 So. 664, 666 (1915) (involving a physician's breach of a contract to attend to a woman at her approaching "accouchement"). In American Railway Express Co. v. Bailey, 142 Miss. 622, 631, 107 So. 761, 763 (1926), a case involving a failure of a finance company to deliver to the plaintiff the correct amount of money cabled to the plaintiff through the finance company's offices, the Mississippi Supreme Court explained that punitive damages could be available when the breach of contract was "attended by some intentional wrong, insult, abuse, or gross negligence, which amounts to an independent tort." In Standard Life Insurance Co. v. Veal, 354 So. 2d 239 (1977), the Mississippi Supreme Court, citing D. L. Fair Lumber Co. v. Weems, 196 Miss. 201, 16 So. 2d 770 (1944) (breach of contract was accompanied by "the breaking down and destruction of another's fence"), American Railway Express Co. v. Bailey, supra, and Hood v. Moffett, supra, upheld an award of punitive damages against a defendant insurance company for failure to pay on a credit life policy. Since Veal, the Mississippi Supreme Court has considered a large number of cases in which plaintiffs have sought punitive damages from insurance companies for failure to pay a claim under an insurance contract, and in a great many of these cases the court has used the identical formulation, first stated in Bailey, of what must "attend" the breach of contract in order for punitive [*50] damages to be recoverable. See, e.g., Employers Mutual Casualty Co. v. Tompkins, 490 So. 2d 897, 902 (1986); State Farm Fire & Casualty Co. v. Simpson, 477 So. 2d 242, 248 (1985); Consolidated American Life Ins. Co. v. Toche, 410 So. 2d 1303, 1304 (1982); Gulf Guaranty Life Ins. Co. v. Kelley, 389 So. 2d 920, 922 (1980); State Farm Mutual Automobile Ins. Co. v. Roberts, 379 So. 2d 321, 322 (1980); New Hampshire Ins. Co. v. Smith, 357 So. 2d 119, 121 (1978); Lincoln National Life Ins. Co. v. Crews, 341 So. 2d 1321, 1322 (1977). Recently the Mississippi Supreme Court stated that "we have come to term an insurance carrier which refuses to pay a claim when there is no reasonably arguable basis to deny it as acting in 'bad faith,' and a lawsuit based upon such an arbitrary refusal as a 'bad faith' cause of action." Blue Cross & Blue Shield of Mississippi, Inc. v. Campbell, 466 So. 2d 833, 842 (1984).

[***LEdHR1F] [1F] Certainly a common-sense understanding of the phrase "regulates insurance" does not support the argument that the Mississippi law of bad faith falls under the saving clause. A common-sense view of the word "regulates" would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi [*50] tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.

[***LEdHR1G] [1G] Neither do the McCarran-Ferguson Act factors support the assertion that the
Mississippi law of bad faith "regulates insurance." Unlike the mandated-benefits law at issue in Metropolitan Life, the Mississippi common law of bad faith does not effect a spreading of policyholder risk. The state common law of bad faith may be said to concern "the policy relationship between the insurer and the insured." The connection [*51] to the insurer-insured relationship [***1555] is attenuated at best, however. In contrast to the mandated-benefits law in Metropolitan Life, the common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, a breach of that contract may in certain circumstances allow the policyholder to obtain punitive damages. The state common law of bad faith is therefore no more "integral" to the insurer-insured relationship than any State's general contract law is integral to a contract made in that State. Finally, as we have just noted, Mississippi's law of bad faith, even if associated with the insurance industry, has developed from general principles of tort and contract law available in any Mississippi breach of contract case. Cf. Hart v. Orion Ins. Co., 453 F.2d 1358 (CA10 1971) (general state arbitration statutes do not regulate the business of insurance under the McCarran-Ferguson Act); Hamilton Life Ins. Co. v. Republic National Life Ins. Co., 408 F.2d 606 (CA2 1969) (same). Accordingly, the Mississippi common law of bad faith at most meets one of the three criteria used to identify the "business of insurance" under the McCarran-Ferguson Act, and used in Metropolitan Life to identify laws that "regulat[e] insurance" under the saving clause.

[***LedHR6] [6]In the present case, moreover, we are obliged in interpreting the saving clause to consider not only the factors by which we were guided in Metropolitan Life, but also the role of the saving clause in ERISA as a whole. On numerous occasions we have noted that "in expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." Kelly v. Robinson, 479 U.S. 36, 43 (1986), quoting Offshore Logistics, Inc. v. Tallentire, 477 U.S. 207, 221 (1986) (quoting Mastro Plastics Corp. v. NLRB, 350 U.S. 270, 285 (1956) (in turn quoting United States v. Heirs of Boisdore, 8 How. 113, 122 (1849))). Because in this case, [*52] the state cause of action seeks remedies for the improper processing of a claim for benefits under an ERISA-regulated plan, our understanding of the saving clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U. S. C. § 1132(a).
enforcement." Russell, supra, at 147, quoting Northwest Airlines, Inc. v. Transport Workers, 451 U.S. 77, 97 (1981). Our examination of these provisions made us "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA." Russell, supra, at 147.

n3 Section 502(a), as set forth in 29 U. S. C. § 1132(a), provides:

"A civil action may be brought --

"(1) by a participant or beneficiary --

"(A) for the relief provided for in subsection (c) of this section [concerning requests to the administrator for information], or

"(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

"(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [breach of fiduciary duty];

"(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

"(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title [information to be furnished to participants];

"(5) except as otherwise provided in subsection (b) of this subsection, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

"(6) by the Secretary to collect any civil penalty under subsection (i) of this section."

In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." Russell, supra, at 146 (emphasis in original).

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. [**1557] This conclusion is fully confirmed by the legislative history of the civil enforcement provision. The legislative history demonstrates that the pre-emptive force of § 502(a) was modeled after § 301 of the LMRA.

[*55] The Conference Report on ERISA describing the civil enforcement provisions of § 502(a) says:

"Under the conference agreement, civil actions may be brought by a participant or beneficiary to recover benefits due under the plan, to clarify rights to receive future benefits under the plan, and for relief from breach of fiduciary responsibility. . . . With respect to suits to enforce benefit rights under the plan or to recover benefits under the plan which do not involve application of the title I provisions, they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction. All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." H. R. Conf. Rep. No. 93-1280, p. 327 (1974) (emphasis added).

Congress was well aware that the powerful pre-emptive force of § 301 [***53] of the LMRA displaced all state actions for violation of contracts between an employer and a labor organization, even when the state action purported to authorize a remedy unavailable under the federal provision. Section 301 pre-empts any "state-law claim [whose resolution] is substantially dependent upon the analysis of the terms of an agreement made between the parties in a labor contract." Allis-Chalmers Corp. v. Lueck, 471 U.S., at 220. As we observed in Allis-Chalmers, the broad pre-emptive effect of § 301 was first analyzed in Teamsters v. Lucas Flour Co., 369 U.S. 95 (1962). In Lucas Flour the Court found that "the dimensions of § 301 require the conclusion that substantive principles of federal labor law must be
paramount in the area covered by the statute." *Id.* , at 103. "In enacting § 301 Congress intended doctrines of federal labor law uniformly to prevail over inconsistent local rules." *Id.* , at 104. Indeed, for purposes of determining federal jurisdiction, this Court has singled out § 301 of the LMRA as having "pre-emptive [*56] force . . . so powerful as to displace entirely any state cause of action 'for violation of contracts between an employer and a labor organization.' Any such suit is purely a creature of federal law . . . ." *Franchise Tax Board of Cal. v. Construction Laborers Vacation Trust for Southern Cal.*, 463 U.S. 1, 23 (1983), referring to *Avco Corp. v. Machinists*, 390 U.S. 557 (1968).

Congress' specific reference to § 301 of the LMRA to describe the civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a). See also H. R. Rep. No. 93-533, p. 12 (1973), reprinted in 2 Senate Committee on Labor and Public Welfare, Legislative History of ERISA, 94th Cong., 2d Sess., 2359 (Commit Print 1976) ("The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws"); 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams) (suits involving claims for benefits "will be regarded as arising under the laws of the United States, in similar fashion to those brought under section 301 of the Labor Management Relations Act"); *id.* , at 29942 (remarks of Sen. Javits) ("it is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans"). [**1558] The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop, indeed, the entire comparison of ERISA's § 502(a) to § 301 of the LMRA, would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws.

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S., at 746, this Court rejected an interpretation of the saving clause of ERISA's express pre-emption provisions, § 514(b)(2)(A), 29 U. S. C. § 1144(b)(2)(A), that saved [*54] from pre-emption [*57] "only state regulations unrelated to the substantive provisions of ERISA," finding that "nothing in the language, structure, or legislative history of the Act" supported this reading of the saving clause. *Metropolitan Life*, however, did not involve a state law that conflicted with a substantive provision of ERISA. Therefore the Court's general observation -- that state laws related to ERISA may also fall under the saving clause -- was not focused on any particular relationship or conflict between a substantive provision of ERISA and a state law. In particular, the Court had no occasion to consider in *Metropolitan Life* the question raised in the present case: whether Congress might clearly express, through the structure and legislative history of a particular substantive provision of ERISA, an intention that the federal remedy provided by that provision displace state causes of action. Our resolution of this different question does not conflict with the Court's earlier general observations in *Metropolitan Life*.

Therefore the Court's general observation -- that state laws related to ERISA may also fall under the saving clause -- was not focused on any particular relationship or conflict between a substantive provision of ERISA and a state law. In particular, the Court had no occasion to consider in *Metropolitan Life* the question raised in the present case: whether Congress might clearly express, through the structure and legislative history of a particular substantive provision of ERISA, an intention that the federal remedy provided by that provision displace state causes of action. Our resolution of this different question does not conflict with the Court's earlier general observations in *Metropolitan Life*.

n4 Because we conclude that Dedeaux's state common law claims fall under the ERISA pre-emption clause and are not rescued by the saving clause, we need not reach petitioner's argument that when an insurance company is engaged in the processing and review of claims for benefits under an employee benefit plan, it is acting in place of the plan's trustees and should be protected from direct state regulation by the deemer clause.

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**REFERENCES:**

Go to Supreme Court Briefs  
Go to Oral Argument Transcript

60 Am Jur 2d, Pensions and Retirement Funds 82; 72 Am Jur 2d, States, Territories, and Dependencies 18; 73 Am Jur 2d, Statutes 142-257; Am Jur 2d, New Topic Service, Pension Reform Act 7, 45


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Index to Annotations, Employee Retirement Income
Security Act; Pre-emption

Annotation References:

Pre-emption of state fair employment laws under
provisions of 514 of Employee Retirement Income

Forfeiture of pension plan benefits as affected by
Employee Retirement Income Security Act (29 USCS
LEXSEE 498 US 52

FMC CORPORATION, PETITIONER v. CYNTHIA ANN HOLLIDAY

No. 89-1048

SUPREME COURT OF THE UNITED STATES


October 2, 1990, Argued
November 27, 1990, Decided

PRIOR HISTORY:
CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT.

DISPOSITION: 885 F. 2d 79, vacated and remanded.

CASE SUMMARY:

OVERVIEW: Petitioner employer provided an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA) for employees and their dependents. Respondent, dependent child of employee, was injured in an automobile accident. Respondent's father brought a negligence action, and petitioner attempted to seek reimbursement for the amounts it paid for respondent's medical expenses. The court vacated and remanded the court of appeals' decision, and held that ERISA preempted the application of Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa. Cons. Stat. § 1720, to petitioner employer's welfare benefit plan for employees. The court held that ERISA's "deemer clause" was not directed solely at laws governing the business of insurance; it was directed at any law of any state that regulates insurance, while the saving clause protected state insurance regulation of insurance contracts purchased by employee benefit plans. A "deemer clause" that exempted employee benefit plans from only those state regulations would encroach upon ERISA's provisions and undermine Congress's desire to avoid endless litigation over the validity of a state action.


LexisNexis(R) Headnotes

SYLLABUS: After petitioner FMC Corporation's self-funded health care plan (Plan) paid a portion of respondent's medical expenses resulting from an automobile accident, FMC informed respondent that it would seek reimbursement under the Plan's subrogation provision from any recovery she realized in her Pennsylvania negligence action against the driver of the vehicle in which she was injured. Respondent obtained a declaratory judgment in Federal District Court that § 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law -- which precludes reimbursement from a claimant's tort recovery for benefit payments by a
program, group contract, or other arrangement -- prohibits FMC's exercise of subrogation rights. The Court of Appeals affirmed, holding that the Employee Retirement Income Security Act of 1974 (ERISA), which applies to employee welfare benefit plans such as FMC's, does not pre-empt § 1720.

Held: ERISA pre-empts the application of § 1720 to FMC's Plan. Pp. 56-65.

(a) ERISA's pre-emption clause broadly establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" a covered employee benefit plan. Although the statute's saving clause returns to the States the power to enforce those state laws that "regulate insurance," the deemer clause provides that a covered plan shall not be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance" for purposes of state laws "purporting to regulate" insurance companies or insurance contracts. Pp. 56-58.

(b) Section 1720 "relate[s] to" an employee benefit plan within the meaning of ERISA's pre-emption provision, since it has both a "connection with" and a "reference to" such a plan. See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97, 77 L. Ed. 2d 490, 103 S. Ct. 2890. Moreover, although there is no dispute that § 1720 "regulates insurance," ERISA's deemer clause demonstrates Congress' clear intent to exclude from the reach of the saving clause self-funded ERISA plans by relieving them from state laws "purporting to regulate insurance." Thus, such plans are exempt from state regulation insofar as it "relates to" them. State laws directed toward such plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such laws. On the other hand, plans that are insured are subject to indirect state insurance regulation insofar as state laws "purporting to regulate insurance" apply to the plans' insurers and the insurers' insurance contracts. This reading of the deemer clause is consistent with Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 735, n.14, 747, 85 L. Ed. 2d 728, 105 S. Ct. 2380, and is respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation, see Jones v. Rath Packing Co., 430 U.S. 519, 525, 51 L. Ed. 2d 604, 97 S. Ct. 1305, including regulation of the "business of insurance," see Metropolitan Life Ins. Co. v. Massachusetts, supra, at 742-744. Narrower readings of the deemer clause -- which would interpret the clause to except from the saving clause only state insurance regulations that are pretexts for impinging on core ERISA concerns or to preclude States from deeming plans to be insurers only for purposes of state laws that apply to insurance as a business, such as laws relating to licensing and capitalization requirements -- are unsupported by ERISA's language and would be fraught with administrative difficulties, necessitating definition of core ERISA concerns and of what constitutes business activity, and thereby undermining Congress' expressed desire to avoid endless litigation over the validity of state action and requiring plans to expend funds in such litigation. Pp. 58-65.

COUNSEL: H. Woodruff Turner argued the cause for petitioner. With him on the briefs was Charles Kelly.

Deputy Solicitor General Shapiro argued the cause for the United States as amicus curiae urging reversal. With him on the brief were Solicitor General Starr, Christopher J. Wright, Allen H. Feldman, Steven J. Mandel, and Mark S. Flynn.

Charles Rothfeld argued the cause for respondent. On the brief were Thomas G. Johnson and David A. Cicola. *

Briefs of amici curiae urging reversal were filed for the Central States, Southeast and Southwest Area Health and Welfare Fund by Anita M. D'Arcy, James L. Coglan, and William J. Nellis; for the Chamber of Commerce of the United States of America by Harry A. Rissetto, E. Carl Uehlein, Jr., and Stephen A. Bokat; for the National Coordinating Committee for Multiemployer Plans by Gerald M. Feder, David R. Levin, and Diana L. S. Peters; for the Teamsters Health and Welfare Fund of Philadelphia & Vicinity et al. by James D. Crawford, James J. Leyden, Henry M. Wick, Jr., and Jack G. Mancuso; and for Travelers Insurance Co. by A. Raymond Randolph, M. Duncan Grant, and Waltraut S. Addy.

Briefs of amici curiae urging affirmance were filed for the American Chiropractic Association by George P. McAndrews and Robert C. Ryan; for the American Optometric Association by Ellis Lyons, Bennett Boskey, and Edward A. Groobert; for the National Conference of State Legislatures et al. by Benna Ruth Solomon and Charles Rothfeld; and for the Pennsylvania Trial Lawyers Association by John Patrick Lydon.

Briefs of amici curiae were filed for the American Podiatric Medical Association by
JUSTICE O'CONNOR delivered the opinion of the Court.

n1 Section 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law is entitled "subrogation" and provides:

"In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits)."

n2 Section 1719, entitled "coordination of benefits," reads:

"(a) General rule. -- Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in section 1711 (relating to required benefits), 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

"(b) Definition. -- As used in this section the term 'program, group contract or other arrangement' includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa. C. S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations)."

Petitioner, FMC Corporation (FMC), operates the FMC Salaried Health Care Plan (Plan), an employee welfare benefit plan within the meaning of ERISA, § 3(1), 29 U. S. C. § 1002(1), that provides health benefits to FMC employees and their dependents. The Plan is self-funded; it does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants. Among its provisions is a subrogation clause under which a Plan member agrees to reimburse the Plan for benefits paid if the member recovers on a claim in a liability action against a third party.

Respondent, Cynthia Ann Holliday, is the daughter of FMC employee and Plan member Gerald Holliday. In 1987, she was seriously injured in an automobile accident. The Plan paid a portion of her medical expenses. Gerald Holliday brought a negligence action on behalf of his daughter in Pennsylvania state court against the driver of the automobile in which she was injured. The parties settled the claim. While the action was pending, FMC notified the Hollidays that it would seek reimbursement for the amounts it had paid for respondent's medical expenses. The Hollidays replied that they would not reimburse the Plan, asserting that § 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa. Cons. Stat. § 1720 (1987), precludes subrogation by FMC. Section 1720 states that in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . payable under section 1719."

n1 Section 1719 refers to benefit payments by "any program, group contract or other arrangement." n2
from enforcing its contractual subrogation provision. According to the court, ERISA pre-empts § 1720 if ERISA's "deemer clause," § 514(b)(2)(B), 29 U. S. C. § 1144(b)(2)(B), exempts the Plan from state subrogation laws. The Court of Appeals, citing Northern Group Services, Inc. v. Auto Owners Ins. Co., 833 F.2d 85, 91-94 (CA6 1987), cert. denied, 486 U.S. 1017, 100 L. Ed. 2d 216, 108 S. Ct. 1754 (1988), determined that "the deemer clause [was] meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." 885 F.2d at 86. Pointing out that the parties had not suggested that the Pennsylvania antisubrogation law addressed "a core type of ERISA matter which Congress sought to protect by the pre-emption provision," id., at 90, the court concluded that the Pennsylvania law is not pre-empted. The Third Circuit's conflicting decisions with decisions of other Courts of Appeals that have construed ERISA's deemer clause to protect self-funded plans from all state insurance regulation. See, e.g., Baxter v. Lynn, 886 F.2d 182, 186 (CA8 1989); Reilly v. Blue Cross and Blue Shield United of Wisconsin, [*407] 846 F.2d 416, 425-426 (CA7), cert. denied, 488 U.S. 856, 102 L. Ed. 2d 117, 109 S. Ct. 145 (1988). We granted certiorari to resolve this conflict, 493 U.S. 1068 (1990), and now vacate and remand.

II

[***LEdHR1B] [1B] [***LEdHR2] [2] [***LEdHR3] [3] In determining whether federal law pre-empts a state statute, we look to congressional intent. " Pre-emption may be either express or implied, and "is compelled whether Congress" [*57] command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 95, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983) (quoting Fidelity Federal Savings & Loan Assn. v. De la Cuesta, 458 U.S. 141, 152-153, 73 L. Ed. 2d 664, 102 S. Ct. 3014 (1982), in turn quoting Jones v. Rath Packing Co., 430 U.S. 519, 525, 51 L. Ed. 2d 604, 97 S. Ct. 1305 (1977)); see also Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-843, 81 L. Ed. 2d 694, 104 S. Ct. 2778 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court . . . must give effect to the unambiguously expressed intent of Congress" (footnote omitted)). We "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." Park 'N Fly, Inc. v. Dollar Park and Fly, Inc., 469 U.S. 189, 194, 83 L. Ed. 2d 582, 105 S. Ct. 658 (1985). Three provisions of ERISA speak expressly to the question of pre-emption:

" [*364] Except as provided in subsection (b) of this section [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 relate to any employee benefit plan." § 514(a), as set forth in 29 U. S. C. § 1144 (a) (pre-emption clause).

"Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 514(b)(2)(A), as set forth in 29 U. S. C. § 1144(b)(2)(A) (saving clause).

"Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or [*58] investment companies." § 514(b)(2)(B), 29 U. S. C. § 1144(b)(2)(B) (deemer clause).

[***LEdHR1C] [1C] We indicated in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985), that these provisions "are not a model of legislative drafting." Id., at 739. Their operation is nevertheless discernible. The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that "regulate insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "pursuing to regulate" insurance companies or insurance contracts.

III

[***LEdHR1D] [1D] [***LEdHR4] [4] Pennsylvania's antisubrogation law "relate[s] to" an employee benefit plan. We made clear in Shaw v. Delta Air Lines, supra, that a law relates to an employee welfare plan if it has "a connection with or reference to such a plan." 463 U.S. 85, 96-97, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (footnote omitted). [*408] We based our reading in part on the
plain language of the statute. Congress used the words "relate to in § 514(a) [the pre-emption clause] in their broad sense." *Id.*, at 98. It did not mean to pre-empt only state laws specifically designed to affect employee benefit plans. That interpretation would have made it unnecessary for Congress to enact ERISA § 514(b)(4), 29 U. S. C. § 1144(b)(4), which exempts from pre-emption "generally applicable criminal laws of a State."

We also emphasized that to interpret the pre-emption clause to apply only to state laws dealing with the subject matters covered by ERISA, such as reporting, disclosure, and fiduciary duties, would be incompatible with the provision's legislative history because the House and Senate versions of the bill that became ERISA contained limited pre-emption clauses, applicable only to state laws relating to specific subjects covered by ERISA. n3 These were rejected in favor of the present language in the Act, "indicating that the section's pre-emptive scope was as broad as its language." *Shaw v. Delta Air Lines*, 463 U. S. at 98.

n3 The bill introduced in the Senate and reported out of the Committee on Labor and Public Welfare would have pre-empted "any and all laws of the States and of political subdivisions thereof as insofar as they may now or hereafter relate to the subject matters regulated by this Act." S. 4, 93d Cong., 1st Sess., § 609(a) (1973). As introduced in the House, the bill that became ERISA would have superseded "any and all laws of the States and of the political subdivisions thereof as insofar as they may now or hereafter relate to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." H. R. 2, 93d Cong., 1st Sess., § 114 (1973). The bill was approved by the Committee on Education and Labor in a slightly modified form. See H. R. 2, 93d Cong., 1st Sess., § 514(a) (1973).

Pennsylvania's antisubrogation law prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation. Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide. Accord, *Alessi v. Raybestos-Manhattan, Inc.*, supra (state law prohibiting offsetting worker compensation payments against pension benefits pre-empted since statute would force employer either to structure all benefit payments in accordance with state statute or adopt different payment formulae for employers inside and outside State). As we stated in *Fort Halifax Packing Co. v. Coyne*, 482 U. S. 1, 10, 96 L. Ed. 2d 1, 107 S. Ct. 2211 (1987), "the most efficient way to meet these [administrative] responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits."

There is no dispute that the Pennsylvania law falls within ERISA's insurance saving clause, which provides, "except as provided in [the deemer clause], nothing in this subchapter [§61] shall be construed to exempt or relieve any person from any law of any State which regulates insurance," § 514(b)(2)(A), 29 U. S. C. § 1144(b)(2)(A) (emphasis added). Section 1720 directly controls the terms of insurance contracts by invalidating
any subrogation provisions that they contain. See Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. at 740-741. It does not merely have an impact on the insurance industry; it is aimed at it. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987). This returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the saving clause by virtue of the deemer clause, therefore, it is not pre-empted.

We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulate insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan’s insurer.

[*62] Our reading of the deemer clause is consistent with Metropolitan Life Ins. Co. v. Massachusetts, supra. That case involved a Massachusetts [***367] statute requiring certain self-funded benefit plans and insurers issuing group health policies to plans to provide minimum mental health benefits. 471 U.S. 724, 734, 105 S. Ct. 2380, 85 L. Ed. 2d 728. In pointing out that Massachusetts had never tried to enforce the portion of the statute pertaining directly to benefit plans, we stated, "in light of ERISA's 'deemer clause,' which states that a benefit plan shall not 'be deemed an insurance company' for purposes of the insurance saving clause, Massachusetts has never tried to enforce [the statute] as applied to benefit plans directly, effectively conceding that such an application of [the statute] would be pre-empted by ERISA's pre-emption clause." Id., at 735, n.14 (citations omitted). We concluded that the statute, as applied to insurers of [**410] plans, was not pre-empted because it regulated insurance and was therefore saved. Our decision, we acknowledged, "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." Id., at 747. "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." Ibid. (footnote omitted).

Our construction of the deemer clause is also respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation. See Jones v. Rath Packing Co., 430 U.S. at 525. In the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U. S. C. § 1011 et seq., Congress provided that 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." 15 U. S. C. § 1012(a). We have identified laws governing the "business of insurance" in the Act to include not only direct regulation of the insurer but also regulation of the substantive terms of [***411] insurance contracts. Metropolitan Life Ins. Co. v. Massachusetts, supra, at 742-744. [*63] By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the "business of insurance."

Respondent resists our reading of the deemer clause and would attach to it narrower significance. According to the deemer clause, "neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." § 514(b)(2)(B), 29 U. S. C. § 1144(b)(2)(B) (emphasis added). Like the Court of Appeals, respondent would interpret the deemer clause to except from the saving clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns. The National Conference of State Legislatures et al. as amici curiae in support of respondent offer an alternative interpretation of the deemer [***368] clause. In their view, the deemer clause precludes States from deeming plans to be insurers only for purposes of state laws that apply to insurance as a business, such as laws relating to licensing and capitalization requirements.

These views are unsupported by ERISA’s language. Laws that purportedly regulate insurance companies or insurance contracts are laws having the "appearance of" regulating or "intending" to regulate insurance
companies or contracts. Black's Law Dictionary 1236 (6th ed. 1990). Congress' use of the word does not indicate that it directed the deemer clause solely at deceit that it feared state legislatures would practice. Indeed, the Conference Report, in describing the deemer clause, omits the word "purporting," stating, "an employee benefit plan is not to be considered as an insurance company, bank, trust company, or investment company (and is not to be considered as engaged in the business of insurance or banking) for purposes of any State law that regulates insurance companies, insurance contracts, banks, trust companies, or investment companies." H. R. Conf. Rep. No. 93-1280, p. 383 (1974).

Nor, in our view, is the deemer clause directed solely at laws governing the business of insurance. It is plainly directed at "any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." § 514(b)(2)(B), 29 U. S. C. § 1144(b)(2)(B). Moreover, it is difficult to understand why Congress would have included insurance contracts in the pre-emption clause if it meant only to pre-empt state laws relating to the operation of insurance as a business. To be sure, the saving and deemer clauses employ differing language to achieve their ends -- the former saving, except as provided in the deemer clause, "any law of any State which regulates insurance" and the latter referring to "any law of any State purporting to regulate insurance companies [or] insurance contracts." We view the language of the deemer clause, however, to be either coextensive with or broader, not narrower, than that of the saving clause. Our rejection of a restricted reading of the deemer clause does not lead to the deemer clause's engulfing the saving clause. As we have pointed out, supra, at 62-63, the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans.

[Congress intended by ERISA to "establish pension plan regulation as exclusively a federal concern." Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 at 523, 68 L. Ed. 2d 402, 101 S. Ct. 1895 (footnote omitted). Our 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. As a result, employers will not face "conflicting or inconsistent State law that are insured by regulated insurance companies (insured plans). Had Congress intended this result, it could have stated simply that "all State laws are pre-empted insofar as they relate to any self-insured employee plan." There would then have been no need for the "saving clause" to exempt state insurance laws from the pre-emption clause, or the "deemer clause," which the Court today reads as merely reinjecting into the scope of ERISA's pre-emption clause those same exempted state laws insofar as they relate to self-insured plans.

From the standpoint of the beneficiaries of ERISA plans -- who after all are the primary beneficiaries of the entire statutory program -- there is no apparent reason for treating self-insured plans differently from insured plans. Why should a self-insured plan have a right to enforce a subrogation clause against an injured employee while an insured plan may not? The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. If Congress had intended such an irrational result, surely it would have expressed it in straightforward English. At least one would expect that
the reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation.

The Court's anomalous result would be avoided by a correct and narrower reading of either the basic pre-emption clause or the deemer clause.

I

The Court has endorsed an unnecessarily broad reading of the words "relate to any employee benefit plan" as they are used in the basic pre-emption clause of § 514(a). I acknowledge that this reading is supported by language in some of our prior opinions. It is not, however, dictated by any prior holding, and I am persuaded that Congress did not intend this clause to cut nearly so broad a swath in the field of state laws as the Court's expansive construction will create.

The clause surely does not pre-empt a host of general rules of tort, contract, and procedural law that relate to benefit plans as well as to other persons and entities. It does not, for example, pre-empt general state garnishment rules insofar as they relate to ERISA plans. Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988). Moreover, the legislative history of the provision indicates that throughout most of its consideration of pre-emption, Congress was primarily concerned about areas of possible overlap between federal and state requirements. Thus, the bill that was introduced in the Senate would have pre-empted state laws insofar as they "relate to the subject matters regulated by this Act," n1 and the House bill more specifically identified state laws relating "to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." n2 Although the compromise that produced the statutory language "relate to any employee benefit plan" is not discussed in the legislative history, the final version is perhaps best explained as an editorial amalgam of the two bills rather than as a major expansion of the section's coverage.

When there is ambiguity in a statutory provision preempting state law, we should apply a strong presumption against the invalidation of well-settled, generally applicable state rules. In my opinion this presumption played an important role in our decisions in Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 96 L. Ed. 2d 1, 107 S. Ct. 2211 (1987), and Mackey v. Lanier Collection Agency & Service, Inc., supra. Application of that presumption leads me to the conclusion that the pre-emption clause should apply only to those state laws that purport to regulate subjects regulated by ERISA or that are inconsistent with ERISA's central purposes. I do not think Congress intended to foreclose Pennsylvania from enforcing the antisubrogation provisions of its state Motor Vehicle Financial Responsibility Law against ERISA plans -- most certainly, it did not intend to pre-empt enforcement of that statute against self-insured plans while preserving enforcement against insured plans.

[*68] II

Even if the "relate to" language in the basic pre-emption clause is read broadly, a proper interpretation of the carefully drafted text of the deemer clause would caution against finding pre-emption in this case. Before identifying the key words in that text, it is useful to comment on the history surrounding enactment of the deemer clause.

The number of self-insured employee benefit plans grew dramatically in the 1960's and early 1970's. n3 The question whether such plans were, or should be, subject to state regulation remained unresolved when ERISA was enacted. It was, however, well recognized as early as 1967 that requiring self-insured plans to comply with the regulatory requirements in state insurance codes would stifle their growth:

"Application of state insurance laws to uninsured plans would make direct payment of benefits pointless and in most cases not feasible. This is because a welfare plan would have to be operated as an insurance company in order to comply with the detailed regulatory requirements of state insurance codes designed with the typical operations of insurance companies in mind. It presumably would be necessary to form a captive insurance company with prescribed capital and surplus, capable of obtaining a certificate of authority from the insurance department of all states in which the plan was 'doing business,' establish premium

n1 S. 4, 93d Cong., 1st Sess., § 609(a) (1973), reprinted at 1 Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print compiled by the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare) 93, 186 (1976) (Leg. Hist.).

n2 H. R. 2, 93d Cong., 1st Sess., § 114 (1973); 1 Leg. Hist. 51.
rates subject to approval by the insurance department, issue policies in the form approved by the insurance department, pay commissions and premium taxes required by the insurance law, hold and deposit reserves established by the insurance department, make investments permitted under the law, and comply with all filing and examination requirements of the insurance department. The result would be to reintroduce [*69] an insurance company, which the direct payment plan was designed to dispense with. Thus it can be seen that the real issue is not whether uninsured plans are to be regulated under state insurance laws, but whether they are to be permitted."


In 1974 while ERISA was being considered in Congress, the first state court to consider the applicability of state insurance laws to self-insured plans held that a self-insured plan could not pay out benefits until it had satisfied the licensing requirements governing insurance companies in Missouri and thereby had subjected itself to the regulations contained in the Missouri insurance code. Missouri v. Monsanto Co., Cause No. 259774 (St. Louis Cty. Cir. Ct., Jan. 4, 1973), rev'd, 517 S.W.2d 129 (Mo. 1974). Although it is true that the legislative history of ERISA or the deemer clause makes no reference to the Missouri case, or to this problem -- indeed, it contains no explanation whatsoever of the reason for enacting the deemer clause -- the text of the clause itself plainly reveals that it was designed to protect pension plans from being subjected to the detailed regulatory provisions that typically apply to all state-regulated insurance companies -- laws that purport to regulate insurance companies and insurance contracts.

The key words in the text of the deemer clause are "deemed," "insurance *[***372] company," and "purporting." n4 It provides [*70] that an employee welfare plan shall not be deemed to be an insurance company or to be engaged in the business of insurance for the purpose of determining whether it is an entity that is regulated by any state law purporting to regulate insurance companies and insurance contracts.

n4 Section 514(b)(2)(B), as set forth in 29 U. S. C. § 1144(b)(2)(B), provides:

"Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." (Emphasis added.)

[**414] Pennsylvania's insurance code purports, in so many words, to regulate insurance companies and insurance contracts. It governs the certification of insurance companies, Pa. Stat. Ann., Tit. 40, § 400 (Purdon 1971), their minimum capital stock and financial requirements to do business, § 386 (Purdon 1971 and Supp. 1990-1991), their rates, e.g., § 532.9 (Purdon 1971) (authorizing Insurance Commissioner to regulate minimum premiums charged by life insurance companies), and the terms that insurance policies must, or may, include, e. g., § 510 (Purdon 1971 and Supp. 1990-1991) (life insurance policies), § 753 (Purdon 1971) (health and accident insurance policies). The deemer clause prevents a State from enforcing such laws purporting to regulate insurance companies and insurance contracts against ERISA plans merely by deeming ERISA plans to be insurance companies. But the fact that an ERISA plan is not deemed to be an insurance company for the purpose of deciding whether it must comply with a statute that purports to regulate "insurance contracts" or entities that are defined as "insurance companies" simply does not speak to the question whether it must nevertheless comply with a statute that expressly regulates subject matters other than insurance.

There are many state laws that apply to insurance companies as well as to other entities. Such laws may regulate some aspects of the insurance business, but do not require one to be an insurance company in order to be subject to their terms. Pennsylvania's Motor Vehicle Financial Responsibility Law is such a law. The fact that petitioner's plan is not deemed to be an insurance company or an insurance contract does not have any bearing on the question whether petitioner, [*71] like all other persons, must nevertheless comply with the Motor Vehicle Financial Responsibility Law.

If one accepts the Court's broad reading of the "relate to" language in the basic pre-emption clause, the answer to the question whether petitioner must comply
with state laws regulating entities including, but not limited to, insurance companies depends on the scope of the saving clause. n5 In this case, I am prepared to accept the Court's broad reading of that clause, but it is of critical importance to me that the category of state laws described in the saving clause is broader than the category described in the deemer clause. A state law "which regulates insurance," and is therefore exempted from ERISA's pre-emption provision by operation of the saving clause, does not necessarily have as its purported subject of regulation an "insurance company" or an activity that is engaged in by persons who are insurance companies. Rather, such a law may aim to regulate another matter altogether, but also have the effect of regulating insurance. The deemer clause, by contrast, reinserts into the scope of ERISA pre-emption only those state laws that "purport to" regulate insurance companies or contracts -- laws such as those which set forth the licensing and capitalization requirements for insurance companies or the minimum required provisions in insurance contracts. While the saving clause thus exempts from the pre-emption clause all state laws that have the broad effect of regulating insurance, the deemer clause simply allows pre-emption of those state laws that expressly regulate insurance and that would therefore be applicable to ERISA plans only if States were allowed to deem such plans to be insurance companies.

n5 Section 514(b)(2)(A), as set forth in 29 U. S. C. § 1144(b)(2)(A), provides:

"Except as provided in subparagraph (B) nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

[*72] Pennsylvania's Motor Vehicle Financial Responsibility Law fits into the broader category of state laws that fall within the saving clause only. The Act regulates persons in addition to insurance companies and affects subrogation and indemnity agreements that are not necessarily insurance contracts. Yet [**415] because it most assuredly is not a law "purporting" to regulate any of the entities described in the deemer clause -- "insurance companies, insurance contracts, banks, trust companies, or investment companies," the deemer clause does not by its plain language apply to this state law. Thus, although the Pennsylvania law is exempted from ERISA's pre-emption provision by the broad saving clause because it "regulates insurance," it is not brought back within the scope of ERISA pre-emption by operation of the narrower deemer clause. I therefore would conclude that petitioner is subject to Pennsylvania's Motor Vehicle Financial Responsibility Law.

I respectfully dissent.

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Index to Annotations, Employee Retirement Income Security Act; Insurance and Insurance Companies; Pre-emption; States

Construction and application of pre-emption exemption, under Employee Retirement Income Security Act (29 USCS 1001 et seq.), for state laws regulating insurance, banking, or securities (29 USCS 1144(b)(2)). 87 ALR Fed 797.


Federal question jurisdiction in declaratory judgment suit challenging state statute or regulation on grounds of federal pre-emption. 69 ALR Fed 753.
NATIONWIDE MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS v. ROBERT T. DARDEN

No. 90-1802

SUPREME COURT OF THE UNITED STATES


January 21, 1992, Argued
March 24, 1992, Decided

PRIOR HISTORY: ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT.

DISPOSITION: 922 F.2d 203, reversed and remanded.

CASE SUMMARY:

PROCEDURAL POSTURE: By writ of certiorari, petitioner insurance companies sought review of a decision from the United States Court of Appeals for the Fourth Circuit that vacated the district court's grant of summary judgment to petitioners on respondent agent's claim for benefits under the Employee Retirement Income Security Act of 1974 (ERISA) brought pursuant to 29 U.S.C.S. § 1132(a).

OVERVIEW: A decision that vacated a grant of summary judgment to an insurance company in its agent's ERISA action was reversed because the appellate court failed to apply the common-law definition of an employee. Respondent's contract provided that he would be entitled to receive retirement benefits if he refrained from selling insurance for competing companies after termination. When respondent became an independent insurance agent, he brought suit under the Employee Retirement Income Security Act of 1974 (ERISA) brought pursuant to 29 U.S.C.S. § 1132(a), claiming that the benefits were vested. The district court granted summary judgment to petitioners. The appellate court vacated because respondent had a reasonable expectation of receiving retirement benefits. On appeal, the Court reversed because the proper test of employee status under 29 U.S.C.S. § 1002(6) was the master-servant relationship as defined by common-law agency doctrine. Because Congress had not specified any other test, it should have been presumed that the traditional definition was intended. The Court remanded for a determination of whether respondent could be considered an employee under agency law.

OUTCOME: The Court reversed because the traditional master-servant relationship as understood by common-law agency doctrine was the test that should have been applied. The Court remanded for a determination of whether respondent qualified as an employee under the common law definition.

LexisNexis(R) Headnotes

SYLLABUS: Contracts between petitioners Nationwide Mutual Insurance Co. et al. and respondent Darden provided, among other things, that Darden would sell only Nationwide policies, that Nationwide would enroll him in a company retirement plan for agents, and that he would forfeit his entitlement to plan benefits if, within a year of his termination and 25 miles of his prior business location, he sold insurance for Nationwide's competitors. After his termination, Darden began selling insurance for those competitors. Nationwide charged that Darden's new business activities disqualified him from receiving his retirement plan benefits, for which he then sued under the Employee Retirement Income Security Act of 1974 (ERISA). The District Court granted summary
justice to Nationwide on the ground that Darden was not a proper ERISA plaintiff because, under common-law agency principles, he was an independent contractor rather than, as ERISA requires, an "employee," a term the Act defines as "any individual employed by an employer." Although agreeing that he "most probably would not qualify as an employee" under traditional agency law principles, the Court of Appeals reversed, finding the traditional definition inconsistent with ERISA's policy and purposes, and holding that an ERISA plaintiff can qualify as an "employee" simply by showing (1) that he had a reasonable expectation that he would receive benefits, (2) that he relied on this expectation, and (3) that he lacked the economic bargaining power to contract out of benefit plan forfeiture provisions. Applying this standard, the District Court found on remand that Darden had been Nationwide's "employee," and the Court of Appeals affirmed.

Held:

1. The term "employee" as used in ERISA incorporates traditional agency law criteria for identifying master-servant relationships. Where a statute containing that term does not helpfully define it, this Court presumes that Congress means an agency law definition unless it clearly indicates otherwise. See, e. g., Community for Creative Non-Violence v. Reid, 490 U.S. 730, 739-740, 104 L. Ed. 2d 811, 109 S. Ct. 2166. ERISA's nominal definition of "employee" is completely circular and explains nothing, and the Act contains no other provision that either gives specific guidance on the term's meaning or suggests that construing it to incorporate traditional agency law principles would thwart the congressional design or lead to absurd results. Since the multifactor common-law test here adopted, see, e. g., id., at 751-752, contains no shorthand formula for determining who is an "employee," all of the incidents of the employment relationship must be assessed and weighed with no one factor being decisive. NLRB v. Hearst Publications, Inc., 322 U.S. 111, 88 L. Ed. 1170, 64 S. Ct. 851; United States v. Silk, 331 U.S. 704, 91 L. Ed. 1757, 67 S. Ct. 1463; Rutherford Food Corp. v. McComb, 331 U.S. 722, 71 L. Ed. 1772, 67 S. Ct. 1473, distinguished. Pp. 322-327.

2. The case is remanded for a determination whether Darden qualifies as an "employee" under traditional agency law principles. P. 328.

COUNSEL: George Robinson Ragsdale argued the cause for petitioners. With him on the briefs were Gordon E. McCutchan, Robert M. Parsons, Craig G. Dalton, Jr., Francis M. Gregory, Jr., and Margaret M. Richardson.

Christopher J. Wright argued the cause for the United States as amicus curiae urging reversal. With him on the brief were Solicitor General Starr, Deputy Solicitor General Mahoney, Allen H. Feldman, and Elizabeth Hopkins.

Marion G. Follin III argued the cause and filed a brief for respondent. *

* Edward N. Delaney and Russell A. Hollrah filed a brief for the National Association of Independent Insurers as amicus curiae urging reversal.

JUDGES: SOUTER, J., delivered the opinion for a unanimous Court.

OPINION:

[**1346]  [***587]  [***LEdHR1A]  [1A]In this case we construe the term "employee" as it appears in § 3(6) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 834, 29 U. S. C. § 1002(6), and read it to incorporate traditional agency law criteria for identifying master-servant relationships.

I

From 1962 through 1980, respondent Robert Darden operated an insurance agency according to the terms of several [*320] contracts he signed with petitioners Nationwide Mutual Insurance Co. et al. Darden promised to sell only Nationwide insurance policies, and, in exchange, Nationwide agreed to pay him commissions on his sales and enroll him in a company retirement scheme called the "Agent's Security Compensation Plan" (Plan). The Plan consisted of two different programs: the "Deferred Compensation Incentive Credit Plan," under which Nationwide annually credited an agent's retirement account with a sum based on his business performance, and the "Extended Earnings Plan," under which Nationwide paid an agent, upon retirement or termination, a sum equal to the total of his policy renewal fees for the previous 12 months.

Such were the contractual terms, however, that Darden would forfeit his entitlement to the Plan's benefits if, within a year of his termination and 25 miles of his prior business location, he sold insurance for Nationwide's competitors. The contracts also disqualified him from receiving those benefits if, after he stopped...
representing Nationwide, he ever induced [**1347] a Nationwide policyholder to cancel one of its policies.

In November 1980, Nationwide exercised its contractual right to end its relationship with Darden. A month later, Darden became an independent insurance agent and, doing business from his old office, sold insurance policies for several of Nationwide's competitors. The company reacted with the charge that his new business activities disqualified him from receiving the Plan benefits to which he would have been entitled otherwise. Darden then sued for the benefits, which he claimed were nonforfeitable because already vested under the terms of ERISA. 29 U. S. C. § 1053(a).

[Darden brought his action under 29 U.S.C. § 1132(a), which enables a benefit plan "participant" to enforce the substantive provisions of ERISA. The Act elsewhere defines "participant" as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit [*321] of any type from an employee benefit plan . . . ." § 1002(7). [***588] Thus, Darden's ERISA claim can succeed only if he was Nationwide's "employee," a term the Act defines as "any individual employed by an employer." § 1002(6).

It was on this point that the District Court granted summary judgment to Nationwide. After applying common-law agency principles and, to an extent unspecified, our decision in United States v. Silk, 331 U.S. 704, 91 L. Ed. 1757, 67 S. Ct. 1463 (1947), the court found that "the total factual context' of Mr. Darden's relationship with Nationwide shows that he was an independent contractor and not an employee." App. to Pet. for Cert. 47a, 50a, quoting NLRB v. United Ins. Co. of America, 390 U.S. 254, 19 L. Ed. 2d 1083, 88 S. Ct. 988 (1968).

The United States Court of Appeals for the Fourth Circuit vacated. Darden v. Nationwide Mutual Ins. Co., 796 F.2d 701 (1986). After observing that "Darden most probably would not qualify as an employee" under traditional principles of agency law, id., at 705, it found the traditional definition inconsistent with the "declared policy and purposes" of ERISA, id., at 706, quoting Silk, supra, at 713, and NLRB v. Heast Publications, Inc., 322 U.S. 111, 131-132, 88 L. Ed. 1170, 64 S. Ct. 851 (1944), and specifically with the congressional statement of purpose found in § 2 of the Act, 29 U. S. C. § 1001. n1 It therefore held that an ERISA plaintiff can qualify as an "employee" simply by showing "(1) that he had a reasonable expectation that he would receive [pension] benefits, (2) that he relied on this expectation, and (3) that he lacked the economic bargaining power to contract out of [benefit plan] forfeiture provisions." [*322] 922 F.2d 203, 205 (CA4 1991) (summarizing 796 F.2d 701 (CA4 1986)). The court remanded the case to the District Court, which then found that Darden had been Nationwide's "employee" under the standard set by the Court of Appeals. 717 F. Supp. 388 (EDNC 1989). The Court of Appeals affirmed. 922 F.2d 203 (1991). n2

n1 The Court of Appeals cited Congress's declaration that "many employees with long years of employment are losing anticipated retirement benefits," that employee benefit plans "have become an important factor affecting the stability of employment and the successful development of industrial relations," and that ERISA was necessary to "assure the equitable character of such plans and their financial soundness." 796 F.2d at 706, quoting 29 U. S. C. § 1001. None of these passages deals specifically with the scope of ERISA's class of beneficiaries.

n2 The Court of Appeals also held that the Deferred Compensation Plan was a pension plan subject to regulation under ERISA, but that the Extended Earnings Plan was not. 922 F.2d at 208. We denied Darden's cross-petition for certiorari, which sought review of that conclusion. 502 U.S. 906 (1991).

In due course, Nationwide filed a petition for certiorari, which we granted on October [**1348] 15, 1991. 502 U.S. 905. We now reverse.

II

We have often been asked to construe the meaning of "employee" where the statute containing the term does not helpfully define it. Most recently we confronted this [***589] problem in Community for Creative Non-Violence v. Reid, 490 U.S. 730, 104 L. Ed. 2d 811, 109 S. Ct. 2166 (1989), a case in which a sculptor and a nonprofit group each claimed copyright ownership in a statue the group had commissioned from the artist. The dispute ultimately turned on whether, by the terms of § 101 of the Copyright Act of 1976, 17 U. S. C. § 101, the statue had been "prepared by an employee within the scope of his or her employment." Because the Copyright Act nowhere defined the term "employee," we unanimously applied the "well established" principle that

"where Congress uses terms that have accumulated settled meaning under . . . the common law, a court must infer, unless the statute otherwise dictates, that
Congress means to incorporate the established meaning of these terms . . . . In the past, when Congress has used the term 'employee' without defining it, we have concluded that Congress intended to describe the conventional [*323] master-servant relationship as understood by common-law agency doctrine. See, e.g., Kelley v. Southern Pacific Co., 419 U.S. 318, 322-323, 42 L. Ed. 2d 498, 95 S. Ct. 472 (1974); Baker v. Texas & Pacific R. Co., 359 U.S. 227, 228, 3 L. Ed. 2d 756, 79 S. Ct. 664 (1959) (per curiam); Robinson v. Baltimore & Ohio R. Co., 237 U.S. 84, 94, 59 L. Ed. 849, 35 S. Ct. 491 (1915)." 490 U.S. at 739-740 (internal quotation marks omitted).

While we supported this reading of the Copyright Act with other observations, the general rule stood as independent authority for the decision.

[***LEdHR1B] [1B] [***LEdHR3] [3] [***LEdHR4A] [4A]So too should it stand here. ERISA's nominal definition of "employee" as "any individual employed by an employer," 29 U. S. C. § 1002(6), is completely circular and explains nothing. As for the rest of the Act, Darden does not cite, and we do not find, any provision either giving specific guidance on the term's meaning or suggesting that construing it to incorporate traditional agency law principles would thwart the congressional design or lead to absurd results. Thus, we adopt a common-law test for determining who qualifies as an "employee" under ERISA, n3 a test we most recently summarized in Reid:

"In determining whether a hired party is an employee under the general common law of agency, we consider the hiring party's right to control the manner and means by which the product is accomplished. Among the other factors relevant to this inquiry are the skill required; the source of the instrumentalities and tools; the location of the work; the duration of the relationship between the parties; whether the hiring party has the right 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 [*324] party's role in hiring and paying assistants; whether the work is part of the regular business of the hiring party; whether the hiring [*350] party is in business; the provision of employee benefits; and the tax treatment of the hired party." 490 U.S. at 751-752 (footnotes omitted).

Cf. Restatement (Second) of Agency § 220(2) (1958) (listing nonexhaustive criteria for identifying master-servant relationship); Rev. Rul. 87-41, 1987-1 Cum. Bull. 296, 298-299 (setting forth 20 factors as guides in determining whether an individual qualifies as a common-law "employee" in various tax law [*1349] contexts). Since the common-law test contains "no shorthand formula or magic phrase that can be applied to find the answer, . . . all of the incidents of the relationship must be assessed and weighed with no one factor being decisive." NLRB v. United Ins. Co. of America, 390 U.S. at 258.

[***LEdHR4B] [4B] n3 As in Reid, we construe the term to incorporate "the general common law of agency, rather than . . . the law of any particular State," Community for Creative Non-Violence v. Reid, 490 U.S. 730, 740, 104 L. Ed. 2d 811, 109 S. Ct. 2166 (1989).

In taking its different tack, the Court of Appeals cited NLRB v. Hearst Publications, Inc., 322 U.S. at 120-129, and United States v. Silk, 331 U.S. at 713, for the proposition that "the content of the term 'employee' in the context of a particular federal statute is 'to be construed 'in the light of the mischief to be corrected and the end to be attained.' " Darden, 796 F.2d at 706, quoting Silk, supra, at 713, in turn quoting Hearst, supra, at 124. But Hearst and Silk, which interpreted "employee" for purposes of the National Labor Relations Act and Social Security Act, respectively, are feeble precedents for unmooing the term from the common law. In each case, the Court read "employee," which neither statute helpfully defined, n4 to imply something broader than the common-law definition; after each opinion, Congress [*325] amended the statute so construed to demonstrate that the usual common-law principles were the keys to meaning. See United Ins. Co., supra, at 256 ("Congressional reaction to [Hearst] was adverse and Congress passed an amendment . . . the obvious purpose of [which] was to have the . . . courts apply general agency principles in distinguishing between employees and independent contractors under the Act"); Social Security Act of 1948, ch. 468, § 1(a), 62 Stat. 438 (1948) (amending statute to provide that term "employee" "does not include . . . any individual who, under the usual common-law rules applicable in


n5 While both Darden and the United States cite a Department of Labor "Opinion Letter" as support for their separate positions, see Brief for Respondent 34-35, Brief for United States as Amicus Curiae 16-18, neither suggests that we owe that letter's legal conclusions any deference under Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844, 81 L. Ed. 2d 694, 104 S. Ct. 2778 (1984).

Quite apart from its inconsistency with our precedents, the Fourth Circuit's analysis reveals an approach infected with circularity and unable to furnish predictable results. Applying the first element of its test, which ostensibly enquires into an employee's "expectations," the Court of Appeals concluded that Nationwide had "created a reasonable expectation on the employees' part that benefits would be paid to them in the future," Darden, 796 F.2d at 706, by establishing "a comprehensive retirement benefits program for its insurance agents," id., at 707. The court thought it was simply irrelevant that the forfeiture clause in Darden's contract "limited" his expectation of receiving pension benefits, since "it is precisely that sort of employer-imposed condition on the employee's anticipations that Congress intended to out-law [*327] with the enactment of ERISA." Id., at 707, n. 7 (emphasis added). Thus, the Fourth Circuit's test would turn not on a claimant's actual "expectations," which the court effectively deemed consequential, ibid., but on his statutory entitlement to relief, which itself depends on his very status as an "employee." This begs the question.

This circularity infects the test's [*3592] second prong as well, which considers the extent to which a claimant has relied on his "expectation" of benefits by "remaining for 'long years,' or a substantial period of time, in the employer's service, and by foregoing other significant means of providing for [his] retirement." Id., at 706. While this enquiry is ostensibly factual, we have seen already that one of its objects may not be: to the extent that actual "expectations" are (as in Darden's case) unnecessary to relief, the nature of a claimant's required "reliance" is left unclear. Moreover, any enquiry into "reliance," whatever it might entail, could apparently lead to different results for claimants holding identical jobs and enrolled in identical plans. Because, for example, Darden failed to make much independent provision for his retirement, he satisfied the "reliance" prong of the Fourth Circuit's test, see 922 F.2d at 206, whereas a more provident colleague who signed exactly the same contracts, but saved for a rainy day, might not. 

[***LEDHR5] [5] To be sure, Congress did not, strictly speaking, "overrule" our interpretation of those statutes, since the Constitution invests the Judiciary, not the Legislature, with the final power to construe the law. But a principle of statutory construction can endure just so many legislative revisitations, and Reid's presumption that Congress means an agency law definition for "employee" unless it clearly indicates otherwise signaled our abandonment of Silk's emphasis [***591] on construing that term "in the light of the mischief to be corrected and the end to be attained." Silk, supra, at 713, quoting Hearst, supra, at 124.

[***LEDHR6] [6] At oral argument, Darden tried to subordinate Reid to Rutherford Food Corp. v. McComb, 331 U.S. 722, 91 L. Ed. 1772, 67 S. Ct. 1473 (1947), which adopted a broad reading of "employee" under the Fair Labor Standards Act (FLSA). And amicus United States, while rejecting Darden's position, also relied on Rutherford Food for the proposition that, when enacting ERISA, Congress must have intended a modified common-law definition of "employee" that would advance, in a way not defined, the Act's "remedial purposes." Brief for United States as Amicus [*326] Curiae 15-21. n5 But Rutherford Food supports neither position. The definition of "employee" in the FLSA evidently derives [**1350] from the child labor statutes, see Rutherford Food, supra, at 728, and, on its face, goes beyond its ERISA counterpart. While the FLSA, like ERISA, defines an "employee" to include "any individual employed by an employer," it defines the verb "employ" expansively to mean "suffer or permit to work." 52 Stat. 1060, § 3, codified at 29 U. S. C. § § 203(e), (g). This latter definition, whose striking breadth we have previously noted, Rutherford Food, supra, at 728, stretches the meaning of "employee" to cover some parties who might not qualify as such under a strict application of traditional agency law principles. ERISA lacks any such provision, however, and the textual asymmetry between the two statutes precludes reliance on FLSA cases when construing ERISA's concept of "employee."
Any such approach would severely compromise the capacity of companies like Nationwide to figure out who their "employees" are and what, by extension, their pension-fund obligations will be. To be sure, the traditional agency law criteria offer no paradigm of determinacy. But their application generally turns on factual variables within an employer's knowledge, thus permitting categorical judgments about the "employee" status of claimants with similar job descriptions. Agency law principles comport, moreover, with our recent precedents and with the common understanding, reflected in those precedents, of the difference between an employee and an independent contractor.

III

While the Court of Appeals noted that "Darden most probably would not qualify as an employee" under traditional agency law principles, Darden, supra, at 705, it did not actually decide that issue. We therefore reverse the judgment and remand the case to that court for proceedings consistent with this opinion.

So ordered.

REFERENCES: Return To Full Text Opinion

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60A Am Jur 2d, Pensions and Retirement Funds 95


13A Federal Procedural Forms, L Ed, Pensions and Retirement Systems 53:45

14A Am Jur Legal Forms 2d, Pension, Profit-Sharing, and Deferred Compensation Plans 200:11-200:15

1 Am Jur Proof of Facts 345, Agency; 1 Am Jur Proof of Facts 2d 711, Independent Contractor Status

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Employment Coordinator B-20,416

Pension Coordinator 48,307

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Index to Annotations, Employee Retirement Income Security Act; Independent Contractors; Insurance Agents and Brokers; Labor and Employment

Annotation References:

The Supreme Court and the post-Erie Federal common law. 31 L Ed 2d 1006.

Determination of "independent contractor" and "employee" status for purposes of 3(e)(1) of the Fair Labor Standards Act (29 USCS 203(e)(1)). 51 ALR Fed 702.

When is individual in training an "employee" for purposes of 3(e)(1) of the Fair Labor Standards Act (29 USCS 203(e)(1)). 50 ALR Fed 632.

Validity, construction, and effect of provision forfeiting or suspending benefits in event of competitive employment as part of retirement or pension plan. 18 ALR3d 1246.
LEXSEE 506 US 125
THE DISTRICT OF COLUMBIA AND SHARON PRATT KELLY, MAYOR,
PETITIONERS v. THE GREATER WASHINGTON BOARD OF TRADE
No. 91-1326
SUPREME COURT OF THE UNITED STATES
506 U.S. 125; 113 S. Ct. 580; 121 L. Ed. 2d 513; 1992 U.S. LEXIS 7847; 61
L. Weekly Fed. S 775; 16 Employee Benefits Cas. (BNA) 1001
November 3, 1992, Argued
December 14, 1992, Decided

PRIOR HISTORY: ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS FOR
THE DISTRICT OF COLUMBIA CIRCUIT.

DISPOSITION: 292 U.S. App. D. C. 209, 948 F.2d
1317, affirmed.

OUTCOME: The Court affirmed the lower court's order
reversing the dismissal of respondent's action.

CASE SUMMARY:
PROCEDURAL POSTURE: Respondent corporation
filed an action against petitioner District of Columbia
and its mayor seeking to enjoin the enforcement of D.C.
Court of Appeals for the District of Columbia Circuit
reversed the trial court's order granting petitioners' motion to dismiss, and petitioners sought review.

required employers that provided health insurance
coverage to their employees to provide equivalent
coverage to their employees while the employees were
receiving or were eligible to receive workers' compensation benefits. The corporation claimed that the statute was void because it was preempted by § 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C.S. § 1144(a). Petitioners claimed that § 514(a) should be construed as not preemting state law if employers could comply with the law through separately administered plans exempt under § 4(b) of the act, 29
U.S.C.S. § 1003(b). The Court upheld the lower court's order reversing the dismissal of the case. The Court ruled that § 36-307(a-1)(1) related to a "welfare plan" within the meaning of 29 U.S.C.S. § 1002(1) and was therefore preempted under § 514(a).

LexisNexis(R) Headnotes
SYLLABUS: Section 2(c)(2) of the District of Columbia
Workers' Compensation Equity Amendment Act of 1990
requires employers who provide health insurance for
their employees to provide equivalent health insurance
coverage for injured employees eligible for workers' compensation benefits. Respondent, an employer affected by this requirement, filed an action in the District Court against petitioners, the District of Columbia and its Mayor, seeking to enjoin enforcement of § 2(c)(2) on the ground that it is pre-empted by § 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), which provides that ERISA supersedes state laws that "relate to any employee benefit plan" covered by ERISA. Although petitioners conceded that § 2(c)(2) relates to an ERISA-covered plan, the court granted their motion to dismiss. Relying on this Court's decision in Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 77
L. Ed. 2d 490, 103 S. Ct. 2890, it held that § 2(c)(2) is not pre-empted because it also relates to respondent's workers' compensation plan, which is exempt from ERISA coverage, and because respondent could comply with the provision by creating a separate unit to...
administer the required benefits. The Court of Appeals reversed, holding that pre-emption of § 2(c)(2) is compelled by § 514(a)'s plain meaning and ERISA's structure.

**Held:** Section 2(c)(2) is pre-empted by ERISA. A state law "relate[s] to" a covered benefit plan for § 514(a) purposes if it refers to or has a connection with such a plan, even if the law is not designed to affect the plan or the effect is only indirect. See, e.g., Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 112 L. Ed. 2d 474, 111 S. Ct. 478. Section 2(c)(2) measures the required health care coverage by reference to "the existing health insurance coverage," which is a welfare benefit plan subject to ERISA regulation. It does not matter that § 2(c)(2)'s requirements also "relate to" ERISA-exempt workers' compensation plans, since ERISA's exemptions do not limit § 514's pre-emptive sweep once it is determined that a law relates to a covered plan. See Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 525, 68 L. Ed. 2d 402, 101 S. Ct. 1895. Petitioners' reliance on Shaw, supra, is misplaced, since the statute at issue there did not "relate to" an ERISA-covered plan. Nor is there any support in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380, for their position that § 514(a) requires a two-part analysis under which a state law relating to an ERISA-covered plan would survive pre-emption if employers could comply with the law through separately administered exempt plans. Pp. 129-133.

**JUDGES:** THOMAS, J., delivered the opinion of the Court, in which REHNQUIST, C. J., and WHITE, BLACKMUN, O'CONNOR, SCALIA, KENNEDY, and SOUTER, JJ., joined. STEVENS, J., filed a dissenting opinion, post, p. 133.

**OPINION BY:** THOMAS

**OPINION:**

[*126] [***518] [**582] JUSTICE THOMAS delivered the opinion of the Court.

[***LEdHR1A] [1A] The District of Columbia requires employers who provide health insurance for their workers to provide equivalent health insurance coverage for injured employees eligible for [*127] workers' compensation benefits. We hold that this requirement is pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. § 1001 et seq. (1982 ed. and Supp. II).

I

ERISA sets out a comprehensive system for the federal regulation of private employee benefit plans, including both pension plans and welfare plans. A "welfare plan" is defined in § 3 of ERISA to include, inter alia, any "plan, fund, or program" maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries "through the purchase of insurance or otherwise." § 3(1), 29 U.S.C. § 1002(1). Section 4 defines the broad scope of ERISA coverage. Subject to certain exemptions, ERISA applies generally to all employee benefit plans sponsored by an employer or employee organization. § 4(a), 29 U.S. C. § 1003(a). Among the plans exempt from ERISA coverage under § 4(b) are those "maintained solely for the purpose of complying with applicable workmen's

ERISA's pre-emption provision assures that federal regulation of covered plans will be exclusive. Section 514(a) provides that "[**519] ERISA "shall [*519] supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. § 514(a), 29 U.S.C. § 1144(a). Several categories of state laws, such as generally applicable criminal laws and laws regulating insurance, banking, or securities, are excepted from ERISA pre-emption by § 514(b), 29 U.S.C. § 1144(b), but none of these exceptions is at issue here.


"Any employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent to the existing health insurance coverage of the employee while the employee receives or is eligible to receive workers' compensation benefits under this chapter." D. C. Code Ann. § 36-307(a-1)(1) (Supp. 1992).

Under § 2(c)(2), the employer must provide such health insurance coverage for up to 52 weeks "at the same benefit level that the employee had at the time the employee received or was eligible to receive workers' compensation benefits." § 36-307(a-1)(3).

Respondent Greater Washington Board of Trade, a nonprofit corporation that sponsors health insurance coverage for its employees, filed this action against the District of Columbia and Mayor Sharon Pratt Kelly seeking to enjoin enforcement of § 2(c)(2) on the ground that the "equivalent" benefits requirement is pre-empted by § 514(a) of ERISA. The District Court granted petitioners' motion to dismiss. App. to Pet. for Cert. 21a. Petitioners conceded that § 2(c)(2) "relate[s] to" an ERISA-covered plan in the sense that the benefits required under the challenged law "are set by reference to covered employee benefit plans." [***583] Id., at 22a. Relying on our opinion in Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983), however, the District Court held that § 2(c)(2) is not pre-empted because it also relates to respondent's workers' compensation plan, which is exempt from ERISA coverage, and because respondent could comply with § 2(c)(2) "by creating a 'separate administrative unit' to administer the required benefits." App. to Pet. for Cert. 24a (quoting Shaw, supra, at 108).

The Court of Appeals reversed. 292 U.S. App. D.C. 209, 948 F.2d 1317 (1991). The court held that pre-emption of [*129] § 2(c)(2) is compelled by the plain meaning of § 514(a) and by the structure of ERISA. Id., at 215-216, 948 F.2d at 1323-1324. In the court's view, ERISA pre-empts a law that relates to a covered plan and is not excepted from pre-emption by § 514(b), regardless of whether the law also relates to an exempt plan. Ibid. The Court of Appeals further concluded that this result would advance the policies and purposes served by ERISA pre-emption. Id., at 217-218, 948 F.2d at 1325-1326. By tying the benefit levels of the workers' compensation plan to those provided in an ERISA-covered plan, "the Equity Amendment Act could [***520] have a serious impact on the administration and content of the ERISA-covered plan." Id., at 217, 948 F.2d at 1325. Because the opinion below conflicts with the Second Circuit's decision in R. R. Donnelley & Sons Co. v. Prevost, 915 F.2d 787 (1990), cert. denied, 499 U.S. 947, 113 L. Ed. 2d 468, 111 S. Ct. 1415 (1991), which upheld against a pre-emption challenge a Connecticut law substantially similar to § 2(c)(2), we granted certiorari. 503 U.S. 970 (1992). We now affirm.

II

[***LEdHR2A] [2A]We have repeatedly stated that a law "relate[s] to" a covered employee benefit plan for purposes of § 514(a) "if it has a connection with or reference to such a plan." Shaw, supra, at 97. E. g., Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990); FMC Corp. v. Holliday, 498 U.S. 52, 58, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990); Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 829, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985). This reading is true to the ordinary meaning of "relate to," see Black's Law Dictionary 1288 (6th ed. 1990), and thus gives effect to the "deliberately expansive" language chosen by Congress. Pilot Life, supra, at 46. See also Morales v. Trans World Airlines, Inc., 504 U.S. 374, 383, 119 L. Ed. 2d 157, 112 S. Ct. 2031 (1992). Under § 514(a), ERISA pre-empts any state law that refers to or has a connection with [*130] covered benefit plans (and that does not fall within a § 514(b) exception) "even if the law is not specifically designed to affect such plans, or the effect is only indirect." Ingersoll-Rand, supra, at 139, and even if the law is "consistent with ERISA's
n1 Pre-emption does not occur, however, if the state law has only a "tenuous, remote, or peripheral" connection with covered plans, Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100, n. 21, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983), as is the case with many laws of general applicability, see Mackey, 486 U.S. at 830-838, and n. 12; cf. Ingersoll-Rand, 498 U.S. at 139.

n3 ERISA does not pre-empt § 2(c)(2) to the extent its requirements are measured only by reference to "existing health insurance coverage" provided under plans that are exempt from ERISA regulation, such as "governmental" or "church" plans, see ERISA § § 4(b)(1) and (2), 29 U.S.C. § § 1003(b)(1) and (2).

n2 In Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 96 L. Ed. 2d 1, 107 S. Ct. 2211 (1987), we construed the word "plan" to connote some minimal, ongoing "administrative" scheme or practice, and held that "a one-time, lump-sum payment triggered by a single event" does not qualify as an employer-sponsored benefit plan. Id., at 12. Petitioners do not contend that employers in the District of Columbia provide health insurance for their employees without thereby administering welfare plans within the meaning of ERISA, and petitioners concede that the existing health insurance sponsored by respondent constitutes an ERISA plan. Tr. of Oral Arg. 14.
qualify as an exempt plan under ERISA § 4(b)(3). Id., at 107. [**585] Thus, unlike § 2(c)(2) of the District's Equity Amendment Act, the New York statute at issue in Shaw did not "relate to" an ERISA-covered plan.

Petitioners nevertheless point to Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985), in which we described Shaw as holding that "the New York Human Rights Law and that State's Disability Benefits Law 'related to' welfare plans governed by ERISA." 471 U.S. at 739. Relying on this dictum and their reading of Shaw, petitioners argue that § 514(a) should be construed to require a two-step analysis: If the state law "relate[s] to" an ERISA-covered plan, it may still survive pre-emption if employers could comply with the law through separately administered plans exempt under § 4(b). See Tr. of Oral Arg. 16-17. But Metropolitan Life construed only the scope of § 514(b)(2)(A)'s safe harbor for state laws regulating insurance, see 471 U.S. at 739-747; it did not purport to add, by its passing reference to Shaw, any further gloss on § 514(a). And although we did conclude in Shaw that both New York laws at issue there related to "employee benefit plan[s]" in general, 463 U.S. at 100, only the Human Rights Law, which barred discrimination by ERISA plans, fell within the pre-emption provision. See 463 U.S. at 100-106. As we have explained, the Disability Benefits Law up-held [*133] in Shaw -- though mandating the creation of a "welfare plan" as defined in ERISA n4 -- did not relate to a welfare plan subject to ERISA regulation. Section 2(c)(2) does, and that is the end of the matter. We cannot engraft a two-step analysis onto a one-step statute.


Workers' compensation laws provide a substitute for tort actions by employees against their employers. They typically base the [*586] amount of the compensation award on the level of the employee's earnings at the time of the injury. In the District of Columbia's workers' compensation law, for example, an employee's "average weekly wages" provide the basic standard for computing the award regardless of the nature of the injury. D. C. Code Ann. § 36-308 (1988 and Supp. 1992). Because an employee who receives health insurance benefits typically has a correspondingly reduced average weekly wage, the District decided to supplement the standard level of workers' compensation with a component reflecting any health insurance benefits the worker receives. The Court seems to be holding today that such a supplement may never be measured by the level of the employee's health insurance coverage -- at least if the state statutes or regulations specifically refer to that component of the calculation.

It is true, as the Court points out, that in Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97, 77 L. Ed. 2d...
490, 103 S. Ct. 2890 (1983), we stated that a law "related to" an employee benefit plan, "in the normal sense of the phrase, if it has a connection with or reference to such a plan." It is also true that we have repeatedly quoted that language in later opinions. n2 Indeed, it has been [*135] reiterated so often that petitioners did not challenge the proposition that the statute at issue in this case "related to" respondent's ERISA plan. It nevertheless is equally true that until today that broad reading of the phrase has not been necessary to support any of this Court's actual holdings.


[***524] Given the open-ended implications of today's holding and the burgeoning volume of litigation involving ERISA preemption claims, n3 I think it is time to take a fresh look at the intended scope of the pre-emption provision that Congress enacted. Let me begin by repeating the qualifying language in the Shaw opinion itself and by emphasizing one word in the statutory text that is often overlooked.

n3 Several years ago a District Judge who had read "nearly 100 cases about the reach of the ERISA preemption clause" concluded that "common sense should not be left at the courthouse door." See Schultz v. National Coalition of Hispanic Mental Health and Human Services Organizations, 678 F. Supp. at 938. A recent LEXIS search indicates that there are now over 2,800 judicial opinions addressing ERISA pre-emption. This growth may be a consequence of the growing emphasis on the meaning of the words "relate to," thus pre-empting reliance on what the District Judge referred to as "common sense."

After explaining why the two New York statutes at issue related to benefit plans, we noted:

"Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan. Cf. American Telephone and Telegraph Co. v. Merry, 592 F.2d 118, 121 (CA2 1979) (state garnishment of a spouse's pension income to enforce alimony and support orders is not pre-empted). The present litigation plainly does not present a borderline question, and we express no views about where it would be appropriate to draw the line." 463 U.S. at 100, n. 21.

[*136] In deciding where that line should be drawn, I would begin by emphasizing the fact that the so-called "pre-emption" provision in ERISA does not use the word "pre-empt." It provides that the provisions of the federal statute shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt *** under section 1003(b) of this title." 29 U.S.C. § 1144(b)(1) (emphasis added). Thus the federal statute displaces state regulation in the field that is regulated by ERISA; it expressly disavows an intent to supersede state regulation of exempt plans; and its text is silent about possible pre-emption of state regulation of subjects not regulated by the federal statute. Thus, if we were to decide this case on the basis of nothing more than the text of the statute itself, we would find no pre-emption (more precisely, no "supersession") of the District's regulation of health benefits for employees receiving workers' compensation because that subject is entirely unregulated by ERISA.

"In the absence of an express congressional command, state law is pre-empted if that law actually conflicts with federal law, see 
PACIFIC GAS & ELECTRIC CO. V. ENERGY RESOURCES CONSERVATION AND DEVELOPMENT Comm'n, 461
U.S. 190, 204, 75 L. Ed. 2d 752, 103 S. Ct. 1713
(1983), or if federal law so thoroughly occupies a legislative field "as to make reasonable the inference that Congress left no room for the States to supplement it." FIDELITY FED. SAV. &
LOAN ASSN. v. DE LA CUESTA, 458 U.S. 141, 153,
73 L. Ed. 2d 664, 102 S. Ct. 3014 (1982) (quoting
RICE v. SANTÉ FE ELEVATOR CORP., 331 U.S. at
230)."

I would not decide this case on ***525 that narrow ground, however, because both the legislative history of ERISA and ***137 prior holdings by this Court have given the supersession provision a broader reading. Thus, for example, in Shaw itself we held that the New York Human Rights Law, which prohibited employers from structuring their employee benefit plans in a manner that discriminated on the basis of pregnancy, was pre-empted even though ERISA did not contain any superseding regulatory provisions. 463 U.S. at 98. State laws that directly regulate ERISA plans, or that make it necessary for plan administrators to operate such plans differently, "relate to" such plans in the sense intended by Congress. In my opinion, a state law's mere reference to an ERISA plan is an insufficient reason for concluding that it is pre-empted -- particularly when the state law itself is related almost solely to plans that Congress expressly excluded from the coverage of ERISA. It is anomalous to conclude that ERISA has superseded state regulation in an area that is expressly excluded from the coverage of ERISA.

The statute at issue in this case does not regulate any ERISA plan or require any ERISA plan administrator to make any changes in the administration of such a plan. Although the statute may grant injured employees who receive health insurance a better compensation package than those who are not so insured, it does so only to prevent a converse windfall going to injured employees who receive high weekly wages and little or no health insurance coverage. n5 Even if the District's statute did encourage an employer to pay higher wages instead of providing better fringe benefits, that would surely be no reason to infer a congressional intent to supersede state regulation of a category of compensation programs that it exempted from federal coverage. Moreover, by requiring an injured worker's compensation to reflect his entire pay package, the statute attempts to replace fully the lost earning power of every injured employee. Nothing [*138] in ERISA suggests an intent to supersede the State's efforts to enact fair [***588] and complete remedies for work-related injuries; it is difficult to imagine how a State could measure an injured worker's health benefits without referring to the specific health benefits that worker receives. Any State that wishes to effect the equitable goal of the District's statute will be forced by the Court's opinion to require a predetermined rate of health insurance coverage that bears no relation to the compensation package of each injured worker. The Court thereby requires workers' compensation laws to shed their most characteristic element: postinjury compensation based [***526] on each individual worker's preinjury level of compensation.

n5 One of the statute's stated goals was "to promote a fairer system of compensation." Preamble to District of Columbia's Workers' Compensation Equity Amendment Act of 1990, 37 D. C. Register 6890 (Nov. 1990).

Instead of mechanically repeating earlier dictionary definitions of the word "relate" as its only guide to decision in an important and difficult area of statutory construction, the Court should pause to consider, first, the wisdom of the basic rule disfavoring federal pre-emption of state laws, and second, the specific concerns identified in the legislative history as the basis for federal pre-emption. The most expansive statement of that purpose was quoted in our opinion in Shaw. As explained by Congressman Dent, the "crowning achievement" of the legislation was the "reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." Id., at 99 (quoting 120 Cong. Rec. 29197 (1974)).

The statute at issue in this case does not regulate even one inch of the pre-empted field, and poses no threat whatsoever of conflicting and inconsistent state regulation. By its holding today the Court enters uncharted territory. Where that holding will ultimately lead, I do not venture to predict. I am persuaded, however, that the Court has already taken a step that Congress neither intended nor foresaw.

Accordingly, I respectfully dissent.

REFERENCES: Return To Full Text Opinion

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When is state or local law pre-empted by Employee Retirement Income Security Act of 1974, as amended (ERISA) (29 USCS 1001 et seq.)--Supreme Court cases


27 Federal Procedure, L Ed, Pensions and Retirement Systems 61:183

29 USCS 1144(a)

Benefits Coordinator 37,605-37,608

Employment Coordinator B-10,614

Pension Coordinator 52,006-52,009

L Ed Digest, District of Columbia 7; States, Territories, and Possessions 38,2

L Ed Index, District of Columbia; Insurance; Pensions and Retirement; Preemption and Preemptive Rights; States; Workers’ Compensation

Annotation References:

Pre-emption, by 514(a) of Employee Retirement Income Security Act of 1974 (29 USCS 1144(a)), of employee's state-law action for infliction of emotional distress. 102 ALR Fed 205.

Construction and application of pre-emption exemption, under Employee Retirement Income Security Act (29 USCS 1001 et seq.), for state laws regulating insurance, banking, or securities (29 USCS 1144(b)(2)). 87 ALR Fed 797.


Employer's plan to grant bonuses to selected employees as "employee welfare plan," "employee pension plan," or "employee benefit plan" within meaning of 29 USCS 1002(1-3) regarding labor law provisions of Employee Retirement Income Security Act of 1974 (29 USCS 1001 et seq.). 55 ALR Fed 390.
PRIOR HISTORY: ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT.

DISPOSITION: 14 F.3d 708, reversed and remanded.

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiff insurers brought actions against defendant state officials, seeking to invalidate state statutes exacting surcharges for hospital care. The United States District Court consolidated the actions and granted summary judgment to the insurers. On review, the United States Court of Appeals for the Second Circuit affirmed. The officials sought further review.

OVERVIEW: The insurers sought relief from N. Y. Pub. Health Law § 2807-c, which required hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by other plans. Section § 2807-c also subjected certain health maintenance organizations to surcharges that varied with the number of Medicaid recipients each enrolled. In granting the insurers' motion for summary judgment, the district court enjoined enforcement of those surcharges against any commercial insurers or HMOs in connection with their coverage of ERISA plans. On review, the court of appeals held that ERISA's pre-emption clause must be read broadly to reach any state law having a connection with, or reference to, covered employee benefit plans. On further review, the Court reversed and remanded because the provisions for surcharges did not relate to employee benefit plans within the meaning of the pre-emption provision of ERISA § 514(a), 29 U.S.C.S. § 1144(a), and accordingly suffered no pre-emption.

OUTCOME: The Court reversed the judgment of the court of appeals that affirmed the judgment entered in favor of the insurers in their action against the state officials.
SYLLABUS: A New York statute requires hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan, and also subjects certain health maintenance organizations (HMO's) to surcharges. Several commercial insurers and their trade associations filed actions against state officials, claiming that § 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA) -- under which state laws that "relate to" any covered employee benefit plan are superceded -- pre-empts the imposition of surcharges on bills of patients whose commercial insurance coverage is purchased by an ERISA plan, and on HMO's insofar as their membership fees are paid by an ERISA plan. Blue Cross/Blue Shield plans (collectively the Blues) and a hospital association intervened as defendants, and several HMO's and an HMO conference intervened as plaintiffs.

The District Court consolidated the actions and granted the plaintiffs summary judgment. The Court of Appeals affirmed, relying on this Court's decisions in Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 77 L. Ed. 2d 490, 103 S. Ct. 2890, and District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125, 121 L. Ed. 2d 513, 113 S. Ct. 580, holding that ERISA's pre-emption clause must be read broadly to reach any state law having a connection with, or reference to, covered benefit plans. The court decided that the surcharges were meant to increase the costs of certain insurance and HMO health care and held that this purposeful interference with the choices that ERISA plans make for health care coverage constitutes a "connection with" ERISA plans triggering pre-emption.

Held: New York's surcharge provisions do not "relate to" employee benefit plans within the meaning of § 514(a) and, thus, are not pre-empted. Pp. 654-668.

(a) Under Shaw, supra, the provisions "relate to" ERISA plans if they have a "connection with," or make "reference to," the plans. They clearly make no reference to ERISA plans, and ERISA's text is unhelpful in determining whether they have a "connection with" them. Thus, the Court must look to ERISA's objectives as a guide to the scope of the state law that Congress understood would survive. Pp. 654-656.

(b) The basic thrust of the pre-emption clause was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans. Thus, ERISA pre-empted state laws that mandate employee benefit structures or their administration as well as those that provide alternative enforcement mechanisms. The purpose and effects of New York's statute are quite different, however. The principal reason for charge differentials is that the Blues provide coverage to many subscribers whom the commercial insurers would reject. Since the differentials make the Blues more attractive, they have an indirect economic effect on choices made by insurance buyers, including ERISA plans. However, an indirect economic influence does not bind plan administrators to any particular choice or preclude uniform administrative practice or the provision of a uniform interstate benefit package. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. Cost uniformity almost certainly is not an object of pre-emption. Rate differentials are common even in the absence of state action, and therefore it is unlikely that ERISA meant to bar such indirect influences under state law. The existence of other common state actions with indirect economic effects on a plan's cost -- such as quality control standards and workplace regulation -- leaves the intent to pre-empt even less likely, since such laws would have to be superceded as well. New York's surcharges leave plan administrators where they would be in any case, with the responsibility to choose the best overall coverage for the money, and thus they do not bear the requisite "connection with" ERISA plans to trigger pre-emption. Pp. 656-662.

(c) This conclusion is confirmed by the decision in Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 100 L. Ed. 2d 836, 108 S. Ct. 2182, that ERISA pre-emption falls short of barring application of general state garnishment statutes to participants' benefits in the hands of an ERISA plan. And New York's surcharges do not impose the kind of substantive coverage requirement binding plan administrators that was at issue in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380, since they do not require plans to deal with only one insurer or to insure against an entire category of illnesses the plans might otherwise choose not to cover. Pp. 662-664.

(d) Any conclusion other than the one drawn here would have the unsettling result of barring any state regulation of hospital costs on the theory that all laws with indirect economic effects on ERISA plans are pre-empted. However, there is no hint in ERISA's legislative history or elsewhere that Congress intended to squelch the efforts of several States that were regulating hospital charges to some degree at the time ERISA was passed. Moreover, such a broad interpretation of § 514 would have rendered nugatory an entire federal statute -- enacted after ERISA by the same Congress -- that gave comprehensive aid to state health care rate regulation. Pp. 664-667.
(e) In reaching this decision, the Court does not hold that ERISA pre-empts only direct regulation of ERISA plans. It is possible that a state law might produce such acute, albeit indirect, economic effects as to force an ERISA plan to adopt a certain scheme of coverage or effectively restrict its choice of insurers, but such is not the case here. P. 668.

COUNSEL: M. Patricia Smith, Assistant Attorney General of New York, argued the cause for petitioners in all cases. With her on the briefs for petitioners in No. 93-1414 were G. Oliver Koppell, Attorney General, Jerry Boone, Solicitor General, Peter H. Schiff and Andrea Green, Deputy Solicitors General, and Jane Lauer Barker, Assistant Attorney General. Robert A. Bicks, Patricia Anne Kuhn, Alan C. Drewsen, Jeffrey D. Chansler, Bartley J. Costello III, Eileen M. Considine, and Beverly Cohen filed briefs for petitioners in No. 93-1408. Jeffrey J. Sherrin, Philip Rosenberg, and H. Bartow Farr III filed briefs for petitioner in No. 93-1415.

Deputy Solicitor General Kneedler argued the cause for the United States as amicus curiae urging reversal. With him on the brief were Solicitor General Days, James A. Feldman, Allen H. Feldman, Nathaniel I. Spiller, and Judith D. Heimlich.

Craig P. Murphy argued the cause for respondents Travelers Insurance Co. et al. in all cases. With him on the brief were Darrell M. Joseph, Stephen M. Shapiro, Kenneth S. Geller, Andrew J. Pincus, Charles Rothfeld, Donald M. Falk, Zoe Baird, Theresa L. Sorota, Philip E. Stano, and Raymond A. d'Amico. Harold N. Iselin argued the cause for respondents New York State Health Maintenance Organization Conference et al. in all cases. With him on the brief were Wendy L. Ravitz and Glen D. Nager.


Briefs of amici curiae urging affirmance were filed for the Association of Private Pension and Welfare Plans et al. by Edward R. Mackiewicz; for Group Health Association of America, Inc., by Alan J. Davis and Brian D. Pedrow; for the Federation of American Health Systems by Carl Weissburg and Robert E. Goldstein; for the National Carriers' Conference Committee by Benjamin W. Boley, David P. Lee, and William H. Dempsey; for the National Coordinating Committee for Multiemployer Plans by Gerald M. Feder and Diana L. S. Peters; for the NYSA-ILA Welfare Fund et al. by C. Peter Lambs, Donato Caruso, Thomas W. Gleeson, Ernest L. Mathews, Jr., and Kevin Marrinan; and for the Trustees of and the Pension Hospitalization Benefit Plan of the Electrical Industry et al. by Edward J. Groarke.

Briefs of amici curiae were filed for the International Foundation of Employee Benefit Plans by Paul J. Ondrasik, Jr., and Sara E. Hauptfuehrer; and for the Self-Insurance Institute of America, Inc., by George J. Pantos.

JUDGES: SOUTER, J., delivered the opinion for a unanimous Court.

OPINIONBY: SOUTER

OPINION:

[*649] [**1673] [***701] JUSTICE SOUTER delivered the opinion of the Court.

[***LEdHR1A] [1A] A New York statute requires hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan, and it subjects certain health maintenance organizations (HMO’s) to surcharges that vary with the number of Medicaid recipients each enrolls. N. Y. Pub. Health Law § 2807-c (McKinney 1993). These cases call for us to decide whether the
Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. § 1001 et seq. (1988 ed. and Supp. V), pre-empts the state provisions for surcharges on bills of patients whose commercial insurance coverage is purchased by employee health-care plans governed by ERISA, and for surcharges on HMO's insofar as their membership fees are paid by an ERISA plan. We hold that the provisions for surcharges do not "relate to" employee benefit plans within the meaning of ERISA's pre-emption provision, § 514(a), 29 U.S.C. § 1144(a), and accordingly suffer no pre-emption.

I

A

New York's Prospective Hospital Reimbursement Methodology (NYPHRM) regulates hospital rates for all in-patient care, except for services provided to Medicare beneficiaries. n1 N. Y. Pub. Health Law § 2807-c (McKinney 1993). n2 The scheme calls for patients to be charged not for the cost of their individual treatment, but for the average cost of treating the patient's medical problem, as classified under one or another of 794 Diagnostic Related Groups (DRG's). The [*650] charges allowable in accordance with DRG classifications are adjusted for a specific hospital to reflect its particular operating costs, capital investments, bad debts, costs of charity care, and the like.

n1 Medicare rates are set by the Federal Government unless States obtain an express authorization from the United States Department of Health and Human Services. See 42 U.S.C. § 1395 et seq.; see also Part II-D, infra.

n2 References are made to the laws of New York as they stood at the times relevant to this litigation.

Patients with Blue Cross/Blue Shield coverage, Medicaid patients, and HMO participants are billed at a hospital's DRG rate. N. Y. Pub. Health Law § 2807-c(1)(a); see also Brief for Petitioners Pataki et al. 4. n3 Others, however, are not. Patients served by commercial insurers providing inpatient hospital coverage on an expense-incurred basis, by self-insured funds directly reimbursing hospitals, and by certain workers' compensation, volunteer firefighters' benefit, ambulance workers' benefit, and no-fault motor vehicle insurance funds, must be billed at the DRG rate plus a 13% surcharge to be retained by the hospital. N. Y. Pub. Health Law § 2807-c(1)(b). For the year ending March 31, 1993, moreover, hospitals were required to bill commercially insured patients for a further 11% surcharge to be turned over to the State, with the result that these patients were charged 24% more than the DRG rate. § 2807-c(11)(i).

n3 Under certain circumstances, New York law permits HMO's to negotiate their own hospital payment schedules subject to state approval. § 2807-c(2)(b)(i).

New York law also imposes a surcharge on HMO's, which varies depending on the number of eligible Medicaid recipients an HMO has enrolled, but which may run as high as 9% of the aggregate monthly charges paid by an HMO for its members' in-patient hospital care. §§ 2807-c(2-a)(a) to (2-a)(e). This assessment is not an increase in the rates to be paid by an HMO to hospitals, but a direct payment by the HMO to the State's general fund.

B

ERISA's comprehensive regulation of employee welfare and pension benefit plans extends to those that provide "medical, surgical, or hospital care or benefits" for plan participants or their beneficiaries "through the purchase of insurance or otherwise." § 3(1), 29 U.S.C. § 1002(1). The federal statute does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans, see § 2, 29 U.S.C. § 1001(b), as by imposing reporting and disclosure mandates, §§ 101-111, 29 U.S.C. §§ 1021-1031, participation and vesting requirements, §§ 201-211, 29 U.S.C. §§ 1051-1061, funding standards, §§ 301-308, 29 U.S.C. §§ 1081-1086, and fiduciary responsibilities for plan administrators, §§ 401-414, 29 U.S.C. §§ 1101-1114. It envisions administrative oversight, imposes criminal sanctions, and establishes a comprehensive civil enforcement scheme. §§ 501-515, 29 U.S.C. §§ 1131-1145. It also pre-empts some state law. § 514, 29 U.S.C. § 1144.

Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the statute, 29 U.S.C. § 1144(a), although pre-emption stops short of "any law of any State which regulates insurance." § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This exception for insurance regulation is itself limited, however, by the provision that an employee welfare benefit plan may not "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . ." § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). Finally, ERISA saves from pre-emption "any generally
C

[***LEdHR2A] [2A] On the claimed authority of ERISA's general pre-emption provision, several commercial insurers, acting as fiduciaries of ERISA plans they administer, joined with their [***703] trade associations to bring actions against state officials in United States District Court seeking to invalidate the 13%, 11%, and [***652] 9% surcharge statutes. The New York State Conference of Blue Cross and Blue Shield plans, Empire Blue Cross and Blue Shield (collectively the Blues), and the Hospital Association of New York State intervened as defendants, and the New York State Health Maintenance Organization Conference and several HMO's intervened as plaintiffs. The District Court consolidated the actions and granted summary judgment to the plaintiffs. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (SDNY 1993). The court found that although the surcharges "do not directly increase a plan's costs or affect the level of benefits to be offered" there could be "little doubt that the surcharges at issue will have a significant effect on the commercial insurers and HMOs which do or could provide coverage for ERISA plans and thus lead, at least indirectly, to an increase in plan costs." *Id.*, at 1003 (footnote omitted). It found that the "entire justification for the surcharges is premised on that exact result -- that the surcharges will increase the cost of obtaining medical insurance through any source other than the Blues to a sufficient extent that customers will switch their coverage to and ensure the economic viability of the Blues." *Ibid.* (footnote omitted). The District Court concluded that this effect on choices by ERISA plans was enough to trigger pre-emption under § 514(b) as regulating insurance. *Id.*, at 1003-1008. The District Court accordingly enjoined enforcement of "those surcharges against any commercial insurers or HMOs in connection with their coverage of . . . ERISA plans." *Id.*, at 1012. n4

n4 The District Court and the Court of Appeals both held that the injunctive remedy was not prohibited by the Tax Injunction Act, 28 U.S.C. § 1341, which provides that federal district courts "shall not enjoin, suspend or restrain the assessment . . . of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State." Although these courts considered the surcharges to be taxes, they found no "plain, speedy and efficient remedy" to exist in state court, since ERISA § 502(e), 29 U.S.C. § 1132(e)(1) (1988 ed., Supp. V), divests state courts of jurisdiction over such claims. See 813 F. Supp. at 1000-1001; *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 713-714 (CA2 1994). Neither party challenges this conclusion and we have no occasion to examine it.

[***LEdHR2B] [2B] Nor do we address the surcharge statute insofar as it applies to self-insured funds. The trial court's ERISA analysis originally led it to enjoin defendants "from enforcing those surcharges against any commercial insurers or HMOs in connection with their coverage of . . . ERISA plans," without any further mention of self-insured funds. 813 F. Supp. at 1012. After staying its decision as to the 13% surcharge pending appeal, see *id.*, at 1012-1015, it ordered all named parties, including the Travelers Insurance Company (which served as fiduciary to a self-insured plan), to pay that surcharge whenever required by state law, see *Travelers Ins. Co. v. New York State Health Maintenance Conference*, No. 92 Civ. 3999 (SDNY Apr. 27, 1993), reprinted in Brief for National Carriers' Conference Committee as *Amicus Curiae* 29a-31a. The Court of Appeals, in turn, did not expressly address this application of the surcharge and, accordingly, we leave it for consideration on remand.

[***653] The Court of Appeals for the Second Circuit affirmed, relying on our decisions in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983), and [*1676] *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 121 L. Ed. 2d 513, 113 S. Ct. 580 (1992), holding that ERISA's pre-emption clause must be read broadly to reach any state law having a connection with, or reference to, covered employee benefit plans. *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 718 (1994). In the light of our decision in *Ingersoll-Rand*, [*704] *Co. v. McClendon*, 498 U.S. 133, 141, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990), the Court of Appeals abandoned its own prior decision in *Rebaldo v. Cuomo*, 749 F.2d 133, 137 (1984), cert. denied, 472 U.S. 1008, 86 L. Ed. 2d 718, 105 S. Ct. 2702 (1985), which had drawn upon the definition of the term "State" in ERISA § 514(c)(2), 29 U.S.C. § 1144(c)(2), to conclude that "a state law must 'purport to regulate . . . the terms and conditions of employee benefit plans' to fall within the preemption provision" of ERISA. 14 F.3d at 719 (internal quotation marks omitted). Rejecting that narrower approach to ERISA pre-emption, it relied on our statement in *Ingersoll-Rand* that under the applicable "broad common-sense meaning," a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law
is not specifically designed to affect such plans, or the
effect is only indirect." 498 U.S. at 139; see 14 F.3d at
718.

[*654] The Court of Appeals agreed with the trial
court that the surcharges were meant to increase the costs
of certain insurance and health care by HMOs, and held
that this "purposeful interference with the choices that
ERISA plans make for health care coverage . . . is
sufficient to constitute [a] 'connection with' ERISA
plans" triggering pre-emption. Id., at 719. The court's
conclusion, in sum, was that "the three surcharges 'relate
to' ERISA because they impose a significant economic
burden on commercial insurers and HMOs" and therefore
"have an impermissible impact on ERISA plan structure
and administration." Id., at 721. In the light of its
conclusion that the surcharge statutes were not otherwise
saved by any applicable exception, the court held them
pre-empted. Id., at 723. It recognized the apparent
conflict between its conclusion and the decision of the
Third Circuit in United Wire, Metal and Machine Health
and Welfare Fund v. Morristown Memorial Hosp., 995
F.2d 1179, 1191, cert. denied, 510 U.S. 944 (1993),
which held that New Jersey's similar rate-setting statute
"does not relate to the plans in a way that triggers
ERISA's preemption clause." See 14 F.3d at 721, n. 3.
We granted certiorari to resolve this conflict, 513 U.S.
920 (1994), and now reverse and remand.

II

[***LEdHR3] [***LEdHR4] [4]Our past cases
have recognized that the Supremacy Clause, U.S. Const.,
Art. VI, may entail pre-emption of state law either
by express provision, by implication, or by a conflict
between federal and state law. See Pacific Gas & Elec.
Co. v. State Energy Resources Conservation and
Development Comm'n, 461 U.S. 190, 203-204, 75 L. Ed.
2d 752, 103 S. Ct. 1713 (1983); Rice v. Santa Fe
Elevator Corp., 331 U.S. 218, 230, 91 L. Ed. 1447, 67 S.
 Ct. 1146 (1947). And yet, despite the variety of these
opportunities for federal preeminence, we have never
assumed lightly that Congress has derogated state
regulation, but instead have addressed claims of pre-
emption with the starting presumption that Congress
does not intend to supplant state law. See Maryland v.
[*655] Louisiana, 451 U.S. 725, 746, 68 L. Ed. 2d 576,
101 S. Ct. 2114 (1981). Indeed, in cases like this one,
where federal law is said to bar state action in fields of
traditional state regulation, see Hillsborough County v.
Automated Medical Laboratories, Inc., 471 U.S. 707,
719, 85 L. Ed. 2d 714, [*705] 105 S. Ct. 2371
(1985), we have worked on the "assumption that the
historic police powers of the States were not to be
superseded by the Federal Act unless that was the clear
and manifest purpose of Congress." Rice, supra, at 230.

See, e. g., Cipollone v. Liggett Group, Inc., 505 U.S.
504, 516, 120 L. Ed. 2d 407, 112 S. Ct. 2608 (1992); id.,
at 532-533 (Blackmun, J., concurring in part, concurring
in judgment in part, and dissenting in part); Metropolitan
Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740, 85 L.
Ed. 2d 728, 105 S. Ct. 2380 (1985); Jones v. Rath
Packing Co., 430 U.S. 519, 51 L. Ed. 2d 604, 97 S. Ct.
1305 [*1677] (1977); Napier v. Atlantic Coast Line R.
Co., 272 U.S. 605, 611, 71 L. Ed. 432, 47 S. Ct. 207
(1926).

[***LEdHR5] [5]Since pre-emption claims turn on
Congress's intent, Cipollone, supra, at 516; Shaw, supra,
at 95, we begin as we do in any exercise of statutory
construction with the text of the provision in question,
and move on, as need be, to the structure and purpose of
the Act in which it occurs. See, e. g., Ingersoll-Rand, supra,
at 138. The governing text of ERISA is clearly
expansive. Section 514(a) marks for pre-emption "all
state laws insofar as they . . . relate to any employee
benefit plan" covered by ERISA, and one might be
excused for wondering, at first blush, whether the words
of limitation ("insofar as they . . . relate") do much
limiting. If "relate to" were taken to extend to the furthest
stretch of its indeterminacy, then for all practical
purposes pre-emption would never run its course, for
"really, universally, relations stop nowhere," H. James,
Roderick Hudson xli (New York ed., World's Classics
1980). But that, of course, would be to read Congress's
words of limitation as mere sham, and to read the
presumption against pre-emption out of the law
whenever Congress speaks to the matter with generality.
That said, we have to recognize that our prior attempt to
construe the phrase "relate to" does not give us much
help drawing the line here.

[***LEdHR1B] [1B] [***LEdHR6] [6]In Shaw, we
explained that "[a] law 'relates to' an employee benefit
plan, in the normal sense of the phrase, if it has a
connection with or reference to such a plan." 463 U.S. at
96-97. The latter alternative, at least, can be ruled out.
The surcharges are imposed upon patients and HMO's,
regardless of whether the commercial coverage or
membership, respectively, is ultimately secured by an
ERISA plan, private purchase, or otherwise, with the
consequence that the surcharge statutes cannot be said to
make "reference to" ERISA plans in any manner. Cf.
Greater Washington Bd. of Trade, 506 U.S. at 130
(striking down District of Columbia law that
'specifically refers to welfare benefit plans regulated by
ERISA and on that basis alone is pre-empted'). But this
still leaves us to question whether the surcharge laws
have a "connection with" the ERISA plans, and here an
uncritical literalism is no more help than in trying to
construe "relate to." For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.

[***706] A

[***LEdHR7A] [7A] As we have said before, § 514 indicates Congress's intent to establish the regulation of employee welfare benefit plans "as exclusively a federal concern." 

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523, 68 L. Ed. 2d 402, 101 S. Ct. 1895 (1981). We have found that in passing § 514(a), Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . [and to prevent] the potential for conflict in substantive law . . . requiring [*657] the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." Ingersoll-Rand, 498 U.S. at 142.

This objective was described in the House of Representatives by a sponsor of the Act, Representative Dent, as being to "eliminate the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29197 (1974). Senator Williams made the same point, that "with the narrow exceptions specified in the bill, the substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." Id., at 29933. The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in [*1678] order to permit the nationally uniform administration of employee benefit plans.

Accordingly in Shaw, for example, we had no trouble finding that New York's "Human Rights Law, which prohibited employers from structuring their employee benefit plans in a manner that discriminated on the basis of pregnancy, and [New York's] Disability Benefits Law, which required employers to pay employees specific benefits, clearly 'related to' benefit plans." 463 U.S. at 97. These mandates affecting coverage could have been honored only by varying the subjects of a plan's benefits whenever New York law might have applied, or by requiring every plan to provide all beneficiaries with a benefit demanded by New York law if New York law could have been said to require it for any one beneficiary. Similarly, Pennsylvania's law that prohibited "plans from . . . requiring reimbursement [from the beneficiary] in the event of recovery from a third party" related to employee benefit plans within the meaning of § 514(a). FMC Corp. v. Holliday, 498 U.S. 52, 60, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990). The law "prohibited plans from being structured in a manner requiring reimbursement in the event of recovery from a third party" and "required plan providers to calculate benefit levels in [*658] Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation," thereby "frustrating plan administrators' continuing obligation to calculate uniform benefit levels nationwide." Ibid. Pennsylvania employees who recovered in negligence actions against tortfeasors would, by virtue of the state law, in effect have been entitled to benefits in excess of what plan administrators intended to provide, and in excess of what the plan provided to employees in other States. Along the same lines, New [*707] Jersey could not prohibit plans from setting workers' compensation payments off against employees' retirement benefits or pensions, because doing so would prevent plans from using a method of calculating benefits permitted by federal law. Alessi, supra, at 524. In each of these cases, ERISA pre-empted state laws that mandated employee benefit structures or their administration. Elsewhere, we have held that state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption. See Ingersoll-Rand, supra.

B

[***LEdHR1C] [1C] [***LEdHR8A] [8A] Both the purpose and the effects of the New York surcharge statute distinguish it from the examples just given. The charge differentials have been justified on the ground that the Blues pay the hospitals promptly and efficiently and, more importantly, provide coverage for many subscribers whom the commercial insurers would reject as unacceptable risks. The Blues' practice, called open enrollment, has consistently been cited as the principal reason for charge differentials, whether the differentials resulted from voluntary negotiation between hospitals and payers as was the case prior to the NYPHRM system, or were created by the surcharges as is the case now. See, e. g., Charge Differential Analysis Committee, New York State Hospital Review and Planning Council, Report (1989), reprinted in Joint Appendix in No. 93-7132 (CA2), pp. 702, 705, 706 (J. A. CA2); J. Corcoran, [*659] Superintendent of Insurance, Update of 1984 Position Paper of The New York State Insurance
of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.

There is, indeed, nothing remarkable about surcharges on hospital bills, or their effects on overall cost to the plans and the relative attractiveness of certain insurers. Rate variations among hospital providers are accepted examples of cost variation, since hospitals have traditionally "attempted to compensate for their financial shortfalls by adjusting their price . . . schedules for patients with commercial health insurance." Thorpe, 12 J. Health Politics, Policy, & Law, at 394. Charge differentials for commercial insurers, even prior to state regulation, "varied dramatically across regions, ranging from 13 to 36 percent," presumably reflecting the geographically disparate burdens of providing for the uninsured. Id., at 400; see id., at 398-399; see also, e. g., Trussell 170 (J. A. CA2, at 664); Bobinski, Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured, 24 U. C. D. L. Rev. 255, 267, and n. 44 (1990).

If the common character of rate differentials even in the absence of state action renders it unlikely that ERISA pre-emption was meant to bar such indirect economic influences under state law, the existence of other common state action with indirect economic effects on a plan's costs leaves the intent to pre-empt even less likely. Quality standards, for example, set by the State in one subject area of hospital services but not another would affect the relative cost of providing those services over others and, so, of providing different packages of health insurance benefits. Even basic regulation of employment conditions will invariably affect the cost and price of services.

[*661] Quality control and workplace regulation, to be sure, are presumably less likely to affect premium differentials among competing insurers, but that does not change the fact that such state regulation will indirectly affect what an ERISA or other plan can afford or get for its money. Thus, in the absence of a more exact guide to intended pre-emption than § 514, it is fair to conclude that mandates for rate differentials would not be pre-empted unless other regulation with indirect effects on plan costs would be superseded as well. The bigger the package of regulation with indirect effects that would fall on the respondents' reading of § 514, the less likely it is that federal regulation of benefit plans was intended to eliminate state regulation of health care costs.

An indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself; commercial insurers and HMO's [***708] may still offer more attractive packages [*660] than the Blues. Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.

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Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation and could not be squared with our prior [*1680] pronouncement that "pre-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered [*709] plans, as is the case with many laws of general applicability." *District of Columbia v. Greater Washington Bd. of Trade,* 506 U.S. at 130, n. 1 (internal quotation marks and citations omitted). While Congress's extension of pre-emption to all "state laws relating to benefit plans" was meant to sweep more broadly than "state laws dealing with the subject matters covered by ERISA[,] reporting, disclosure, fiduciary responsibility, and the like," *Shaw,* 463 U.S. at 98, and n. 19, nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern, see *Hillsborough County v. Automated Medical Laboratories, Inc.,* 471 U.S. at 719; 1 B. Furrow, T. Greaney, [*662] S. Johnson, T. Jost, & R. Schwartz, Health Law §§ 1-6, 1-23 (1995).

[*LEdHR7B] [7B]In sum, cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those "conflicting directives" from which Congress meant to insulate ERISA plans. See 498 U.S. at 142. Such state laws leave plan administrators right where they would be in any case, with the responsibility to choose the best overall coverage for the money. We therefore conclude that such state laws do not bear the requisite "connection with" ERISA plans to trigger pre-emption.

C

This conclusion is confirmed by our decision in *Mackey v. Lanier Collection Agency & Service, Inc.,* 486 U.S. 825, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988), which held that ERISA pre-emption falls short of barring application of a general state garnishment statute to participants' benefits in the hands of an ERISA welfare benefit plan. We took no issue with the argument of the *Mackey* plan's trustees that garnishment would impose administrative costs and burdens upon benefit plans, *id.,* at 831, but concluded from the text and structure of ERISA's pre-emption and enforcement provisions that "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits." *Id.,* at 831-832. If a law authorizing an indirect source of administrative cost is not pre-empted, it should follow that a law operating as an indirect source of merely economic influence on administrative decisions, as here, should not suffice to trigger pre-emption either.

The commercial challengers counter by invoking the earlier case of *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985), which considered whether a State could mandate coverage of specified minimum mental-healthcare [*663] benefits by policies insuring against hospital and surgical expenses. Because the regulated policies included those bought by employee welfare benefit plans, we recognized that the law "directly affected" such plans. *Id.,* at 732. Although we went on to hold that the law was ultimately saved from pre-emption [*710] by the insurance saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), respondents proffer the first steps in our decision as support for their argument that all laws affecting ERISA plans through their impact on insurance policies "relate to" such plans and are pre-empted unless expressly saved by the statute. The challengers take *Metropolitan Life* too far, however.

The Massachusetts statute applied not only to "any blanket or general policy of insurance . . . or any policy of accident and sickness insurance" but also to "any employees' health and welfare fund which provided hospital expense and surgical expense benefits." *Id.,* at 730, n. 11. In fact, the State did not even try to defend its law as unrelated to employee benefit plans for the purpose of § 514(a). *Id.,* at 739. As a result, there was no reason to distinguish with any [*1681] precision between the effects on insurers that are sufficiently connected with employee benefit plans to "relate to" the plans and those effects that are not. It was enough to address the distinction bluntly, saying on the one hand that laws like the one in *Metropolitan Life* relate to plans since they "bear indirectly but substantially on all insured benefit plans, . . . requiring them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy," *ibid.,* but saying on the other that "laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans," *id.,* at 741. Even this basic distinction recognizes that not all regulations that would influence the cost of insurance would relate to employee benefit plans within the meaning of § 514(a). If, for example, a State were to regulate sales of insurance by commercial insurers more stringently [*664] than sales by insurers not for profit, the relative cost of commercial insurance would rise; we would nonetheless say, following *Metropolitan Life,* that
such laws "do not 'relate to' benefit plans in the first instance." Ibid. And on the same authority we would say the same about the basic tax exemption enjoyed by nonprofit insurers like the Blues since the days long before ERISA, see Marmor, New York's Blue Cross and Blue Shield, 1934-1990: The Complicated Politics of Nonprofit Regulation, 16 J. Health Politics, Policy, & Law 761, 769 (1991) (tracing New York Blue Cross's special tax treatment as a prepayment organization back to 1934); 1934 N. Y. Laws, ch. 595; and yet on respondents' theory the exemption would necessarily be pre-empted as affecting insurance prices and plan costs.

In any event, Metropolitan Life cannot carry the weight the commercial insurers would place on it. The New York surcharges do not impose the kind of substantive coverage requirement binding plan administrators that was at issue in Metropolitan Life. Although even in the absence of mandated coverage there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate, no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues. As they currently stand, the surcharges do not require plans to deal with only one insurer, or to insure against an [*665] entire category of illnesses they might otherwise choose to leave without coverage.

D


Even more revealing is the National Health Planning and Resources Development Act of 1974 (NHPRDA), Pub. L. 93-641, 88 Stat. 2225, § 1-3, repealed by Pub. L. 99-660, title VII, § 701(a), 100 Stat. 3799, which [*1682] was adopted by the same Congress that passed ERISA, and only months later. The NHPRDA sought to encourage and help fund state responses to growing health care costs and the widely diverging availability of health services. § 2, 88 Stat. 2226-2227; see generally National Gerimiedical Hospital and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378, 383-388, 69 L. Ed. 2d 89, 101 S. Ct. 2415 (1981). It provided for the organization and partial funding of regional "health systems agencies" responsible for gathering data as well as for planning and developing health resources in designated health service areas. 88 Stat. 2229-2242. The scheme called for designating state health planning and [*666] development agencies in qualifying States to coordinate development of health services policy. Id., at 2242-2244. These state agencies, too, would be eligible for federal funding, id., at 2249, including grants "for the purpose of demonstrating the effectiveness of State Agencies regulating rates for the provision of health care . . . within the State." Ibid. Exemption from ERISA pre-emption is nowhere mentioned as a prerequisite to the receipt of such funding; indeed, the only legal prerequisite to be eligible for rate regulation grants was "satisfactory evidence that the State Agency has under State law the authority to carry out rate regulation functions in accordance with this section . . . ." Ibid.

[***LedHR1F] [1F] The Secretary was required to provide technical assistance to the designated agencies by promulgating "[a] uniform system for calculating [*712] rates to be charged to health insurers and other health institutions payors by health service institutions." Id., at 2254. Although the NHPRDA placed substantive restrictions on the system the Secretary could establish, the subject matter (and therefore the scope of envisioned state regulation) covers the same ground that New York's surcharges tread. The Secretary's system was supposed to:

"(A) be based on an all-inclusive rate for various categories of patients . . . .[

"(B) provide that such rates reflect the true cost of providing services to each such category of patients . . . .["
“(C) provide for an appropriate application of such system in the different types of institutions . . . [and] “(D) provide that differences in rates to various classes of purchasers (including health insurers, direct service payors, and other health institution payors) be based on justified and documented differences in the costs of operation of health service institutions made [*667] possible by the actions of such purchasers.” Id., at 2254-2255.

The last-quoted subsection seems to envision a system very much like the one New York put in place, but the significant point in any event is that the statute's provision for comprehensive aid to state health care rate regulation is simply incompatible with pre-emption of the same by ERISA. To interpret ERISA's pre-emption provision as broadly as respondents suggest would have rendered the entire NHPRDA utterly nugatory, since it would have left States without the authority to do just what Congress was expressly trying to induce them to do by enacting the NHPRDA. Given that the NHPRDA was enacted after ERISA and by the same Congress, it just makes good sense to reject such an interpretation. n6

n6 The history of Medicare regulation makes the same point, confirming that Congress never envisioned ERISA pre-emption as blocking state health care cost control, but rather meant to encourage and rely on state experimentation like New York's. See generally K. Davis, G. Anderson, D. Rowland, & E. Steinberg, Health Care Cost Containment 23-25, 81, 99 (1990). Since the time DRG systems were tried out in the 1960's and 1970's, Congress has consistently shown its awareness and encouragement of controlled payment alternatives to the federal regulatory scheme. The Social Security Amendments of 1967, Pub. L. 90-248, § 402(a), 81 Stat. 930-931, as amended 42 U.S.C. § 1395b-1, for example, granted the Secretary of Health, Education, and Welfare (now Health and Human Services) the authority to waive Medicare rules to allow for physician and hospital reimbursement according to approved state payment schedules. In the Social Security Amendments of 1972, Pub. L. 92-603, § 222(a)(5), 86 Stat. 1391, Congress specifically called upon the Secretary to report on prospective reimbursement schemes that had been thus favored already or could be in the future. Later on, after the development of all-payor ratesetting schemes like the NYPRM and New Jersey's Health Care Cost Reduction Act of 1978, 1978 N. J. Laws, ch. 83, Congress's Medicare waiver provisions evolved to the point of explicit reference to a State's commitment to apply its hospital reimbursement control system to a substantial portion of hospitals and inpatient services statewide. See 42 U.S.C. §§ 1395ww(c)(1), (c)(5)(A). Indeed, in its Report on the Social Security Amendments of 1983, the House Committee on Ways and Means recommended that States should not be held to traditional DRG-based reimbursement systems. "State systems provide a laboratory for innovative methods of controlling health care costs, and should, therefore, not be limited to one methodology." H. R. Rep. No. 98-25, pt. 1, pp. 146-147 (1983). The Committee concluded that "State systems covering all payors have proven effective in reducing health costs and should be encouraged. Such State programs may be useful models for our national system." Id., at 147-148. While the history of Medicare waivers and implementing legislation enacted after ERISA itself is, of course, not conclusive proof of the congressional intent behind ERISA, the fact that Congress envisioned state experiments with comprehensive hospital reimbursement regulation supports our conclusion that ERISA was not meant to pre-empt basic rate regulation.

[*668] [**1683] III

That said, we do not hold today [***713] that ERISA pre-empted only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter. See, e. g., Ingersoll-Rand, 498 U.S. at 139; Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987); Shaw, 463 U.S. at 98. We acknowledge that a state law might 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, and that such a state law might indeed be pre-empted under § 514. But as we have shown, New York's surcharges do not fall into either category; they affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.
The judgment of the Court of Appeals is therefore reversed, and the cases are remanded for further proceedings consistent with this opinion.

*It is so ordered.*

**REFERENCES:** Return To Full Text Opinion

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- 43 Am Jur 2d, Insurance 18; 60A Am Jur 2d, Pensions and Retirement Funds 118, 124
- 29 USCS 1144(a)
- Benefits Coordinator 37,607, 37,627
- Employment Coordinator B-10,506
- Pension Coordinator 52,009, 80,120, 80,141
- L Ed Digest, States, Territories, and Possessions 38.2
- L Ed Index, Accident and Health Insurance; Pensions and Retirement; Preemption and Preemptive Rights
- ALR Index, Employee Retirement Income Security Act; Health and Accident Insurance; Health Organizations; Insurance and Insurance Companies; Pre-emption

Annotation References:

- When is state or local law pre-empted by Employee Retirement Income Security Act of 1974 ,as amended (ERISA) (29 USCS 1001 et seq.)-- Supreme Court cases. 121 L Ed 2d 783.

  Supreme Court's views as to whether enactment, amendment, or repeal of statute pending appeal applies to such appeal. 108 L Ed 2d 1061.

- Construction and application of pre-emption exemption, under Employee Retirement Income Security Act (29 USCS 1001 et seq.), for state laws regulating insurance, banking, or securities (29 USCS 1144(b)(2)). 87 ALR Fed 797.
LEXSEE 117 S CT 832

CALIFORNIA DIVISION OF LABOR STANDARDS ENFORCEMENT, ET AL.,
PETITIONERS v. DILLINGHAM CONSTRUCTION, N. A., INC., AND MANUEL
J. ARCEO, DBA SOUND SYSTEMS MEDIA

No. 95-789.

SUPREME COURT OF THE UNITED STATES

519 U.S. 316; 117 S. Ct. 832; 136 L. Ed. 2d 791; 1997 U.S. LEXIS 691; 65
U.S.L.W. 4097; 133 Lab. Cas. (CCH) P58,209; 20 Employee Benefits Cas. (BNA) 2425;
3 Wage & Hour Cas. 2d (BNA) 1255; 97 Cal. Daily Op. Service 1066; 97 Daily Journal
DAR 1590; 10 Fla. L. Weekly Fed. S 279

November 5, 1996, Argued
February 18, 1997, Decided

PRIOR HISTORY: ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS FOR
LEXIS 4524.

DISPOSITION: 57 F.3d 712, reversed and remanded.

CASE SUMMARY:

PROCEDURAL POSTURE: Petitioner California
Division of Labor Standards Enforcement sought review
of the decision by the United States Court of Appeals for
the Ninth Circuit that the preemption provision of the
Employee Retirement Income Security Act of 1974, 29
U.S.C.S. § 1001 et seq., superseded the state prevailing
wage law for apprentices in unapproved programs
working on public projects, in respondent contractors'
action to enjoin petitioner.

OVERVIEW: Petitioner sought review of the appeals
court decision holding that the preemption provision of
the Employee Retirement Income Security Act of 1974
(ERISA), 29 U.S.C.S. § 1001 et seq., superseded the
state prevailing wage law for apprentices in unapproved
programs. Respondents brought the original action to
prevent petitioner from halting payment on the public
contract due to violation of the state prevailing wage law
applicable to apprentices, Cal. Lab. Code § 1777.5
(1997). The Court noted that the state apprenticeship
programs were not necessarily ERISA plans, and
concluded that United States Congress did not intend that
ERISA preempt state prevailing wage laws applicable to
apprenticeship programs. California's prevailing wage
laws for apprentices and apprenticeship standards did not
have a "connection with," or "relate to" ERISA plans.
The Court reversed the judgment.

OUTCOME: The Court reversed the judgment that the
preemption provision of the Employee Retirement
Income Security Act of 1974 (ERISA) superseded the
state prevailing wage law for apprentices in unapproved
programs. The Court held that the savings clause of
ERISA prevented the preemption of the state law
applicable to respondent contractors' employees in the
public project.

CORE TERMS: apprenticeship, pre-emption,
apprentice, wage, prevailing wage, contractor, public
works, Fitzgerald Act, state law, pre-empted, training,
regulation, electronic, prevailing wage law, superseded,
employee welfare benefit plan, employee benefit,
employee benefit plan, state regulation, saving clause,
expansive, pre-empt, intend, prevailing, journeyman,
surcharge, separate fund, promulgated, vacation,
coverage

LexisNexis(R) Headnotes
The Davis-Bacon Act, 40 U.S.C.S. §§ 276a to 276a-5, requires that the wages paid on federal public works projects equal wages paid in the project's locale on similar, private construction jobs.

California requires contractors who are awarded public works projects to pay their workers not less than the general prevailing rate of per diem wages for work of a similar character in the locality in which the public work is performed. Cal. Lab. Code § 1771 (1989).

Under both the Davis-Bacon Act and California's prevailing wage law, public works contractors may pay less than the prevailing journeyman wage to apprentices in apprenticeship programs that meet standards promulgated under the National Apprenticeship Act, 29 U.S.C.S. § 50; 29 C.F.R. § 29.5(b)(5) (1996); Cal. Lab. Code § 1777.5 (1997).


California's state apprenticeship agency, the California Apprenticeship Council (CAC), has been authorized under 29 C.F.R. § 29.12 to approve apprenticeship programs for federal purposes. California has also charged the CAC with approving apprenticeship programs for purposes of California's prevailing wage statute. Cal. Lab. Code § 3071 (1989).

An apprenticeship program in California may be sponsored by an individual employer, an individual labor union, a group of employers, a group of labor organizations, or by a joint management-labor venture, a so-called joint apprenticeship committee. Cal. Lab. Code § 3075 (1989).

A law relates to a covered employee benefit plan for purposes of § 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C.S. § 1144(a), if it: (1) has a connection with; or (2) reference to such a plan.

A law that does not refer to Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1001 et seq., plans may yet be pre-empted if it has a "connection with" ERISA plans. To determine whether a state law has the forbidden connection, the court looks both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans.

Where federal law is said to bar state action in fields of traditional state regulation, courts assume that the historic police powers of the states were not to be superseded by the federal act unless that was the clear and manifest purpose of United States Congress.


A fund established to pay vacation benefits constitutes an employee welfare benefit plan.
Income Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1001 et seq., plan. An apprenticeship program meeting the substantive standards set forth in the Fitzgerald Act, 29 U.S.C.S. § 50, regulations can be approved whether or not its funding apparatus is of a kind as to bring it under ERISA.

Public Contracts Law > Business Aids & Assistance > Labor Laws

[H117] To supply apprentices eligible for the apprenticeship wage to federal public works contractors, an apprenticeship program must meet the standards promulgated by California under the Fitzgerald Act, 29 U.S.C.S. § 50.

SYLLABUS: California requires a public works project contractor to pay its workers the prevailing wage in the project's locale, but allows payment of a lower wage to participants in a state-approved apprenticeship program. After respondent Dillingham Construction subcontracted some of the work on its state contract to respondent Arceo, doing business as Sound Systems Media, the latter entered a collective-bargaining agreement that included an apprenticeship wage scale and provided for affiliation with an apprenticeship committee that ran an unapproved program. Sound Systems Media thereafter relied on that committee for its apprentices, to whom it paid the apprentice wage. Petitioner California Division of Apprenticeship Standards issued a notice of noncompliance to both Dillingham and Sound Systems Media, charging that paying the apprentice wage, rather than the prevailing journeyman wage, to apprentices from an unapproved program violated the state prevailing wage law. Respondents sued to prevent petitioners from interfering with payment under the prevailing wage law. Respondents sued to prevent petitioners from interfering with payment under the subcontract, alleging, inter alia, that § 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA) pre-empted enforcement of the state law. The District Court granted petitioners summary judgment, but the Ninth Circuit reversed, holding that the apprenticeship program was an "employee welfare plan" under ERISA § 3(1), and that the state law "related to" the plan and was therefore superseded under § 514(a).

Held: California's prevailing wage law does not "relate to" employee benefit plans, and thus is not pre-empted by ERISA. Pp. 323-324.

(a) A state law "relate[s] to" a covered employee benefit plan for § 514(a) purposes if it (1) has a "connection with" or (2) "reference to" such a plan. E. g., District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125, 129, 121 L. Ed. 2d 513, 113 S. Ct. 580. A law has the forbidden reference where it acts immediately and exclusively upon ERISA plans, as in Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 100 L. Ed. 2d 836, 108 S. Ct. 2182, or where the existence of such plans is essential to its operation, as in, e. g., Greater Washington Bd. of Trade, supra, and Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 112 L. Ed. 2d 474, 111 S. Ct. 478. To determine whether a state law has a connection with ERISA plans, this Court looks both to ERISA's objectives as a guide to the scope of the state law that Congress understood would survive, New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656, 131 L. Ed. 2d 695, 115 S. Ct. 1671, and to the nature of the law's effect on ERISA plans, 514 U.S. at 658-659. Where federal law is said to pre-empt state action in fields of traditional state regulation, this Court assumes that the States' historic police powers are not superseded unless that was Congress' clear and manifest purpose. E. g., 514 U.S. at 655. Pp. 323-325.

(b) Because it appears that approved apprenticeship programs need not be ERISA plans, the California law does not make "reference to" such plans. On its face, the law seems to allow the lower apprentice wage only to a contractor who acquires apprentices through a "joint apprenticeship committee"--an apprenticeship program sponsored by the collective efforts of management and organized labor. To comport with federal law, the expenses of such a committee must be defrayed out of moneys placed into a separate fund, the existence of which triggers ERISA coverage. However, applicable regulations make clear that the class of apprenticeship program sponsors who may provide approved apprentices under California law is broad enough to include a single employer who defrays the costs of its program out of general assets. An employee benefit program so funded, and not paid for through a separate fund, is not an ERISA plan. See, e. g., Massachusetts v. Morash, 490 U.S. 107, 115, 104 L. Ed. 2d 98, 109 S. Ct. 1668. The California law is indifferent to the funding, and, thus, to the ERISA coverage, of apprenticeship programs; accordingly, it makes no "reference to" ERISA plans. Pp. 325-328.

(c) Nor does the California law have a "connection with" ERISA plans. In every relevant respect, that law is indistinguishable from the New York statute upheld in Travelers, supra. As with the New York statute, the Court discerns no congressional intent to pre-empt the areas of traditional state regulation with which the California law is concerned. 514 U.S. at 661. And, like the New York statute, the California prevailing wage law does not bind ERISA plans--legally or as a practical matter--to anything. It merely provides some measure of economic incentive to apprenticeship programs to
comport with the State's apprenticeship standards by authorizing lower wage payments to workers enrolled in approved apprenticeship programs. Cf. 514 U.S. at 668. This Court could not hold the California law superseded based on so tenuous a relation without doing grave violence to the presumption that Congress does not intend the pre-emption of state laws in traditionally state-regulated areas. Pp. 328-334.

JUDGES: THOMAS, J., delivered the opinion for a unanimous Court. SCALIA, J., filed a concurring opinion, in which GINSBURG, J., joined, post, p. 334.

OPINIONBY: THOMAS


The State of California requires a contractor on a public works project to pay its workers the prevailing wage in the project's locale. An exception to this requirement permits a contractor to pay a lower wage to workers participating in an approved apprenticeship program. This case presents the question whether the pre-emption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. § 1001 et seq., supersedes California's prevailing wage law to the extent that the law prohibits payment of an apprentice wage to an apprentice trained in an unapproved program. We conclude that California's law does not "relate to" employee benefit plans, and thus is not pre-empted.

I

A

Since 1931, [HN1] the Davis-Bacon Act, 46 Stat. 1494, as amended, 40 U.S.C. § 276a to 276a-5, has required that the wages paid on federal public works projects equal wages paid in the project's locale on similar, private construction jobs. [HN2] California, in 1937, adopted a similar statute, which requires contractors who are awarded public works projects to pay their workers "not less than the general prevailing rate of per diem wages for work of a similar character in the locality in which the public work is performed." Cal. Lab. Code Ann. § 1771 (West 1989). [HN3] Under both the Davis-Bacon Act and California's prevailing wage law, public works contractors may pay less than the prevailing journeyman wage to apprentices in apprenticeship programs that meet standards promulgated under the National Apprenticeship Act, 50 Stat. [*320] 664, as amended, 29 U.S.C. § 50 (known popularly as the Fitzgerald Act). n1 See 29 CFR § 29.5(b)(5) (1996); Cal. Lab. Code Ann. § 1777.5 (West 1989 and Supp. 1997). In most circumstances, California public works contractors are not obliged to employ apprentices, but if they do, the apprentice wage is only permitted for those apprentices in approved programs.

n1 [HN4] The Fitzgerald Act provides: "The Secretary of Labor is authorized and directed to formulate and promote the furtherance of labor standards necessary to safeguard the welfare of apprentices, to extend the application of such standards by encouraging the inclusion thereof in contracts of apprenticeship, to bring together employers and labor for the formulation of programs of apprenticeship, [and] to cooperate with State agencies engaged in the formulation and promotion of standards of apprenticeship . . . ." 29 U.S.C. § 50.


[HN6] An apprenticeship program in California may be sponsored by an individual employer, an individual labor union, a group of employers, a group of labor organizations, or by a joint management-labor venture (a so-called joint apprenticeship committee). See Cal. Lab. Code Ann. § 3075 (West 1989).
In the spring of 1987, respondent Dillingham Construction was awarded a public works contract as the general contractor for the construction of the Sonoma County Main Adult Detention Facility. Dillingham subcontracted electronic installation work to respondent Manuel J. Arceo, doing business as Sound Systems Media.

When Sound Systems Media was awarded the subcontract, it was signatory to a collective-bargaining agreement that provided a wage scale for apprentices, and required Sound Systems Media to contribute to a CAC-approved apprenticeship program, the Northern California Sound and Communications Joint Apprenticeship Training Committee.

In May 1988, after work on the project was underway, the existing union withdrew its representation of Sound Systems Media employees. Two months later, Sound Systems Media entered a new collective-bargaining agreement with a different union. That agreement, like the earlier one, included a scale of wages for apprentices and provided for an affiliation with a joint apprenticeship committee, the Electronic and Communications Systems Joint Apprenticeship Training Committee (Electronic and Communications Systems JATC). Sound Systems Media relied on this new committee for its apprentices, to whom it paid the apprentice wage provided in the collective-bargaining agreement. The Electronic and Communications Systems JATC, however, did not seek CAC approval until August 1989 and did not gain approval until October 1990. That approval was not retroactive.

In March 1989, yet another union filed a complaint against Sound Systems Media with petitioner Division of Apprenticeship Standards of the California Department of Industrial Relations. Petitioner issued a notice of noncompliance to both Dillingham Construction and Sound Systems Media, charging that Sound Systems Media had violated Cal. Lab. Code Ann. § 1771 (West 1989) by paying the apprentice wage, rather than the prevailing journeyman wage, to apprentices from a non-approved program. The County of Sonoma was ordered to withhold certain moneys from Dillingham Construction for the violation.

Respondents filed suit to prevent petitioners from interfering with payment under the subcontract. Their complaint alleged, inter alia, that ERISA pre-empted enforcement of the prevailing wage law. Respondents argued that the Electronic and Communications Systems JATC was an "employee welfare benefit plan" within the meaning of ERISA § 3(1), 29 U.S.C. § 1002(a), n2 and that California's prevailing wage statute "relate[d] to" it, and was therefore superseded by ERISA's pre-emption provision, § 514(a), 29 U.S.C. § 1144(a). n3 The District Court agreed that the prevailing wage statute "relate[d] to" ERISA plans, but concluded [*323] that pre-emption was forestalled by ERISA's saving clause, § 514(d), 29 U.S.C. § 1144(d). n4 [*837] Pre-emption of the prevailing wage statute, the District Court determined, would "impair the purposes of the Fitzgerald Act and its regulations within the meaning of ERISA's savings clause." Dillingham Constr. N. A., Inc. v. County of Sonoma, 778 F. Supp. 1522, 1530 (ND Cal. 1991).

n2 Section 3(1) defines an "employee welfare benefit plan" as: [HN7] "Any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants . . . (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds or prepaid legal services . . . " 29 U.S.C. § 1002(1) (emphasis added).

n3 The pre-emption clause provides that ERISA [HN8] "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a).

n4 ERISA's saving clause provides that [HN9] "nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any laws of the United States . . . or any rule or regulation issued under any such law." 29 U.S.C. § 1144(d).

The Court of Appeals for the Ninth Circuit reversed. 57 F.3d 712 (1995). Agreeing with the District Court, the Ninth Circuit held that the Electronic and Communications Systems JATC was an employee welfare benefit plan and that § 1777.5 "relate[d] to" it. 57 F.3d at 718-719. Because California's prevailing wage statute was not an "enforcement mechanism" of the Fitzgerald Act, however, the Ninth Circuit parted company with the District Court and held that § 1777.5 was not preserved by ERISA's saving clause. 57 F.3d at 721. The decision of the Court of Appeals accorded with that of the Court of Appeals for the Tenth Circuit in National Elevator Industry, Inc. v. Calhoon, 957 F.2d 1555, cert. denied, 506 U.S. 953, 121 L. Ed. 2d 331, 113 S. Ct. 406 (1992). Both decisions conflict--as to whether
a state prevailing wage law "relate[s] to" apprenticeship programs, and as to the reach of the saving clause--with that [***799] of the Eighth Circuit in Minnesota Chapter of Associated Builders and Contractors, Inc. v. Minnesota Dept. of Labor and Industry, 47 F.3d 975 (1995). We granted certiorari, 517 U.S. 1133 (1996), and now reverse.

II

Both lower courts determined, and neither party disputes, that the Electronic and Communications Systems JATC was a "plan, fund, or program [that] was established or is maintained for the purpose of providing for its participants . . . [**324] apprenticeship or other training programs." § 3(1), 29 U.S.C. § 1002(1). The question thus presented to us is whether California's prevailing wage statute "relate[s] to" that "employee welfare benefit plan" within the meaning of ERISA's pre-emption clause.


[HN12] A law that does not refer to ERISA plans may yet be pre-empted if it has a "connection with" ERISA plans. Two Terms ago, we recognized that an "uncritical literalism" in applying [***800] this standard offered scant utility in determining Congress' intent as to the extent of § 514(a)'s reach. Travelers, 514 U.S. at 656. Rather, to determine whether a state law has the forbidden connection, we look both to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," ibid., as well as to the nature of the effect of the state law on

[***HR3] ERISA plans, 514 U.S. at 658-659.

As is always the case in our pre-emption jurisprudence, [HN13] where "federal law is said to bar state action in fields of traditional state regulation, . . . we have worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" 514 U.S. at 655 (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 91 L. Ed. 1447, 67 S. Ct. 1146 (1947)) (citation omitted).

A

Respondents and several of their amici urge us to conclude that § 1777.5 makes "reference to" ERISA plans. Because it seems that approved apprenticeship programs need not necessarily be ERISA plans, we decline to do so.

On its face, § 1777.5 appears to allow the lower apprentice wage only to a contractor who acquires apprentices through a "joint apprenticeship committee"--an apprenticeship program sponsored by the collective efforts of management and organized labor. See Cal. Lab. Code Ann. § § 3075, 3076 (West 1989). Were this the true extent of the prevailing [*326] wage law's reach, respondents' "reference to" argument might be more persuasive. The CAC has, however, promulgated
regulations making clear that the class of apprenticeship program sponsors who may provide approved apprentices is broader. See 8 Cal. Code Regs. § 230.1(a) (1992) ("Registered apprentices can only be obtained from the Apprenticeship Committee of the craft or trade in the area of the site of the public work") (emphasis added); id., § 228(c) (defining an apprenticeship committee as "an apprenticeship program sponsor"); Cal. Lab. Code Ann. § 3075 (West 1989) (stating that an "apprenticeship program sponsor may be a joint apprenticeship committee, unilateral management or labor apprenticeship committee, or an individual employer"). An apprenticeship program, it would seem, can be maintained by a single employer, and its costs can be defrayed out of that employer's general assets.

To comport with § 302(c)(6) of the Labor-Management Relations Act, 1947, 61 Stat. 157, as amended, 29 U.S.C. § 186(c)(6), the expenses of any joint apprenticeship committee must be defrayed out of moneys placed into a separate fund. The existence of that fund triggers ERISA coverage over programs like that of the Electronic and Communications Systems JATC. See ERISA Advisory Op. No. 94-14A (Apr. 20, 1994). But [HN14] an employee benefit program not funded through a separate fund is not an ERISA plan. In Massachusetts v. Morash, 490 U.S. 107, 104 L. Ed. 2d 98, 109 S. Ct. 1668 (1989), we recognized a distinction between vacation benefits paid out of an accumulated fund and those paid out of an employer's general assets. [HN15] A fund established to pay vacation benefits, we held, constituted an employee welfare benefit plan; the [***801] policy at issue in Morash, whereby vacation benefits were paid out of general assets, did not. The distinction, we concluded, was compelled by ERISA's object and policy:

"In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees [*327] benefits from accumulated funds. To that end, it established extensive reporting, disclosure, [***839] and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." Id., at 115 (citation and footnote omitted).

Benefits paid out of an employer's general assets presented risks indistinguishable from "the danger of defeated expectations of wages for services performed," a hazard with which ERISA is unconcerned. Ibid.

The Secretary has carried this funded/unfunded distinction into areas that are, we think, analogous to that of apprenticeship programs. See, e. g., 29 CFR § 2510.3-1(k) (1994) (scholarship programs paid for out of an employer's general assets are not ERISA plans); § 2510.3-1(b)(3)(iv) (training provided on the job with general assets does not constitute ERISA plan); see also ERISA Advisory Op. No. 94-14A (Apr. 20, 1994) (apprenticeship programs paid for out of trust funds are ERISA plans); ERISA Advisory Op. No. 83-32A (June 21, 1983) (in-house professional development program financed out of general assets is not an ERISA plan). Although none of these regulations specifically answers the question whether an unfunded apprenticeship program is covered by ERISA, they suggest--as does our decision in Morash--that it is not. n5

n5 We are told that "most state-approved apprenticeship programs in the construction industry in California appear to be ERISA plans." Brief for United States as Amicus Curiae 17, n. 8. Between April and June 1994, California had 175 joint apprenticeship programs and 13 "unilateral" ones. Ibid. As noted above, the costs of the joint apprenticeship programs are necessarily defrayed out of separate funds. The Government points out that some of the 13 unilateral programs may also have separate funds. Ibid. No party before us has established that all programs do. Cf. The Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 711 (CA2 1994) (noting that 88% of "non-elderly Americans have private health care insurance through [ERISA] plans"), rev'd by New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995).

[*328] [HN16] Section 1777.5, then, "functions irrespective of . . . the existence of an ERISA plan." Ingersoll-Rand Co., 498 U.S. at 139. An apprenticeship program meeting the substantive standards set forth in the Fitzgerald Act regulations can be approved whether or not its funding apparatus is of a kind as to bring it under ERISA. See Southern Cal. ABC, 4 Cal. 4th at 429, n. 1, 841 P.2d at 1014, n. 1. Section 1777.5 is indifferent to the funding, and attendant ERISA coverage, of apprenticeship programs. Accordingly, California's prevailing wage statute does not make reference to ERISA plans. We turn now to the question whether it nonetheless has a "connection with" such plans.

B

In Shaw v. Delta Air Lines, Inc., we held that the New York Human Rights Law, which prohibited
"employers from structuring their employee [***802] benefit plans in a manner that discriminates on the basis of pregnancy," and New York's Disability Benefits Law, which required "employers to pay employees specific benefits," "relate[d] to" ERISA plans. 463 U.S. at 97. Shaw and other of our ERISA pre-emption decisions, see, e.g., FMC Corp. v. Holliday, 498 U.S. 32, 112 L. Ed. 2d 336, 111 S. Ct. 403 (1990); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 68 L. Ed. 2d 402, 101 S. Ct. 1895 (1981), presented us with state statutes that "mandated employee benefit structures or their administration"; in those cases, we concluded that these requirements amounted to "connection[s] with" ERISA plans. See Travelers, 514 U.S. at 658.

The state law at issue in Travelers, our most recent exercise in ERISA pre-emption, stands in considerable contrast. That statute regulated hospital rates, and required hospitals to exact surcharges (ranging from 9% to 24% of the rate set under the statute) from patients whose hospital bills were paid by any of a variety of non-Blue Cross/Blue Shield providers. Because ERISA plans, as might be expected, were predominant among the purchasers of insurance, see Brief [*329] for Petitioner in Travelers, O. T. 1994, No. 93-1408, p. 1-2, the statute was asserted to run afoul of ERISA's pre-emption provision. [**840] The differential rates charged to commercially insured patients and to patients insured by Blue Cross/Blue Shield (collectively "the Blues") made commercial insurance relatively more expensive--and relatively less attractive. The resulting cost variations encouraged insurance purchasers, including ERISA plans, to provide insurance benefits through the Blues. Commercial insurers argued that these cost variations and their resulting economic effects had a "connection with" those ERISA plans, requiring pre-emption of the law that dictated them.

We upheld the statute. The "indirect economic influence" of the surcharge, we noted, did not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." 514 U.S. at 659. Nor did the indirect influence of the surcharge "preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wished[d] to provide one." 514 U.S. at 660. Indeed, if ERISA were concerned with any state action--such as medical-care quality standards or hospital workplace regulations--that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach, and the words "relate to" would limit nothing. 514 U.S. at 660-661. We also noted that several States regulated hospital charges at the time that ERISA was enacted, and yet neither ERISA's language nor legislative history made any mention of pre-empting these state efforts. n6

n6 In fact, the very same Congress that enacted ERISA adopted, a short time later, the National Health Planning and Resources Development Act of 1974 (NHPRDA), Pub. L. 93-641, 88 Stat. 2225, § § 1-3, repealed by Pub. L. 99-660, title VII, § 701(a), 100 Stat. 3799, which "sought to encourage and help fund state responses to growing health care costs and the widely diverging availability of health services." Travelers, supra, at 665. The NHPRDA had in mind a system akin to New York's, and we thought it unlikely that the Congress that enacted ERISA would later have sought to encourage a state program that ERISA would pre-empt.

[*330] We think that, in every relevant [***803] respect, California's prevailing wage statute is indistinguishable from New York's surcharge program. At the outset, we note that apprenticeship standards and the wages paid on state public works have long been regulated by the States. As discussed in Part I-A, supra, California has required that prevailing wages be paid on its public works projects for nearly as long as Congress has required them to be paid on federal projects, and for more than 40 years prior to the enactment of ERISA. Similarly, California has legislated in the apprenticeship area for the better part of this century. See, e.g., The Shelley-Maloney Apprentice Labor Standards Act, 1939 Cal. Stat. 220, codified at Cal. Lab. Code § 3070 et seq. Congress, in the Fitzgerald Act, recognized pre-existing state efforts in regulating apprenticeship programs and apparently expected that those efforts would continue. See 29 U.S.C. § 50 (directing the Secretary of Labor "to cooperate with State agencies engaged in the formulation and promotion of standards of apprenticeship"); see also H. R. Rep. No. 945, 75th Cong., 1st Sess., 2 (1937).

That the States traditionally regulated these areas would not alone immunize their efforts; ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation. The wages to be paid on public works projects and the substantive standards to be applied to apprenticeship training programs are, however, quite remote from the areas with which ERISA is expressly concerned--"reporting, disclosure, fiduciary responsibility, and the like." Travelers, supra, 514 U.S. at 661 (quoting Shaw, 463 U.S. at 98). A reading of § 514(a) resulting in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be "unsettling," Travelers, [***841] 514 U.S. at 665. n7
of indication in ERISA and its legislative history of any intent on the part of Congress to pre-empt state apprenticeship training standards, or state prevailing wage laws that incorporate them, we are reluctant to alter our ordinary "assumption that the historic police powers of the States were not to be superseded by the Federal Act." Rice, 331 U.S. at 230. n8 Accordingly, as in [*332] Travelers, we address the substance of the California statute with the presumption that ERISA did not intend to supplant it.

n7 In Travelers, we were convinced that Congress did not intend pre-emption of New York's law both by the lack of any positive indication that Congress harbored such an intent, and by indirect evidence--the NHRPRA--that the Congress that enacted ERISA did not intend to supersede state laws like New York's regulation of hospital charges. 514 U.S. at 664-668. We face here a similar absence of positive indications on the part of Congress that apprenticeship or prevailing wage statutes would be superseded. The United States further argues that the Fitzgerald Act is analogous to the NHRPRA: Were we to hold § 1777.5 pre-empted "that result 'would leave States without the authority to do just what Congress was expressly trying to induce them to do by enacting the Fitzgerald Act.'" Brief for United States as Amicus Curiae 22 (internal quotation marks and brackets omitted). In Travelers, we thought it implausible that the Congress that enacted ERISA intended to pre-empt state laws that the same Congress subsequently sought to encourage with the NHRPRA. It is not, however, inconceivable for the ERISA Congress to intend the pre-emption of state statutes resulting from the pre-existing Fitzgerald Act. So, the United States' analogy is not decisive. It does, however, aid our conclusion that Congress' silence on the pre-emption of state statutes that Congress previously sought to foster counsels against pre-emption here.

n8 Respondents and two of their amici point to bills introduced in Congress for the purpose, at least in part, of overruling lower court decisions holding prevailing wage statutes like California's pre-empted. See Brief for Respondent 23, Brief for Signatory Members of the Coalition to Preserve ERISA Pre-emption as Amicus Curiae 11, and Brief for Associated Builders and Contractors Inc. et al., as Amici Curiae 26-27 (all citing H. R. 1036, 103d Cong., 1st Sess. (1993); S. 1580, 103d Cong., 1st Sess. (1993)). It is argued that Congress' unwillingness to amend § 514(a) in response to these decisions is evidence that Congress believed that those opinions accurately interpreted ERISA's pre-emptive scope. We have rejected similar arguments before. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 114, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989); United States v. Price, 361 U.S. 304, 313, 4 L. Ed. 2d 334, 80 S. Ct. 326 (1960) ("The views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one").

Like New York's surcharge requirement, the apprenticeship portion of the prevailing wage statute does not bind ERISA plans to anything. No apprenticeship program is required by California law to meet California's standards. See Southern Cal. ABC, 4 Cal. 4th at 428, 841 P.2d at 1013. If a contractor chooses to hire apprentices for a public works project, it need not hire them from an approved program (although if it does not, it must pay these apprentices journeyman wages). So, apprenticeship programs that have not gained CAC approval may still supply public works contractors with apprentices. Unapproved apprenticeship programs also may supply apprentices to private contractors. n9 The effect of § 1777.5 on ERISA apprenticeship programs, therefore, is merely to provide some measure of economic incentive to comport with the State's requirements, at least to the extent that those programs seek to provide apprentices who can work on public works projects at a lower wage.

n9 In New York, we are told, "approximately half of all construction is not subject to state or federal prevailing wage requirements." Brief for State of Washington et al. as Amici Curiae 21, n. 14 (citing F. W. Dodge Division, McGraw-Hill Information Systems, Inc. (1996)).

Apprenticeship programs have confronted these differential economic incentives since well before the enactment of ERISA, and would face them today even if California had no prevailing wage statute. [HN17] To supply apprentices eligible for the apprenticeship wage to federal public works contractors, an apprenticeship program must meet the standards promulgated by California under the Fitzgerald Act. n10 What is [*333] more, with or without [**842] the possibility of being able to provide apprentices eligible for a lower wage on public projects, apprenticeship programs in California
have other incentives to seek CAC approval. See
Southern Cal. **805 ABC, supra, at 429, 841 P.2d at
1013 ("In California, additional financial incentives exist
in the form of direct financial subsidies for training
provided by approved programs," and because "an
apprentice who completes an approved training program
obtains a certificate of completion naming him or her a
skilled journeyman in the chosen trade"). It cannot be
gainsaid that § 1777.5 has the effect of encouraging
apprenticeship programs--including ERISA plans--to
meet the standards set out by California, but it has not
been demonstrated here that the added inducement
created by the wage break available on state public
works projects is tantamount to a compulsion upon
apprenticeship programs. n11

n10 It may also be that, because California's
standards are "substantively similar," Southern
California ABC, 4 Cal. 4th at 434, 841 P.2d at
1017, to the Federal standards, multistate
apprenticeship programs are not saddled with
"the administrative and financial burden of
complying with conflicting directives among
States or between States and the Federal
Government." Ingersoll-Rand Co. v. McClendon,
498 U.S. 133, 142, 112 L. Ed. 2d 474, 111 S. Ct.
478 (1990). Then again, the area of
apprenticeship training may be one where
uniformity of substantive standards across States
is impossible. See Brief for United States as
Amicus Curiae 20 ("Prevailing wages in different
States--or even in different areas of a single
State--may vary substantially, and training
requirements for membership in skilled trades
may also vary among different trades, different
communities, and different States"). We need not
resolve this question. Suffice it to say that the
federal and state apprenticeship standards are not
mandatory, and California's standards do not
result in disuniformities different in kind from
those that would exist without them.

n11 It is not conclusive as to California's
apprenticeship programs, but we note that some
data support the conclusion that the prevailing
wage break for approved apprenticeship
programs does not present ERISA plans with a
Hobson's choice. Amici State of Washington et al.
informed us that "while the federal government
and twenty-seven of the thirty-one states which have
prevailing wage laws have [a wage break], it is
estimated that only fifty percent of apprentices in
this country are in state or federally 'approved'
programs." Brief for State of Washington et al. as
Amici Curiae 20, and n. 13.

[*334] The effect of the prevailing wage statute on
ERISA-covered apprenticeship programs in California is
substantially similar to the effect of New York law on
ERISA plans choosing whether to provide health
insurance benefits in New York through the Blues, or
through a commercial carrier. The prevailing wage
statute alters the incentives, but does not dictate the
choices, facing ERISA plans. In this regard, it is "no
different from myriad state laws in areas traditionally
subject to local regulation, which Congress could not
possibly have intended to eliminate." Travelers, 514 U.S.
at 668. We could not hold pre-empted a state law in an
area of traditional state regulation based on so tenuous a
relation without doing grave violence to our presumption
that Congress intended nothing of the sort. We thus
conclude that California's prevailing wage laws and
apprenticeship standards do not have a "connection
with," and therefore do not "relate to," ERISA plans. n12

n12 Because we determine that § 1777.5
does not "relate to" ERISA plans, we need not
determine whether ERISA's saving clause, §
514(d), 29 U.S.C. § 1144(d), nonetheless
forestalls pre-emption.

III

For the reasons stated herein, the judgment below is
reversed, and the case is remanded for further
proceedings consistent with this opinion.

It is so ordered.

CONCURBY: SCALIA

CONCUR:

JUSTICE SCALIA, with whom JUSTICE
GINSBURG joins, concurring.

Since ERISA was enacted in 1974, this Court has
accepted certiorari in, and decided, no less than 14
cases to resolve conflicts in the Courts of Appeals regarding
ERISA pre-emption of various sorts of state law. n1 The
[**843] rate of acceptance, [*335] moreover, has not
[***806] diminished (we have taken two more ERISA
pre-emption cases so far this Term), n2 suggesting that
our prior decisions have not succeeded in bringing clarity
to the law.

n1 In addition to the case at bar, the Court
has addressed the application of ERISA's pre-

n2 See Boggs v. Boggs, cert. granted, post, p. 957; De Buono v. NYSA-ILA Medical and Clinical Services Fund, cert. granted, post, p. 926.

I join the Court's opinion today because it is a fair description of our prior case law, and a fair application of the more recent of that case law. Today's opinion is no more likely than our earlier ones, however, to bring clarity to this field--precisely because it does obeisance to all our prior cases, instead of acknowledging that the criteria set forth in some of them have in effect been abandoned. Our earlier cases sought to apply faithfully the statutory prescription that state laws are pre-empted "insofar as they . . . relate to any employee benefit plan." Hence the many statements, repeated today, to the effect that the ERISA pre-emption provision has a "broad scope," an "expansive sweep," is "broadly worded," "deliberately expansive," and "conspicuous for its breadth." Ante, at 324. But applying the "relate to" provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else.

Accord, New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995). The statutory text provides an illusory test, unless the Court is willing to decree a [*336] degree of pre-emption that no sensible person could have intended--which it is not.

I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the "relate to" clause of the pre-emption provision is meant, not to set forth a test for pre-emption, but rather to identify the field in which ordinary field pre-emption applies--namely, the field of laws regulating "employee benefit plan[s] described in section 1003(a) of this title and not exempt under section 1003(b) of this title," 29 U.S.C. § 1144(a). Our new approach to ERISA pre-emption is set forth in John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank, 510 U.S. 86, 99, 126 L. Ed. 2d 524, 114 S. Ct. 517 (1993): "We discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional pre-emption analysis." I think it accurately describes our current ERISA jurisprudence to say that we apply ordinary field pre-emption, and, of course, ordinary conflict pre-emption. See generally Silkwood v. Kerr-McGee Corp., 464 U.S. 238, 248, 78 L. Ed. 2d 443, 104 S. Ct. 615 (1984) (explaining general principles of field and conflict [*807] pre-emption); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 91 L. Ed. 1447, 67 S. Ct. 1146 (1947) (field pre-emption); Florida Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142-143, 10 L. Ed. 2d 248, 83 S. Ct. 1210 (1963) (conflict pre-emption). Nothing more mysterious than that; and except as establishing that, "relates to" is irrelevant.

REFERENCES: Go to Supreme Court Brief(s) Go to Oral Argument Transcript
LEXSEE 520 US 806

BARRA A. DE BUONO, NEW YORK COMMISSIONER OF HEALTH, ET AL., PETITIONERS v. NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, ETC., ET AL.

No. 95-1594

SUPREME COURT OF THE UNITED STATES


February 24, 1997, Argued
June 2, 1997, Decided

PRIOR HISTORY: ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT.

DISPOSITION: 74 F.3d 28, reversed.

CASE SUMMARY:

PROCEDURAL POSTURE: The Court of Appeals for the Second Circuit reversed the district court's denial of relief in respondent trustees' action against petitioner state officials to enjoin future assessments and to obtain a refund of tax paid under the Health Facility Assessment. Petitioners were granted certiorari.

OVERVIEW: Trustees brought an action against state officials alleging that the Health Facility Assessment (HFA) was a state law that related to the fund to which they were trustees within the meaning of § 514(a) of the Employee Retirement Income Security Act (ERISA), 29 U.S.C.S. § 1144(a), and was, therefore, pre-empted as it applied to hospitals run by ERISA plans. The United States Supreme Court found that there was nothing in the operation of the HFA that would make it the type of state law that Congress intended ERISA to supersede. The HFA had not forbidden a method of calculating pension benefits that federal law permitted, nor required employers to provide certain benefits. Nor was it a case in which the existence of a pension plan was a critical element of a state law cause of action, nor one in which the state statute contained provisions that expressly referred to ERISA or ERISA plans. A consideration of the actual operation of the state statute showed that the HFA was one of myriad state laws of general applicability that imposed some burdens on the administration of ERISA plans but did not relate to them within the meaning of § 514(a), 29 U.S.C.S. § 1144(a).

OUTCOME: The judgment was reversed.

CORE TERMS: state law, pre-empted, pre-emption, Tax Injunction Act, patient, beneficiaries, indirect, federal jurisdiction, state tax, jurisdictional issue, federal law, expansive, starting, speedy, enjoin, health care, general application, gross receipts, jurisdictional, federal-court, familiarity, regulation, diagnostic, supplant, insurer, intend, rested, myriad, Health Law, pension benefits

LexisNexis(R) Headnotes


Labor & Employment Law > Employee Retirement Income Security Act (ERISA) > Federal
Circuit reinstated its judgment, distinguishing insured by a Blue Cross/Blue Shield plan--the Second requiring hospitals to collect surcharges from patients that ERISA did not pre-empt a New York statute Ed. 2d 695, 115 S. Ct. 1671--in which this Court held of members higher fees. On remand from this Court in light could cause the plan to limit its benefits or to charge plan be available to provide plan members with benefits, and reducing the amount of Fund assets that would otherwise incidental impact on benefit plans. The Second Circuit because it is a tax of general application having only an District Court concluded that the HFA is not pre-empted emptied as applied to hospitals run by ERISA plans. The the meaning of § 514(a) of ERISA, and is therefore pre-empted as applied to hospitals operated in a field that has been traditionally occupied by the States: the regulation of health and safety matters. Hillborough County v. Automated Medical Laboratories, Inc., 471 U.S. 707, 715, 85 L. Ed. 2d 714, 105 S. Ct. 2371. Nothing in the HFA's operation convinces this Court that it is the type of state law that Congress intended ERISA to supercede. It is one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not "relate to" them within the meaning of the governing statute.

SYLLABUS: New York's Health Facility Assessment (HFA) imposes a tax on gross receipts for patient services at, inter alia, diagnostic and treatment centers. The NYSA-ILA Medical and Clinical Services Fund (the Fund), which administers a plan subject to the Employee Retirement Income Security Act (ERISA), owns and operates New York treatment centers for longshore workers, retirees and their dependents. Respondents, the Fund's trustees, discontinued paying the tax and filed this action to enjoin petitioner state officials from making future assessments and to obtain a refund, alleging that the HFA is a state law that "relates to" the Fund within the meaning of § 514(a) of ERISA, and is therefore pre-empted as applied to hospitals run by ERISA plans. The District Court concluded that the HFA is not pre-empted because it is a tax of general application having only an incidental impact on benefit plans. The Second Circuit reversed, reasoning that the HFA relates to the Fund by reducing the amount of Fund assets that would otherwise be available to provide plan members with benefits, and could cause the plan to limit its benefits or to charge plan members higher fees. On remand from this Court in light of New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 131 L. Ed. 2d 695, 115 S. Ct. 1671--in which this Court held that ERISA did not pre-empt a New York statute requiring hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan--the Second Circuit reinstated its judgment, distinguishing Travelers on the ground that the statute there at issue had only an indirect economic influence on the decisions of ERISA plan administrators, whereas the HFA depletes the Fund's assets directly, and thus has an immediate impact on an ERISA plan's operations.

Held: Section 514(a) does not preclude New York from imposing a gross receipts tax on ERISA funded medical centers. Pp. 5-10.

(a) When the Second Circuit initially found the HFA pre-empted, it relied substantially on an expansive and literal interpretation of the words "relate to" in § 514(a). It appears to have adhered to that approach on remand, failing to give proper weight to Travelers' rejection of such a strictly literal reading. In Travelers, the Court unequivocally concluded that the "relates to" language was not intended to modify "the starting presumption that Congress does not intend to supplant state law." 514 U.S. at 654. In evaluating whether the normal presumption against pre-emption has been overcome in a particular case, this Court must look to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive. Id., at 656. Pp. 5-7.

(b) Following that approach here, the HFA clearly operates in a field that has been traditionally occupied by the States: the regulation of health and safety matters. Hillborough County v. Automated Medical Laboratories, Inc., 471 U.S. 707, 715, 85 L. Ed. 2d 714, 105 S. Ct. 2371. Nothing in the HFA's operation convinces this Court that it is the type of state law that Congress intended ERISA to supercede. It is one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not relate to them within the statute's meaning. See, e.g., Travelers, 514 U.S. 645, 131 L. Ed. 2d 695, 115 S. Ct. 1671. The supposed difference between direct and indirect impact--upon which the Second Circuit relied in distinguishing this case from Travelers--cannot withstand scrutiny. While the Fund has arranged to provide medical benefits for its beneficiaries directly, had it chosen to purchase the services at independently run hospitals, those hospitals would have passed their HFA costs onto the Fund through their rates. Although the tax would be "indirect," its impact on the Fund's decisions would be in all relevant respects identical to the "direct" impact felt here. Pp. 7-9.

74 F.3d 28, reversed.

COUNSEL:

M. Patricia Smith argued the cause for petitioners.
Edwin S. Kneedler argued the cause for the United States, as amicus curiae, by special leave of court.

Donato Caruso argued the cause for respondents.

JUDGES: STEVENS, J., delivered the opinion of the Court, in which REHNQUIST, C. J., and O'CONNOR, KENNEDY, SOUTER, GINSBURG, and BREYER, JJ., joined. SCALIA, J., filed a dissenting opinion, in which THOMAS, J., joined.

OPINION BY: STEVENS

OPINION: [**1749] [***26] JUSTICE STEVENS delivered the opinion of the Court.

This is another Employee Retirement Income Security Act (ERISA) pre-emption case. n1 Broadly stated, the question presented is whether hospitals operated by ERISA plans are subject to the same laws as other hospitals. More precisely, the question is whether the opaque language in ERISA's § 514(a) n2 precludes New York from imposing a gross receipts tax on the income of medical centers operated by ERISA funds. We hold that New York may collect its tax.

In 1990, faced with the choice of either curtailing its Medicaid program or generating additional revenue to reduce the program deficit, the New York General Assembly enacted the Health Facility Assessment (HFA). n3 The HFA imposes a tax on gross receipts for patient services at hospitals, residential health care facilities, and diagnostic and treatment centers. n4 The assessments become a part of the State's general revenues.


The issue has also generated an avalanche of litigation in the lower courts. See Greater Washington Board of Trade, 506 U.S. at 133, and n. 3 (STEVENS, J., dissenting) (observing that in 1992, a LEXIS search uncovered more than 2,800 opinions on ERISA pre-emption).

n2 [HN1] Section 514(a) of ERISA informs us that "except as provided in subsection (b) of this section, the provisions of this [statute] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 88 Stat. 897, 29 U.S.C. § 1144(a). None of the exceptions in subsection (b) is directly at issue in this case.

I

In 1990, faced with the choice of either curtailing its Medicaid program or generating additional revenue to reduce the program deficit, the New York General Assembly enacted the Health Facility Assessment (HFA). n3 The HFA imposes a tax on gross receipts for patient services at hospitals, residential health care facilities, and diagnostic and treatment centers. n4 The assessments become a part of the State's general revenues.


n4 In addition to taxing the income derived from patient services at these facilities, the HFA taxes investment income and certain operating income. N. Y. Pub. Health Law § § 2807-d(3)(c), 2807-d(3)(d) (McKinney 1993). The taxation of these activities is not challenged here.

Respondents are the trustees of the NYSA-ILA Medical and Clinical Services Fund (the Fund), which administers a self-insured, multiemployer welfare benefit plan. The Fund owns and operates three medical centers-two in New York and one in New Jersey—that provide medical, dental and other health care benefits primarily to longshore workers, retirees, and their dependents. The New York centers are licensed by the
State as "diagnostic and treatment centers," App. 80, and are thus subject to a 0.6 percent tax on gross receipts under the HFA. N. Y. Pub. Health Law § 2807-d(2)(c) (McKinney 1993).

During the period from January through November of 1991, respondents paid HFA assessments totaling $7,066 based on the two New York hospitals' patient care income of $1,177,670. At that time, they discontinued the payments and brought this action against appropriate state officials (petitioners) to enjoin future assessments and to obtain a refund of the tax paid in 1991. The complaint alleged that the HFA is a state law that "relates to" the Fund within the meaning of § 514(a) of ERISA, and is therefore pre-empted [*1750] as applied to hospitals run by ERISA plans.

[n5] In response to the complaint filed in 1992, petitioners objected to federal jurisdiction, relying on the Tax Injunction Act, 28 U.S.C. § 1341, which provides that federal courts "shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State." Respondents contended that the statute did not apply because the New York courts do not provide the "plain" remedy required to bar federal jurisdiction. The District Court appears to have agreed with respondents, see App. to Pet. for Cert. 19a, but when it ultimately granted summary judgment and dismissed the complaint, it did not squarely decide the question, id., at 19a, 22a-23a. The Court of Appeals did not address the Tax Injunction Act in either of its two opinions in this case and there is no suggestion anywhere in the papers that the State raised the issue before that court. The Second Circuit had previously held, however, that the Tax Injunction Act is not a bar to actions such as this. See Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 713-714 (1993), rev'd on other grounds, New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995). In Travelers, we noted, but did not re-examine, that conclusion. See id., at 652-653, n. 4. In the case at bar, the Court of Appeals presumably was satisfied that its jurisdiction was secure for the reasons given in Travelers. Before this Court, no party in either Travelers or the current case has mentioned the Tax Injunction Act or questioned the Court of Appeals' conclusion that a "plain" remedy is unavailable in the New York courts. Given our settled practice of according respect to the courts of appeals' greater familiarity with issues of state law, cf. Bishop v. Wood, 426 U.S. 341, 346-347, 48 L. Ed. 2d 684, 96 S. Ct. 2074 and n. 10 (1976), and the State's active participation in nearly four years of federal litigation with no complaint about federal jurisdiction, it is appropriate for us to presume that the Court of Appeals correctly determined that, under these circumstances, New York courts did not provide a "plain" remedy barring federal consideration of the state tax.

[n6] See, e.g., Mackey, 486 U.S. at 838 (generally applicable garnishment law not pre-empted); Fort Halifax Packing Co., 482 U.S. at 19 (state law requiring one-time severance payment not pre-empted).

The first petition for certiorari in this case was filed before we handed down our opinion in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995). In that case we held that ERISA did not pre-empt a New York statute that required hospitals
to collect surcharges from patients covered by a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan. *Id.* at 649–651. After deciding *Travelers*, we vacated the judgment of the Court of Appeals in this case and remanded for further consideration in light of that opinion. 514 U.S. 1094 (1995).

On remand the Court of Appeals reinstated its original judgment. The court distinguished the statute involved in *Travelers* on the ground that--by imposing a tax on the health insurance carriers who provided coverage to plans and their beneficiaries--it had only an indirect economic influence on the ERISA plan administrators, whereas the HFA "depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan," *NYSA-ILA Medical and Clinical Services Fund v. Axelrod, M. D.*, 74 F.3d 28, 30 (1996). We granted the New York officials' second petition for certiorari, 519 U.S. (1996), and now reverse.

II

When the Second Circuit initially found the HFA pre-empted as applied to Fund-operated hospitals, that court relied substantially on an expansive and literal interpretation of the words "relate to" in § 514(a) of ERISA. 27 F.3d at 826. In reconsidering the case on remand, the court appears to have adhered to that approach, failing to give proper weight to *Travelers'* rejection of a strictly literal reading of § 514(a).

In *Travelers*, as in our earlier cases, we noted that the literal text of § 514(a) is "clearly expansive." 514 U.S. at 655. But we were quite clear in that case that the text could not be read to "extend to the furthest stretch of its indeterminacy, [or] for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere,' H. James, Roderick Hudson xli (New York ed., World's Classics 1980)."

*Ibid.* n7

n7 See also *Dillingham Constr.*, 519 U.S. at (slip op., at 2) (SCALIA, J., concurring) ("Applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else").

In our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear "connection with or reference to," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983), ERISA benefit plans. But in *Travelers* we confronted directly the question whether ERISA's "relates to" language was intended to modify "the starting presumption that Congress does not intend to supplant state law." 514 U.S. at 654. n8 We unequivocally concluded that it did not, and we acknowledged "that our prior attempts to construe the phrase 'relate to' do not give us much help drawing the line here." 514 U.S. at 655. In order to evaluate whether the normal presumption against pre-emption has been overcome in a particular case, we concluded that we "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Ibid.*, at 656. We endorsed that approach once again earlier this Term in concluding that California's prevailing wage law was not pre-empted by ERISA, *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, N. A., Inc., 519 U.S., , 117 S. Ct. 832, 136 L. Ed. 2d 791, 1997 U.S. LEXIS 691, *27* (1997).

n8 [HN2] Where "federal law is said to bar state action in fields of traditional state regulation . . . we have worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Travelers*, 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 91 L. Ed. 1447, 67 S. Ct. 1146 (1947). See also *Dillingham Constr.*, 519 U.S. at , 117 S. Ct. 832, 136 L. Ed. 2d 791, 1997 U.S. LEXIS 691, *25*.

n9 "The prevailing wage statute alters the incentives, but does not dictate the choices, facing ERISA plans. In this regard, it is 'no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.' *Travelers*, 514 U.S. at 668. We could not hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing of the sort. We thus conclude that California's prevailing wage laws and apprenticeship standards do not have a 'connection with,' and therefore do not 'relate to,' ERISA plans." *Dillingham Constr.*, 519 U.S. at (slip op., at 17).
Following that approach here, we begin by noting that the historic police powers of the State include the regulation of matters of health and safety. *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 715, 85 L. Ed. 2d 714, 105 S. Ct. 2371 (1985). While the HFA is a revenue raising measure, rather than a regulation of hospitals, it clearly operates in a field that "has been traditionally occupied by the States." *Ibid* (quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 525, 51 L. Ed. 2d 604, 97 S. Ct. 1305 (1977)). Respondents therefore bear the considerable burden of overcoming *Travelers*, 514 U.S. at 654.

Indeed, the Court of Appeals rested its conclusion in no small part on the fact that the HFA "targets only the health care industry." *NYSA-ILA Medical and Clinical Services Fund v. Axelrod, M. D.*, 27 F.3d 823, 827 (CA2 1994). Rather than warranting pre-emption, this point supports the application of the "starting presumption" against pre-emption.

There is nothing in the operation of the HFA that convinces us it is the type of state law that Congress intended ERISA to supersede. This is not a case in which New York has forbidden a method of calculating pension benefits that federal law permits, or required employers to provide certain benefits. Nor is it a case in which the existence of a pension plan is a critical element of a state law cause of action, or one in which the state statute contains provisions that expressly refer to ERISA or ERISA plans.

The respondents place great weight on the fact that in 1983 Congress added a specific provision to ERISA to save Hawaii's Prepaid Health Care Act from pre-emption, and that in so doing, the legislature noted that ERISA generally does preempt "any State tax law relating to employee benefit plans." 29 U.S.C. § 1144(b) (5)(B)(i). See Brief for Respondents 17-23. But there is no significant difference between the language in this provision and the pre-emption provision in § 514(a), and we are unconvinced that a stricter standard of pre-emption should apply to state tax provisions than to other state laws.

See, e.g., *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 524-525 ("Whatever the purpose or purposes of the New Jersey statute, we conclude that it 'relates to pension plans' governed by ERISA because it eliminates one method for calculating pension benefits--integration--that is permitted by federal law").


See, e.g., *Ingersoll-Rand Co.*, 498 U.S. at 139-140 ("We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan. . . . Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension plan itself").

See *Mackey*, 486 U.S. at 828-830 (a provision that explicitly refers to ERISA in defining the scope of the state law's application is pre-empted); *Greater Washington Board of Trade*, 506 U.S. at 130-131 ("Section 2(c)(2) of the District's Equity Amendment Act specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is pre-empted").
facility would have passed the expense of the HFA onto the Fund and its plan beneficiaries through the rates it set for the services provided. The Fund then would have had to decide whether to cover a more limited range of services for its beneficiaries, or perhaps to charge plan members higher rates. Although the tax in such a circumstance would be "indirect," its impact on the Fund's decisions would be in all relevant respects identical to the "direct" impact felt here. Thus, the supposed difference between direct and indirect impact--upon which the Court of Appeals relied in distinguishing this case from *Travelers*--cannot withstand scrutiny. Any state tax, or 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 pre-empted by the federal statute. n16

As we acknowledged in *Travelers*, there might be a state law whose economic effects, intentionally or otherwise, were so acute "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers" and such a state law "might indeed be pre-empted under § 514," 514 U.S. at 668. That is not the case here.

The judgment of the Court of Appeals is reversed.

* It is so ordered.

**DISSENT**

**SCALIA**

**DISSENT**

JUSTICE SCALIA, with whom JUSTICE THOMAS joins, dissenting.

"It is the duty of this court to see to it that the jurisdiction of the Circuit Court, which is defined and limited by [*818] statute, is not exceeded." *Louisville & Nashville R. Co. v. Motley*, 211 U.S. 149, 152, 53 L. Ed. 126, 29 S. Ct. 42 (1908). Despite our obligation to examine federal-court jurisdiction even if the issue is not raised by either party, *ibid.*, and despite the Court's explicit acknowledgement, *ante*, at 3, n. 5, of the possibility that jurisdiction over this case is barred by the Tax Injunction Act, 28 U.S.C. § 1341, the Court proceeds to decide the merits of respondents' ERISA pre-emption challenge. The Court offers two grounds for passing over the threshold question of jurisdiction: our "settled practice of according respect to the courts of appeals' greater familiarity with issues of state law," and petitioner's "active participation in nearly four years of federal litigation with no complaint about federal jurisdiction." *Ante*, at 4, n. 5. In my view, neither of these factors justifies our proceeding without resolving the issue of jurisdiction.

The Tax Injunction Act bars federal-court jurisdiction over an action seeking to enjoin a state tax (such as the one at issue here) where "a plain, speedy and efficient remedy may be had in the Courts of such State." 28 U.S.C. § 1341; see *Arkansas v. Farm Credit Servs. of Central Ark.*, post, at 3 (describing the Act as a "jurisdictional rule" and "broad jurisdictional barrier"). The District Court in this case suggested that the Tax Injunction Act might not bar jurisdiction here, since New York courts might not afford respondents a "plain" remedy within the meaning of the Act. See *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 1993 U.S. Dist. LEXIS 2011, No. 92 Civ. 2779 (SDNY, Feb. 18, 1993), App. to Pet. for Cert. 19a. That suggestion was not, however, based upon the District Court's resolution of any "issues of state law," as today's opinion intimates, *ante*, at 4, n. 5; rather, it rested upon the District Court's conclusion that uncertainty over the implications of a federal statute--§ 502(e)(1) of ERISA, 29 U.S.C. § 1132(e)(1)--might render the availability of a state [*818] court remedy not [*819] "plain." App. to Pet. for Cert. 19a. * The Court of Appeals, in [*1754] turn, made no mention of the jurisdictional issue, presumably because, under controlling Circuit precedent, jurisdiction was secure: The Second Circuit had previously held that state courts could not provide any remedy for ERISA-based challenges to state taxes within the meaning of the Tax Injunction Act, since "Congress has divested the state courts of jurisdiction" over ERISA claims. *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 714 (1993) (citing ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1)), rev'd on other grounds sub nom. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995). That holding (like the District Court's discussion of the issue in this case) in no way turns on New York state law, so I am at a loss to understand the Court's invocation [*819] of "our settled practice of according respect to the courts' of appeals' greater familiarity with issues of state law," *ante*, at 4, n. 5, as a basis for overlooking the question whether the Tax Injunction Act bars federal-court jurisdiction.

* That the District Court rested its conclusion on 29 U.S.C. § 1132(e)(1) is demonstrated by the sole authorities it cited in support of that conclusion: *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (SDNY 1993), aff'd in part and rev'd in part, 14 F.3d 708 (CA2 1993), rev'd on other grounds sub nom. *New York State
Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995); and National Carriers' Conference Committee v. Heffernan, 440 F. Supp. 1280, 1283 (Conn. 1977). The only argument in Travelers that supports the conclusion reached here is the argument that "because ERISA generally confers exclusive jurisdiction on the federal courts [under 29 U.S.C. § 1132(e)(1)], a New York state court might well feel compelled to dismiss a state court action on the grounds that its jurisdiction has been preempted. . . . Thus, at a minimum the availability of a state court remedy is not 'plain.'" 813 F. Supp. at 1001 (internal quotation marks and brackets omitted). Likewise, Heffernan (which arose in Connecticut, not New York) offers pertinent reasoning based only on federal law: "Jurisdiction over suits arising under ERISA is, with minor exceptions, vested exclusively in the federal courts. 29 U.S.C. § 1132(e)(1). If this suit were brought before a . . . state court, that court might well feel compelled to dismiss the action on the grounds that its jurisdiction had been preempted. . . . Thus, at a minimum the availability of a state court remedy is not 'plain.'" 440 F. Supp. at 1283 (footnote omitted).

The second factor relied upon by the Court in support of its treatment of the jurisdictional issue is that petitioner dropped the issue after the District Court failed to adopt her interpretation of the Tax Injunction Act. But the fact that petitioner has "actively participated in nearly four years of federal litigation with no complaint about federal jurisdiction," ibid., cannot possibly confer upon us jurisdiction that we do not otherwise possess. It is our duty to resolve the jurisdictional question, whether or not it has been preserved by the parties. Sumner v. Mata, 449 U.S. 539, 548, n. 2, 66 L. Ed. 2d 722, 101 S. Ct. 764 (1981); Louisville & Nashville R. Co., 211 U. S. at 152. In Sumner we confronted the identical circumstance presented here--a jurisdictional argument raised before the District Court but abandoned before the Court of Appeals--and felt the need to address the jurisdictional issue. 449 U. S. at 547, n. 2.

I have previously noted the split among the Circuits on the question whether the Tax Injunction Act deprives federal courts of jurisdiction over ERISA-based challenges to state taxes. See Barnes v. E-Systems, Inc. Group Hospital Medical & Surgical [***33] Ins. Plan, 501 U.S. 1301, 1302-1303, 115 L. Ed. 2d 1087, 112 S. Ct. 1 (1991) (SCALIA, J., in chambers). In a prior case, we expressly left the question open, saying that "we express no opinion [on] whether a party [can] sue under ERISA to enjoin or to declare invalid a state tax levy, despite the Tax Injunction Act"; we noted that the answer would depend on whether "state law provides no 'speedy and efficient remedy'" and on whether "Congress intended § 502 of ERISA to be an exception to the Tax Injunction Act." Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for Southern Cal., 463 U.S. 1, 20, n. 21, 77 L. Ed. 2d 420, 103 S. Ct. 2841 (1983). Because I am [*820] uncertain of the federal courts' jurisdiction over this case, I would set the jurisdictional issue for briefing and argument, and would resolve that issue before reaching the merits of respondents' ERISA pre-emption claim. Accordingly, I respectfully dissent from today's opinion.

REFERENCES: Return To Full Text Opinion
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60A Am Jur 2d, Pensions and Retirement Funds 118, 127
27 Federal Procedure, L Ed, Pensions and Retirement Systems 61:283

29 USCS 1144

Employment Coordinator B-10,506, B-10,523
Pension Coordinator 52,009, 52,019, 80,114
L Ed Digest, States, Territories, and Possessions 38.2
L Ed Index, Gross Receipts Tax; Pensions and Retirement

ALR Index, Employee Retirement Income Security Act; Gross Receipts Taxes; Pre-Emption

Annotation References:

Supreme Court's construction and application of Tax Injunction Act (28 USCS 1341, and similar predecessor provisions), restricting Federal District Courts from interfering with assessment, levy, or collection of state taxes. 132 L Ed 2d 997.

When is state or local law pre-empted by Employee Retirement Income Security Act of 1974, as amended (ERISA) (29 USCS 1001 et seq.)— Supreme Court cases. 121 L Ed 2d 783.
LEXSEE 526 US 358

UNUM LIFE INSURANCE COMPANY OF AMERICA, PETITIONER v. JOHN E. WARD

No. 97-1868

SUPREME COURT OF THE UNITED STATES


February 24, 1999, Argued
April 20, 1999, Decided

PRIOR HISTORY: $=P1390 *1 ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT.

DISPOSITION: 135 F.3d 1276, affirmed in part, reversed in part, and remanded.

CASE SUMMARY:

PROCEDURAL POSTURE: Petitioner sought review of the decision from the United States Court of Appeals for the Ninth Circuit, which held that California's notice-prejudice rule was not preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C.S. § 1001 et seq., because it was a law which regulated insurance.

OVERVIEW: Respondent submitted a disability claim to petitioner outside the time limit set in the policy, and petitioner denied his claim. Respondent filed suit to recover his disability benefits under an Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1001 et seq., which governed insurance policy issued by petitioner. The district court granted petitioner's summary judgment motion, and the lower court reversed that ruling. The lower court relied on California's notice-prejudice rule and state agency law. Petitioner sought review of the lower court's decision. The Court affirmed the part of the lower court's decision which involved the notice-prejudice rule. The Court held that the lower court properly concluded that notice-prejudice was a rule of law governing the insurance relationship distinctively. It concluded that the notice-prejudice rule, as a matter of common sense, regulated insurance and, thus, escaped preemption under the ERISA saving clause, 29 U.S.C.S. § 1144(b)(2)(A). However, the Court reversed the portion of the lower court's ruling which relied on state agency law. The lower court improperly interpreted state agency law.

OUTCOME: The Court affirmed the lower court's ruling that California's notice-prejudice rule was a law which regulated insurance, and was, therefore, saved from preemption by ERISA. The Court reversed the lower court's ruling which was based upon agency law because the Court held that California's agency law, did relate to employee benefit plans, and, therefore, did not occupy ground outside ERISA's preemption clause. The Court remanded the action.

CORE TERMS: notice-prejudice, insurer, preemption, insured, insurance industry, regulation, notice, forfeiture, saving clause, state law, disability, saved, regulate insurance, actual prejudice, common-sense, amicus curiae, employee benefit, disability benefits, preemption clause, timely notice, policyholder, preempted, long-term, insurance contract, proof of claim, integral part, public policy, late notice, mandatory, business of insurance

LexisNexis(R) Headnotes
**Pensions & Benefits Law > Employee Retirement Income Security Act (ERISA) > Federal Preemption**


**Insurance Law > Regulation of Insurance > ERISA Preemption**


**Insurance Law > Regulation of Insurance > ERISA Preemption > Insurance Law > Regulation of Insurance > Claims Investigations & Practices**

[HN3] California's notice-prejudice rule is a law which regulates insurance and is therefore saved from preemption by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1001 et seq. California's agency law does relate to employee benefit plans and therefore does not occupy ground outside ERISA's preemption clause, 29 U.S.C.S. § 1144(a).

**Insurance Law > Regulation of Insurance > ERISA Preemption > Claims Investigations & Practices**

[HN4] California's notice-prejudice rule prescribes a defense based on an insured's failure to give timely notice of a claim requires the insurer to prove that it suffered actual prejudice. Prejudice is not presumed from delayed notice alone. The insurer must show actual prejudice, not the mere possibility of prejudice.

**Insurance Law > Regulation of Insurance > ERISA Preemption**

[HN5] The following framework is used for resolving whether a state law "regulates insurance" within the meaning of the saving clause, 29 U.S.C.S. § 1144(b)(2)(A), of the Employee Retirement Income Security Act of 1974, 29 U.S.C.S. § 1001 et seq. First, a court asks whether, from a common-sense view of the matter, the contested prescription regulates insurance. Second, a court considers three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C.S. § 1011 et seq.: first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

**SYLLABUS:** Defendant-petitioner UNUM Life Insurance Company of America (UNUM) issued a long-term group disability policy to Management Analysis Company (MAC) as an insured welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The policy provides that proofs of claim must be furnished to UNUM, at the latest, one year and 180 days after the onset of disability. Under the admitted facts of this case, plaintiff-respondent Ward, a MAC employee, became permanently disabled on May 5, 1992. In late February or early March 1993, he qualified for state disability benefits in California, where he worked, and thereupon informed MAC of his disability. In April 1994, Ward asked MAC whether its long-term disability plan covered his condition. When MAC told him it did, Ward completed a benefits application and sent it to MAC, which processed the application and forwarded it to UNUM. UNUM received proof of Ward's claim on April 11, 1994. Because this notice was late under the policy terms, UNUM advised Ward that his claim was denied as untimely. Ward filed this suit under ERISA's civil enforcement provision, 29 U.S.C. § 1132(a), to recover the disability benefits provided by the plan. He argued that, because a California employer administering an insured group health plan should be deemed to act as the insurance company's agent under Elfstrom v. New York Life Ins. Co., 67 Cal. 2d 503, 512, 432 P.2d 731, 737, 63 Cal. Rptr. 35, his notice of permanent disability to MAC, in February or March 1993, sufficed to supply timely notice to UNUM. The District Court rejected this argument, concluding that California's Elfstrom rule is subject to ERISA's preemption clause, § 1144(a), which states that ERISA provisions "shall supersede . . . State laws" to the extent that those laws "relate to any employee benefit plan." In rendering summary judgment for UNUM, the District Court further held that the Elfstrom rule is not preserved under ERISA's saving clause, § 1144(b)(2)(A), which exempts from preemption "any law of any State which regulates insurance." The Ninth Circuit reversed, identifying two grounds on which Ward might prevail. First, that court relied on California's "notice-prejudice" rule, under which an insurer cannot avoid liability although the proof of claim is untimely, unless the insurer shows it suffered actual prejudice from the delay. Following its precedent, the appeals court held that the notice-prejudice rule is saved from ERISA preemption as a law that "regulates insurance." Second, and contingently, the Ninth Circuit held that the Elfstrom agency rule does not "relate to" employee benefit plans, and therefore is not preempted by reason of ERISA. The court remanded the case for a determination whether
UNUM suffered actual prejudice from Ward's late notice of claim; and if so, whether, under Elfstrom, Ward could prevail because he had timely filed his claim.

Held:

1. California's notice-prejudice rule is a "law . . . which regulates insurance," and is therefore saved from preemption by ERISA. Pp. 5-14.

(a) Because the parties agree that the notice-prejudice rule falls under ERISA's preemption clause as a state law that "relates to" employee benefit plans, their dispute hinges on whether the rule "regulates insurance" and thus escapes preemption under the saving clause. This Court's precedent provides a framework for resolving that question. First, the Court asks whether, from a "common-sense view of the matter," the contested prescription regulates insurance. E.g., Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740, 85 L. Ed. 2d 728, 105 S. Ct. 2380. Second, the Court considers three factors to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act: whether the regulation (1) has the effect of transferring or spreading a policyholder's risk, (2) is an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry. 471 U.S. at 743. Pp. 5-6.

(b) The Ninth Circuit correctly concluded that the notice-prejudice rule "regulates insurance" as a matter of common sense. This Court does not normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law, see Runyon v. McCrary, 427 U.S. 160, 181-182, 49 L. Ed. 2d 415, 96 S. Ct. 2586, and there is no cause to do so here. Because it controls the terms of the insurance relationship by requiring the insurer to prove prejudice before enforcing proof-of-claim requirements, the California rule, by its very terms, is directed specifically at the insurance industry and is applicable only to insurance contracts. The rule thus appears to satisfy the common-sense view as a regulation that homes in on the insurance industry and does not just have an impact on that industry. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 95 L. Ed. 2d 39, 107 S. Ct. 1549. The Court rejects UNUM's argument that the rule cannot be held to "regulate insurance" because it is merely an industry-specific application of the general principle that disproportionate forfeiture should be avoided in the enforcement of contracts. While the notice-prejudice rule is an application of the maxim that law abhors a forfeiture, it is an application of a special order, a rule mandatory for insurance contracts, not a principle a court may pliably employ when the circumstances so warrant. Tellingly, UNUM has identified no California authority outside the insurance-specific notice-prejudice context indicating that, as a matter of law, failure to abide by a contractual time condition does not work a forfeiture absent prejudice.

(c) The notice-prejudice rule regulates the "business of insurance" within the meaning of the McCarran-Ferguson Act. Preliminarily, the Court rejects UNUM's assertion that a state regulation must satisfy all three McCarran-Ferguson factors in order to "regulate insurance." Those factors are considerations to be weighed, Pilot Life, 481 U.S. at 49, and none is necessarily determinative in itself, Union Labor Life Ins. Co. v. Pireno, 438 U.S. 119, 129, 73 L. Ed. 2d 647, 102 S. Ct. 3002. The Metropolitan Life Court called the factors "relevant," 471 U.S. at 743, and looked to them as checking points, not separate essential elements that must each be satisfied. The Court need not determine whether the rule at issue satisfies the first, "risk-spreading." McCarran-Ferguson factor, because the remaining factors, verifying the common-sense view, are securely satisfied. Meeting the second factor, the notice-prejudice rule serves as an integral part of the insurance relationship because it changes the bargain between insurer and insured; it effectively creates a mandatory contract term that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision. The third factor--whether the rule is limited to insurance entities -- is also well met, since it is aimed at the insurance industry and does not merely have an impact upon it. See FMC Corp. v. Holliday, 498 U.S. 52, 61, 112 L. Ed. 2d 356, 111 S. Ct. 403.

2. The Court rejects UNUM's assertion that the notice-prejudice rule conflicts in three ways with substantive provisions of ERISA. First, UNUM's contention that the rule, by altering the notice provisions of the insurance contract, conflicts with ERISA's requirement that plan fiduciaries act "in accordance with the documents and instruments governing the plan," § 1104(a)(1)(D), overlooks controlling precedent and makes scant sense. This Court has repeatedly held that state laws mandating insurance contract terms are saved from preemption under § 1144(b)(2)(A). See, e.g., Metropolitan Life, 471 U.S. at 758. Under UNUM's interpretation, however, States would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could
displace any state regulation simply by inserting a contrary term in plan documents. This interpretation would virtually read the saving clause out of ERISA. Second, whatever the merits of UNUM's view that § 1132(a) preempts any action for plan benefits brought under state rules such as notice-prejudice, the issue is not implicated here. Because Ward sued under § 1132(a)(1)(B) "to recover benefits due . . . under the terms of his plan," invoking the notice-prejudice rule as the relevant rule of decision for his § 1132(a) suit, the case does not raise the question whether § 1132(a) provides the sole launching ground for an ERISA enforcement action. Finally, the Court rejects UNUM's suggestion that the notice-prejudice rule conflicts with § 1133, which requires plans to provide notice and the opportunity for review of denied claims, or with Department of Labor regulations providing that a claim is filed when the requirements of a reasonable claim filing procedure have been met. By allowing a longer period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations. Pp. 14-16.

3. California's Elfstrom agency rule "relates to" ERISA plans, and therefore does not occupy ground outside ERISA's preemption clause. Contrary to the Ninth Circuit's view that Elfstrom is consistent with this Court's ERISA preemption precedent because it does not dictate the manner in which the plan will be administered, deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration: It would force the employer, as plan administrator, to assume a role, with attendant legal duties and consequences, that it has not undertaken voluntarily; and it would affect not merely the plan's bookkeeping obligations regarding to whom benefits checks must be sent, but would also regulate the basic services that a plan may or must provide to its participants and beneficiaries. Pp. 16-18.

135 F.3d 1276, affirmed in part, reversed in part, and remanded.

COUNSEL:

William J. Kayatta, Jr. argued the cause for petitioner.

Edwin S. Kneedler argued the cause for the United States, as amicus curiae, by special leave of court.

Jeffrey I. Erlich argued the cause for respondent.

JUDGES: GINSBURG, J., delivered the opinion for a unanimous Court.

OPINIONBY: GINSBURG

OPINION: [*363] [***469] [**1384] JUSTICE GINSBURG delivered the opinion of the Court.


The context here is a suit to recover disability benefits under an ERISA-governed insurance policy issued by defendant-petitioner UNUM Life Insurance Company of America (UNUM). Plaintiff-respondent John E. Ward submitted his proof of claim to UNUM outside the time limit set in the policy, and UNUM therefore denied Ward's claim.

Ruling in Ward's favor, and reversing the District Court's summary judgment for UNUM, the Court of Appeals for the Ninth Circuit relied on decisional law in California, the State in which Ward worked and in which his employer operated. The Ninth Circuit's judgment rested on two grounds. That [*364] court relied first on California's "notice-prejudice" rule, under which an insurer cannot avoid liability although the proof of claim is untimely, unless the insurer shows it was prejudiced by the delay. The notice-prejudice rule is saved from preemption, the Court of Appeals held, because it is "law . . . which regulates insurance." See Ward v. Management Analysis Co. Employee Disability Benefit Plan, 135 F.3d 1276, 1280 (1998).

The Court of Appeals announced a further ground for reversing the District Court's judgment for UNUM, one that would come into play if the insurer proved prejudice due to the delayed notice. Under California's decisions, the Ninth Circuit said, the employer could be deemed an agent of the insurer in administering group
insurance policies. Ward's employer knew of his disability within the time the policy allowed for proof of claim. The Ninth Circuit held that the generally applicable agency law reflected in the California cases does not "relate to" employee benefit plans, and therefore is not preempted. See 135 F.3d at 1281-1283, 1287-1288.

We granted certiorari, 525 U.S. (1998), and now affirm the Court of Appeals' first disposition, and reverse the second. [HN3] California's notice-prejudice rule, we agree, is a "law . . . which regulates insurance," and is therefore saved from preemption by ERISA. California's agency law, we further hold, does "relate to" employee benefit plans, and therefore does not occupy ground outside ERISA's preemption clause.

I

UNUM issued a long-term group disability policy to Management Analysis Company (MAC) as an insured welfare benefit plan governed by ERISA, effective November 1, 1983. The policy provides that proofs of claim must be furnished to UNUM, at the latest, one year and 180 days after the onset of disability.

Ward was employed by MAC from 1983 until May 1992. Throughout this period, premiums for the disability policy [*365] were deducted from Ward's paycheck. Under the admitted facts of the case, Ward became permanently disabled with severe leg pain on the date of his resignation, May 5, 1992. See 135 F.3d at 1280.

Ward's condition was diagnosed as diabetic neuropathy in December 1992. In late February or early March 1993, he qualified for state disability benefits and thereafter informed MAC of his disability and inquired about continuing health insurance benefits. In July 1993, Ward received a determination of eligibility for Social Security disability [***471] benefits and forwarded a copy of this determination to MAC's human resources division. See id., at 1279. In April 1994, Ward discovered among his papers a booklet describing the long-term disability plan and asked MAC whether the plan covered his condition. When MAC told him he was covered, Ward completed an application for benefits and forwarded it to MAC. In turn, and after filling in the employer information section, MAC forwarded the application to UNUM. UNUM received proof of Ward's claim on April 11, 1994. See ibid. This notice was late under the terms of the policy, which required submission of proof of claim by November 5, 1993. See id., at 1280. By letter dated April 13, 1994, UNUM advised Ward that his claim was denied as untimely. See id., at 1279.

In September 1994, Ward filed suit against the MAC plan under § 502 of ERISA, 29 U.S.C. § 1132, to recover the disability benefits provided by the plan. UNUM appeared as a defendant and answered on behalf of itself and the plan. See 135 F.3d at 1279. To the District Court, Ward argued that under Elfstrom v. New York Life Ins. Co., 67 Cal. 2d 503, 512, 432 P.2d 731, 737, 63 Cal. Rptr. 35 (1967) (en banc), a California employer that administers an insured group health plan should be deemed to act as the agent of the insurance company. Therefore, Ward asserted, his notice of permanent disability to MAC, in February or March 1993, sufficed to supply timely notice to UNUM. See App. to Pet. for Cert. 30a. The District [*366] Court rejected this argument, concluding that the agency rule announced in Elfstrom "relates to" ERISA plans; hence it is preempted under § 514(a), 29 U.S.C. § 1144(a). See App. to Pet. for Cert. 30a. The District Court further held that the Elfstrom rule is not saved from preemption as a law that "regulates insurance" within the compass of ERISA's insurance saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). App. to Pet. for Cert. 31a. Accordingly, the court rendered summary judgment in UNUM's favor. See id., at 33a.

The Court of Appeals for the Ninth Circuit reversed, identifying two grounds on which Ward might prevail. First, following the Ninth Circuit's recent decision in Cisneros v. UNUM Life Ins. Co., 134 F.3d 939 (1998), the appeals court held that California's notice-prejudice rule is saved from ERISA preemption as a law that "regulates insurance"; under the notice-prejudice rule, Ward's late notice would not preclude his ERISA claim absent proof that the insurer suffered actual prejudice because of the delay. See 135 F.3d at 1280. Second, and contingently, the Ninth Circuit held that the Elfstrom rule, under which the employer could be deemed an agent of the insurer, does not "relate to" employee benefit plans, and therefore is not preempted by reason of ERISA. See 135 F.3d at 1287 (internal quotation marks omitted). The court accordingly remanded the case to the District Court for a determination whether UNUM suffered actual prejudice on account of the late submission of Ward's notice of claim; and if so, whether, under the reasoning of Elfstrom, Ward could nevertheless prevail because he had timely filed his claim. See 135 F.3d at 1289.

[***472] II

[***LEdHR3B] [3B] [***LEdHR5A] [5A] [***LEdHR6A] [6A] [HN4] California's notice-prejudice rule prescribes: "[A] defense based on an insured's failure to give timely notice [of a claim] requires the insurer to prove that it suffered actual prejudice. Prejudice is not presumed [*367] from delayed notice alone. The insurer must show actual prejudice, not the mere

The parties agree that the notice-prejudice rule falls under ERISA's preemption clause, § 514(a), as a state law that "relates to" an employee benefit plan. n1 Their dispute hinges on this question: Does the rule "regulate insurance" and thus escape preemption under the saving clause, § 514(b)(2)(A). n2

n1 Common-law rules developed by decisions of state courts are "State law" under ERISA. See 29 U.S.C. § 1144(c)(1) ("The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law.").

n2 State laws that purport to regulate insurance by "deeming" a plan to be an insurance company are outside the saving clause and remain subject to preemption. See § 1144(b)(2)(B). Self-insured ERISA plans, therefore, are generally sheltered from state insurance regulation. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985). Because this case does not involve a self-insured plan, this limitation on state regulatory authority is not at issue here.

The Ninth Circuit concluded that California's notice-prejudice rule "regulates insurance" as a matter of common sense. See *Cisneros*, 134 F.3d at 945. We do not normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law, see *Runyon v. McCrory*, 427 U.S. 160, 181-182, 49 L. Ed. 2d 415, 96 S. Ct. 2586 (1976), and we lack cause to do so here. The California notice-prejudice rule controls the terms of the insurance relationship by "requiring the insurer to prove prejudice before enforcing proof-of-claim requirements." *Cisneros*, 134 F.3d at 945. As the Ninth Circuit observed, the rule, by its very *[***473]* terms, "is directed specifically at the insurance industry and is applicable only to insurance contracts." *Ibid*.; see Brief for United States as *Amicus Curiae* 12 ("Our survey of California law reveals no cases where the state courts apply the notice-prejudice rule as such outside the insurance area. Nor is this surprising, given that the rule is stated in terms of prejudice to an 'insurer' resulting from untimeliness of notice."). The rule thus *[*1387]* appears to satisfy the common-sense view as a regulation that homes in on the insurance industry and does "not just have an impact on [that] industry." *Pilot Life*, 481 U.S. at 50.

We do not find it fair to bracket California's notice-prejudice rule for insurance contracts with Mississippi's
broad gauged "bad faith" claim for relief. Insurance policies like UNUM's frame timely notice provisions as conditions precedent to be satisfied by the insured before an insurer's contractual obligation arises. See 1 B. Witkin, Summary of California Law, Contracts § 726, p. 657 (9th ed. 1987); Zurn Engineers v. Eagle Star Ins. Co., 61 Cal. App. 3d 493, 499, 132 Cal. Rptr. 206, 210 (2d Dist. 1976). Ordinarily, "failure to comply with conditions precedent . . . prevents an action by the defaulting party to enforce the contract." 14 Cal. Jur. 3d, Conditions Precedent, § 3, p. 1383 (1974). A recent California decision, Platt Pacific Inc. v. Andelson, 6 Cal. 4th 307, 862 P.2d 158 (1993) (en banc), is illustrative. In that case, the California Supreme Court adhered to the normal course: It refused to excuse a plaintiff's failure to comply with a contractual requirement to timely demand arbitration, although there was no allegation that the defendant had been prejudiced by the plaintiff's lapse. The plaintiff had forfeited the right to pursue arbitration, even though there was no allegation that the defendant had been prejudiced by the plaintiff's lapse. The plaintiff had forfeited the right to pursue arbitration, the court concluded, for "the condition precedent [of a timely demand] was neither legally excused nor changed by a modification of the parties' written agreement." Id. at 321, 862 P.2d at 167. "A contrary conclusion," the court stated, "would undermine the law of contracts by vesting in one contracting party the power to unilaterally convert the other contracting party's conditional obligation into an independent, unconditional obligation notwithstanding the terms of the agreement." Id. at 314, 862 P.2d at 162.

It is no doubt true that diverse California decisions bear out the maxim that "law abhors a forfeiture" n3 and that the [*1383] [*371] notice-prejudice rule is an application of that maxim. But it is an application of a special order, a rule mandatory for insurance contracts, not a principle a court may pliably employ when the circumstances so warrant. Tellingly, UNUM has identified no California authority outside the insurance-specific notice-prejudice context indicating that as a matter of law, failure to abide by a contractual time condition does not work a forfeiture absent prejudice. Outside the notice-prejudice context, the burden of justifying a departure from a contract's written terms generally rests with the party seeking the departure. See, e.g., American Bankers Mortgage Corp. v. Federal Home Loan Mortgage Corp., 75 F.3d 1401, 1413 (CA9 1996); CQL Original Products, Inc. v. National Hockey League Players' Assn., 39 Cal. App. 4th 1347, 1357-1358, n.6, 46 Cal. Rptr. 2d 412, 418, n.6 (4th Dist. 1995). In short, the notice-prejudice rule is distinctive most notably because it is a rule firmly applied to insurance contracts, not a general principle guiding a court's discretion in a range of matters. n4

n3 UNUM cites a handful of California cases of this genre. They do not cast doubt on our disposition. In Conservatorship of Rand, 49 Cal. App. 4th 835, 57 Cal. Rptr. 2d 119 (4th Dist. 1996), the court found that a county court rule governing notice to a conservatee of potential liability for fees and costs did not comply with statutory notice requirements, but excused the defective notice because the conservatee had suffered no prejudice. See 49 Cal. App. 4th at 838-841, 57 Cal. Rptr. 2d at 121-123. Rand was not a contract case at all; it concerned the consequences of a court's violation of a state-created notice provision in the context of a judicial proceeding. Industrial Asphalt Inc. v. Garrett Corp., 180 Cal. App. 3d 1001, 226 Cal. Rptr. 17 (2d Dist. 1986), concerned the notice requirements imposed by California's mechanics lien law and turned on principles of statutory rather than contract interpretation. See 180 Cal. App. 3d at 1005-1006, 226 Cal. Rptr. at 18-19. In Industrial Asphalt, moreover, the complaining party had received actual notice of the claim underlying the lien. Ibid. Neither case suggests that California courts are generally unwilling or reluctant to enforce time conditions in private contracts as written.

The older decisions on which UNUM relies are no more instructive. The contract at issue in Ballard v. MacCallum, 15 Cal. 2d 439, 101 P.2d 692 (1940) (en banc), contained contradictory clauses, some appearing to provide for forfeiture in the event of default, others appearing to contemplate an opportunity to cure. See id., at 442, 101 P.2d at 694. The court invoked a general presumption against forfeitures only to resolve the conflict. See id., at 444, 101 P.2d at 695. Finally, in Henck v. Lake Hemet Water Co., 9 Cal. 2d 136, 69 P.2d 849 (1937) (en banc), a water supplier attempted to escape the terms of a long-term delivery contract on the ground that the water recipient had not timely made annual payment. The California Supreme Court rejected the supplier's plea, observing that "in a proper case," equity permits a court to excuse a lapse like the recipient's in order to avoid forfeiture. See 9 Cal. 2d at 144, 142, 69 P.2d at 852. The Henck court carefully weighed the competing interests of the parties and relied in part on the water supplier's fault in inducing the late payment. See 9 Cal. 2d at 144-145, 69 P.2d at 853; cf. Restatement (Second) of Contracts § 229, Comment c, Reporter's Note (1979) (courts are likely to excuse obligor's failure strictly to
adhere to a performance timetable where obligee has induced the failure).

These decisions support the uncontroverted propositions that the law disfavors forfeitures and that in case-specific circumstances California courts will excuse the breach of a time or notice provision in order to avoid an inequitable forfeiture. None of the decisions even remotely suggests that failures to comply with contractual notice periods are excused as a matter of law absent prejudice; none, therefore, suggests that the notice-prejudice rule is merely a routine application of a general antiforfeiture principle.

n4 UNUM features § 229 of the Restatement (Second) of Contracts (1979), and urges that the notice-prejudice rule fits within its compass. Section 229 provides that "to the extent that the non-occurrence of a condition would cause disproportionate forfeiture, a court may excuse the non-occurrence of that condition unless its occurrence was a material part of the agreed exchange." The notice-prejudice rule, however, is mandatory rather than permissive; it requires California courts to excuse a failure to provide timely notice whenever the insurer cannot carry the burden of showing actual prejudice, and it allows no argument over the materiality of the time prescription.

California's insistence that insurers show prejudice before they may deny coverage because of late notice is grounded in policy concerns specific to the insurance industry. See Brief for Council of State Governments et al. as Amici Curiae 10-14. That grounding is key to our decision. Announcing the notice-prejudice rule in Campbell v. Allstate Ins. Co., 60 Cal. 2d 303, 384 P.2d 155, 32 Cal. Rptr. 827 (1963) (en banc), the California Supreme Court emphasized the "public policy of this state" in favor of compensating insureds. Id. at 307, 384 P.2d at 157; see ibid. (weighing the relative burdens of notice-prejudice on insurers and insureds). Subsequent notice-prejudice rulings have likewise focused on insurance industry policy and governance. See, e.g., Hanover Ins. Co. v. Carroll, 241 Cal. App. 2d 558, 570, 50 Cal. Rptr. 704, 712 (1st Dist. 1966) (public policy respecting compensation of insurees); Northwestern Title Security Co. v. Flack, 6 Cal. App. 3d 134, 143-144, 85 Cal. Rptr. 693, 698 (1st Dist. 1970) (extending notice-prejudice rule to "claims-type" policies; rejecting contention that sound public policy required limitation of rule to "occurrence-type" policies); Pacific Employers Ins. Co. v. Superior Court, 221 Cal. App. 3d 1348, 1359-1360, 270 Cal. Rptr. 779, 784-785 (2d Dist. 1990) (evaluating insurance industry public policy considerations [*1389] in reaching the opposite conclusion). Decisions of courts in other States similarly indicate that the notice-prejudice rule addresses policy concerns specific to insurance. See, e.g., Cooper v. Government Employees Ins. Co., 51 N.J. 86, 94, 237 A.2d 870, 874 (1968) (failure to adopt notice-prejudice would "disserve the public interest, for insurance is an instrument of a social policy that the victims of negligence be compensated"); Great American Ins. Co. v. C.G. Tate Construction Co., 303 N.C. 387, 395, 279 S.E.2d 769, 774 (1981) ("The [notice-prejudice] rule we adopt today has the advantages [*373] of promoting social policy and fulfilling the reasonable expectations of the purchaser while fully protecting the ability of the insurer to protect its own interests."); Alcazar v. Hayes, 982 S.W.2d 845, 851-853 (Tenn. 1998) (surveying the "compelling public law justifications" that support departing from traditional contract interpretation in favor of notice-prejudice).

In sum, the Ninth Circuit properly concluded that notice-prejudice is a rule of law governing the insurance relationship distinctively. We reject UNUM's contention that the rule merely restates a general principle disfavoring forfeitures and conclude instead that notice-prejudice, as a matter of common sense, regulates insurance.

[*372]

[*374] Circuit correctly recognized,
Metropolitan Life asked first whether the law there in question "fits a common-sense understanding of insurance regulation," Cisneros, 134 F.3d at 945, and then looked to the McCarran-Ferguson factors as checking points or "guideposts, not separate essential elements . . . that must each be satisfied" to save the State's law, 134 F.3d at 946.

[***LEdHR3F] [3F]The first McCarran-Ferguson factor asks whether the rule at issue "has the effect of transferring or spreading a policyholder's risk." Metropolitan Life, 471 U.S. at 743 (internal quotation marks omitted). The Ninth Circuit determined that the notice-prejudice rule does not satisfy that criterion because it "does not alter the allocation of risk for which the parties initially contracted, namely the risk of lost income from long-term disability." Cisneros, 134 F.3d at 946. The United States as amicus curiae, however, suggests that the notice-prejudice rule might be found to satisfy the McCarran-Ferguson "risk-spreading" factor: "Insofar as the notice-prejudice rule shifts the risk of late notice and stale evidence from the insured to the insurance company in some instances, it has the effect of raising premiums and spreading risk among policyholders." Brief for United States as Amicus Curiae 14. We need not pursue this point, because the remaining McCarran-Ferguson factors, verifying the common-sense view, are securely satisfied.

Meeting the second factor, the notice-prejudice rule serves as "an integral part of the policy relationship between the insurer and the insured." Metropolitan Life, 471 U.S. at 743. California's rule changes the bargain between insurer and insured; it "effectively creates a mandatory contract term" that requires the insurer to [**1390] prove prejudice before enforcing a timeliness-of-claim provision. Cisneros, 134 F.3d at 946. As the Ninth Circuit stated: "The [notice-prejudice] rule dictates the [***477] terms of the relationship between [*375] the insurer and the insured, and consequently, is integral to that relationship." Ibid. n5

n5 We reject UNUM's suggestion that because the notice-prejudice rule regulates only the administration of insurance policies, not their substantive terms, it cannot be an integral part of the policy relationship. See Metropolitan Life, 471 U.S. at 728, n. 2 (including laws regulating claims practices and requiring grace periods in catalogue of state laws that regulate insurance).

The third McCarran-Ferguson factor—which asks whether the rule is limited to entities within the insurance industry—is also well met. As earlier explained, see supra, at 6-11, California's notice-prejudice rule focuses on the insurance industry. The rule "does not merely have an impact on the insurance industry; it is aimed at it." FMC Corp. v. Holliday, 498 U.S. 52, 61, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990).

III

[***LEdHR9B] [9B]UNUM's "contra plan term" argument overlooks controlling precedent and makes scant sense. We have repeatedly held that state laws mandating insurance contract terms are saved from preemption under § 1144(b)(2)(A). See Metropolitan Life, 471 U.S. at 738 ("Massachusetts' mandated-benefit law is a 'law which regulates insurance' and so is not preempted by ERISA as it applies to insurance contracts [*376] purchased for plans subject to ERISA."); FMC Corp., 498 U.S. at 64 ("If a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts."). Under UNUM's interpretation of § 1104(a)(1)(D), however, States would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by inserting a contrary term in plan documents. This interpretation would virtually "read the saving clause out of ERISA." Metropolitan Life, 471 U.S. at 741. n6

n6 We recognize that applying the States' varying insurance regulations creates disuniformities for "national plans that enter into local markets to purchase insurance." Metropolitan Life, 471 U.S. at 747. As we have observed, however, "such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." Ibid.
brought under state rules such as notice-prejudice. Whatever the merits of UNUM's view of § 502(a)'s preemptive force, n7 the issue is not implicated here. [*377] [**1391] Ward sued under § 502(a)(1)(B) "to recover benefits due . . . under the terms of his plan." The notice-prejudice rule supplied the relevant rule of decision for this § 502(a) suit. The case therefore does not raise the question whether § 502(a) provides the sole launching ground for an ERISA enforcement action.

n7 We discussed this issue in Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987). That case concerned Mississippi common law creating a cause of action for bad faith breach of contract, law not specifically directed to the insurance industry and therefore not saved from ERISA preemption. In that context, the Solicitor General, for the United States as amicus curiae, urged the exclusivity of § 502(a), ERISA's civil enforcement provision, and observed that § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor Management Relations Act, 1947 (LMRA), 29 U.S.C. § 185. The Court agreed with the Solicitor General's submission. 481 U.S. at 52-56.

In the instant case, the Solicitor General, for the United States as amicus curiae, has endeavored to qualify the argument advanced in Pilot Life. See Brief 20-25. Noting that "LMRA Section 301 does not contain any statutory exception analogous to ERISA's insurance savings provision," the Solicitor General now maintains that the discussion of § 502(a) in Pilot Life "does not in itself require that a state law that 'regulates insurance,' and so comes within the terms of the savings clause, is nevertheless preempted if it provides a state-law cause of action or remedy." Brief 25; see also id., at 23 ("The insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated-benefits laws."). We need not address the Solicitor General's current argument, for Ward has sued under § 502(a)(1)(B) for benefits due, and seeks only the application of saved state insurance law as a relevant rule of decision in his § 502(a) action.

[***LEdHR11B] [11B]Finally, we reject UNUM's suggestion that the notice-prejudice rule conflicts with § 503 of ERISA, 29 U.S.C. § 1133, which requires plans to provide notice and the opportunity for review of denied claims, or with Department of Labor regulations providing that "[a] claim is filed when the requirements of a reasonable claim filing procedure . . . have been met," 29 CFR § 2560.503-1(d) (1998). By allowing a longer period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations. See Brief for United States as Amicus Curiae 19, n. 9.

IV

[***LEdHR4B] [4B]Ward successfully maintained in the Ninth Circuit that MAC had timely notice of his disability and that his notice to MAC could be found to have served as notice to UNUM on the theory that MAC, as administrator of the group policy, acted as UNUM's agent. The policy itself provides otherwise:

"For all purposes of this policy, the policyholder [MAC] acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company [UNUM] without a written authorization." App. to Pet. for Cert. 44a. [*378]

California law rendered that policy provision ineffective, the Ninth Circuit appeared to conclude, because under the rule stated in Elfstrom v. New York Life Ins. Co., 67 Cal. 2d 512, 432 P.2d at 737, "the employer is the agent of the insurer in performing the duties of administering group insurance policies." Thus, the Ninth Circuit instructed that, on remand, if UNUM was found to have suffered actual prejudice on account of Ward's late notice of claim, the [***479] District Court should then determine whether the claim was timely under Elfstrom. 135 F.3d 1276 at 1282.

Ward does not argue in this Court that the Elfstrom rule, as comprehended by the Ninth Circuit, is a law that "regulates insurance." See Brief for Respondent 35 (the Ninth Circuit applied "general principles of agency law," not a rule determining when "employers who administer insured plans are agents of the insurer as a matter of law"). Indeed, it is difficult to tell from the Court of Appeals opinion precisely what rule or principle that court derived from Elfstrom. See Brief for Respondent 35 ("The court below did not actually apply the Elfstrom rule in this case."); 135 F.3d at 1283, and n. 6 (endorsing the reasoning of Paulson v. Western Life Ins. Co, 292 Ore. 38, 636 P.2d 935 (1981), an Oregon Supreme Court decision that purported to reconcile Elfstrom with an apparently conflicting body of case law). Whatever the contours of Elfstrom may be, the Ninth Circuit held that the state law emerging from that case does not "relate to" an ERISA plan within the meaning of § 1144(a), and therefore escapes preemption. See 135 F.3d at 1287.
In this determination, the Ninth Circuit was mistaken. The Court of Appeals stated, without elaboration, that *Elfstrom* does not dictate "the manner in which the plan will be administered," and therefore is consistent with this Court's ERISA preemption precedent. *Ibid.*; see *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657-658, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995) (identifying among laws that "relate to" employee benefit plans those that [*379*] "mandate employee benefit structures or their administration"). The Ninth Circuit's statement is not firmly grounded. [**1392**]

As persuasively urged by the United States in its *amicus curiae* brief, deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration. It would "force the employer, as plan administrator, to assume a role, with attendant legal duties and consequences, that it has not undertaken voluntarily"; it would affect "not merely the plan's bookkeeping obligations regarding to whom benefits checks must be sent, but [would] also regulate the basic services that a plan may or must provide to its participants and beneficiaries." Brief 27. Satisfied that the *Elfstrom* rule "relates to" ERISA plans, we reject the Ninth Circuit's contrary determination.  

** * ***

For the reasons stated, the judgment of the Court of Appeals is affirmed in part and reversed in part, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

REFERENCES: Return To Full Text Opinion

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27 Am Jur 2d, Employment Relationship 85, 90, 92, 94

*15 USCS 1011 et seq.; 29 USCS 1144(a), 1144(b)(2)(A)*

L Ed Digest, States, Territories, and Possessions 38.2

L Ed Index, Pensions and Retirement

Annotation References:

Supreme Court's views as to validity, construction, and application of McCarran-Ferguson Act (*15 USCS 1011-1015*), concerning regulation of business of insurance by state or federal law. *125 L Ed 2d 879.*

When is a state or local law pre-empted by Employee Retirement Income Security Act of 1974, as amended (ERISA) (*29 USCS 1001 et seq.*)-- Supreme Court cases. *121 L Ed 2d 783.*
RUSH PRUDENTIAL HMO, INC., PETITIONER v. DEBRA C. MORAN ET AL.

No. 00-1021

SUPREME COURT OF THE UNITED STATES


January 16, 2002, Argued
June 20, 2002, Decided

NOTICE:

The LEXIS pagination of this document is subject to change pending release of the final published version.

PRIOR HISTORY: ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT.


DISPOSITION: 230 F.3d 959, affirmed.

CASE SUMMARY:

PROCEDURAL POSTURE: Respondent beneficiary of petitioner health maintenance organization's (HMO) plan regulated by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1001 et seq., sued the HMO to enforce an independent review decision under 215 Ill. Comp. Stat. 125/4-10 (2000). The U.S. Court of Appeals for the Seventh Circuit had reversed a decision that denied the claim on the ground that ERISA preempted the independent review statute.

OVERVIEW: The HMO denied coverage for an unconventional surgery for the beneficiary's shoulder pain as not medically necessary. While the ensuing lawsuit was pending, the beneficiary went ahead with surgery at her own expense. An independent medical review of her claim, found that the procedure was medically necessary. The Court held that the Illinois statute was a law "directed toward" the insurance industry, and an insurance regulation under a commonsense view, thus it was not preempted by ERISA. The Court rejected the HMO's arguments holding that the state statute did not enlarge a claim beyond the benefits available in any action brought under 29 U.S.C.S. § 1132(a). The Court noted that the state statute bore a closer resemblance to second-opinion requirements than to arbitration schemes. The state law operated before the stage of judicial review and its effect was no greater than that of mandated-benefit regulation.

OUTCOME: The judgment of the circuit court was affirmed.

LexisNexis(R) Headnotes

SYLLABUS: Petitioner Rush Prudential HMO, Inc., a health maintenance organization (HMO) that contracts to provide medical services for employee welfare benefits plans covered by the Employee Retirement Income Security Act of 1974 (ERISA), denied respondent Moran's request to have surgery by an unaffiliated specialist on the ground that the procedure was not medically necessary. Moran made a written demand for an independent medical review of her claim, as guaranteed by § 4-10 of Illinois's HMO Act, which further provides that "in the event that the reviewing physician determines the covered service to be medically necessary," the HMO "shall provide" the service. Rush refused her demand, and Moran sued in state court to compel compliance with the Act. That court ordered the review, which found the treatment necessary, but Rush
again denied the claim. While the suit was pending, Moran had the surgery and amended her complaint to seek reimbursement. Rush removed the case to federal court, arguing that the amended complaint stated a claim for ERISA benefits. The District Court treated Moran's claim as a suit under ERISA and denied it on the ground that ERISA preempted § 4-10. The Seventh Circuit reversed. It found Moran's reimbursement claim preempted by ERISA so as to place the case in federal court, but it concluded that the state Act was not preempted as a state law that "relates to" an employee benefit plan, 29 U.S.C. § 1144(a), because it also "regulates insurance" under ERISA's saving clause, § 1144(b)(2)(A).


(a) In deciding whether a law regulates insurance, this Court starts with a commonsense view of the matter, Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740, 85 L. Ed. 2d 728, 105 S. Ct. 2380, which requires a law to "be specifically directed toward" the insurance industry, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 95 L. Ed. 2d 39, 107 S. Ct. 1549. It then tests the results of the commonsense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act. Pp. 6-18.

(1) The Illinois HMO Act is directed toward the insurance industry, and thus is an insurance regulation under a commonsense view. Although an HMO provides healthcare in addition to insurance, nothing in the saving clause requires an either-or choice between healthcare and insurance. Congress recognized, the year before passing ERISA, that HMOs are risk-bearing organizations subject to state insurance regulation. That conception has not changed in the intervening years. States have been adopting their own HMO enabling Acts, and at least 40, including Illinois, regulate HMOs primarily through state insurance departments. Rush cannot submerge HMOs' insurance features beneath an exclusive characterization of HMOs as health care providers. And the argument of Rush and its amici that § 4-10 sweeps beyond the insurance industry, capturing organizations that provide no insurance and regulating noninsurance activities of HMOs that do, is based on unsound assumptions. Pp. 9-16.

(2) The McCarran-Ferguson factors confirm this conclusion. A state law does not have to satisfy all three factors to survive preemption, and § 4-10 clearly satisfies two. The independent review requirement satisfies the factor that a provision regulate "an integral part of the policy relationship between the insurer and the insured." Union Labor Life Ins. Co. v. Pireno. 458 U.S. 119, 129, 73 L. Ed. 2d 647, 102 S. Ct. 3002. Illinois adds an extra review layer when there is an internal disagreement about an HMO's denial of coverage, and the reviewer both applies a medical care standard and construes policy terms. Thus, the review affects a policy relationship by translating the relationship under the HMO agreement into concrete terms of specific obligation or freedom from duty. The factor that the law be aimed at a practice "limited to entities within the insurance industry," ibid., is satisfied for many of the same reasons that the law passes the commonsense test: It regulates application of HMO contracts and provides for review of claim denials; once it is established that HMO contracts are contracts for insurance, it is clear that § 4-10 does not apply to entities outside the insurance industry. Pp. 16-18.

(b) This Court rejects Rush's contention that, even though ERISA's saving clause ostensibly forecloses preemption, congressional intent to the contrary is so clear that it overrides the statutory provision. Pp. 18-30.

(1) The Court has recognized an overpowering federal policy of exclusivity in ERISA's civil enforcement provisions located at 29 U.S.C. § 1132(a); and it has anticipated that in a conflict between congressional polices of exclusively federal remedies and the States' regulation of insurance, the state regulation would lose out if it allows remedies that Congress rejected in ERISA, Pilot Life, 481 U.S. at 54. Rush argues that § 4-10 is preempted for creating the kind of alternative remedy that this Court disparaged in Pilot Life, one that subverts congressional intent, clearly expressed through ERISA's structure and legislative history, that the federal remedy displace state causes of action. Rush overstates Pilot Life's rule. The enquiry into state processes alleged to "supplement or supplant" ERISA remedies, 481 U.S. at 56, has, up to now, been more straightforward than it is here. Pilot Life, Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 87 L. Ed. 2d 96, 105 S. Ct. 3085, and Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 112 L. Ed. 2d 474, 111 S. Ct. 478, all involved an additional claim or remedy that ERISA did not authorize. In contrast, the review here may settle a benefit claim's fate, but the state statute does not enlarge the claim beyond the benefits available in any § 1132(a) action. And although the reviewer's determination would presumably replace the HMO's as to what is medically necessary, the ultimate relief available would still be what ERISA authorizes in a § 1132(a) suit for benefits. This case therefore resembles the claims-procedure rule that the Court sustained in UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 143 L. Ed. 2d 462, 119
Section 4-10's procedure does not fall within 

(2) Nor does § 4-10's procedural imposition interfere 
unreasonably with Congress's intention to provide a 
uniform federal regime of "rights and obligations" under 
ERISA. Although this Court has recognized a limited 
exception from the saving clause for alternative causes of 
action and alternative remedies, further limits on 
insurance regulation preserved by ERISA are unlikely to 
deserve recognition. A State might provide for a type of 
review that would so resemble an adjudication as to fall 
within \textit{Pilot Life}'s categorical bar, but that is not the case 
here. Section 4-10 is significantly different from 
common arbitration. The independent reviewer has no 
free-ranging power to construe contract terms, but 
instead confines review to the single phrase "medically 
necessary." That reviewer must be a physician with 
credentials similar to those of the primary care physician 
and is expected to exercise independent medical 
judgment, based on medical records submitted by the 
parties, in deciding what medical necessity requires. This 
process does not resemble either contract interpretation 
or evidentiary litigation before a neutral arbiter as much 
as it looks like the practice of obtaining a second 
opinion. In addition, § 4-10 does not clash with any 
differential standard for reviewing benefit denials in 
judicial proceedings. ERISA itself says nothing about a 
standard. It simply requires plans to afford a beneficiary 
some mechanism for internal review of a benefit denial 
and provides a right to a subsequent judicial forum for a 
claim to recover benefits. Although certain 
"discretionary" plan interpretations may receive 
decision from a reviewing court, see \textit{Firestone Tire 
& Rubber Co. v. Bruch}, 489 U.S. 101, 115, 103 L. Ed. 2d 
80, 109 S. Ct. 948, nothing in ERISA requires that 
medical necessity decisions be "discretionary" in the first 

230 F.3d 959, affirmed.

COUNSEL:

John J. Roberts, Jr., Philadelphia, PA, for petitioner.

Daniel P. Albers, Chicago, IL, for respondents.

JUDGES: SOUTER, J., delivered the opinion of the 
Court, in which STEVENS, O'CONNOR, GINSBURG, 
and BREYER, JJ., joined. THOMAS, J., filed a 
dissenting opinion, in which REHNQUIST, C. J., and 
SCALIA and KENNEDY, JJ., joined.

OPINIONBY: SOUTER

OPINION: [**2156] [***385] [*359]
In 1996, when Moran began to have pain and numbness in her right shoulder, Dr. Arthur LaMarre, her primary care physician, unsuccessfully administered "conservative" treatments such as physiotherapy. In October 1997, Dr. LaMarre recommended that Rush approve surgery by an unaffiliated specialist, Dr. Julia Terzis, who had developed an unconventional treatment for Moran's condition. Although Dr. LaMarre said that Moran would be "best served" by that procedure, Rush denied the request and, after Moran's internal appeals, affirmed the denial on the ground that the procedure was not "medically necessary." 230 F.3d 959, 963 (CA7 2000). Rush instead proposed that Moran undergo standard surgery, performed by a physician affiliated with Rush.

In January 1998, Moran made a written demand for an independent medical review of her claim, as guaranteed by § 4-10 of Illinois's HMO Act, 215 Ill. Comp. Stat., ch. 125, § 4-10 et seq. (2000), which provides:

"Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient . . ., primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service."

The Act defines a "Health Maintenance Organization" as

"any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." Ch. 125, § 1-2. n1

n1 In the health care industry, the term "Health Maintenance Organization" has been defined as "[a] prepaid organized delivery system where the organization and the primary care physicians assume some financial risk for the care provided to its enrolled members . . . . In a pure HMO, members must obtain care from within the system if it is to be reimbursed." Weiner & de Lissovoy, Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans, 18 J. of Health Politics, Policy and Law 75, 96 (Spring 1993) (emphasis in original). The term "Managed Care Organization" is used more broadly to refer to any number of systems combining health care delivery with financing. Id., at 97. The Illinois definition of HMO does not appear to be limited to the traditional usage of that term, but instead is likely to encompass a variety of different structures (although Illinois does distinguish HMOs from pure insurers by regulating "traditional" health insurance in a different portion of its insurance laws, 215 Ill. Comp. Stat., ch. 5 (2000)). Except where otherwise indicated, we use the term "HMO" because that is the term used by the State and the parties; what we intend is simply to describe the structures covered by the Illinois Act.

When Rush failed to provide the independent review, Moran sued in an Illinois state court to compel compliance with the state Act. Rush removed the suit to Federal District Court, arguing that the cause of action was "completely preempted" under ERISA. 230 F.3d at 964.

While the suit was pending, Moran had surgery by Dr. Terzis at her own expense and submitted a $94,841.27 reimbursement claim to Rush. Rush treated the claim as a renewed request for benefits and began a new inquiry to determine coverage. The three doctors consulted by Rush determined that the surgery had been medically unnecessary.

Meanwhile, the federal court remanded the case back to state court on Moran's motion, concluding that because Moran's request for independent review under § 4-10 would not require interpretation of the terms of an ERISA plan, the claim was not "completely preempted" so as to permit removal under 28 U.S.C. § 1441. 230 F.3d at 964. The state court enforced the state statute and ordered Rush to submit to review by an independent physician. The doctor selected was a reconstructive surgeon at Johns Hopkins Medical Center, Dr. A. Lee Dellon. Dr. Dellon decided that Dr. Terzis's treatment had been medically necessary, based on the definition of medical necessity in Rush's Certificate of Group Coverage, as well as his own medical judgment. Rush's medical director, however, refused to concede that the surgery had been medically necessary, and denied Moran's claim in January 1999.
n2 In light of our holding today that § 4-10 is not preempted by ERISA, the propriety of this ruling is questionable; a suit to compel compliance with § 4-10 in the context of an ERISA plan would seem to be akin to a suit to compel compliance with the terms of a plan under 29 U.S.C. § 1132(a)(3). Alternatively, the proper course may have been to bring a suit to recover benefits due, alleging that the denial was improper in the absence of compliance with § 4-10. We need not resolve today which of these options is more consonant with ERISA.

n3 No party has challenged Rush's status as defendant in this case, despite the fact that many lower courts have interpreted ERISA to permit suits under § 1132(a) only against ERISA plans, administrators, or fiduciaries. See, e.g., Everhart v. Allmerica Financial Life Ins. Co., 275 F.3d 751, 754-756 (CA9 2001); Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186, 187 (CA11 1997); Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1490 (CA7 1996). Without commenting on the correctness of such holdings, we assume (although the information does not appear in the record) that Rush has failed to challenge its status as defendant because it is, in fact, the plan administrator. This conclusion is buttressed by the fact that the plan's sponsor has granted Rush discretion to interpret the terms of its coverage, and by the fact that one of Rush's challenges to the Illinois statute is based on what Rush perceives as the limits that statute places on fiduciary discretion. Whatever Rush's true status may be, however, it is immaterial to our holding.

The Court of Appeals for the Seventh Circuit reversed. 230 F.3d 959 (2000). Although it found Moran's state-law reimbursement claim completely preempted by ERISA so as to place the case in federal court, the Seventh Circuit did not agree that the substantive provisions of Illinois's HMO Act were so preempted. The court noted that although ERISA broadly preempts any state laws that "relate to" employee benefit plans, 29 U.S.C. § 1144(a), [***388] state laws that "regulate [*364] insurance" are saved from preemption, § 1144(b)(2)(A). The court held that the Illinois HMO Act was such a law, the independent review requirement being little different from a state-mandated contractual term of the sort this Court had held to survive ERISA preemption. See 230 F.3d at 972 (citing UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 375-376, 143 L. Ed. 2d 462, 119 S. Ct. 1380 (1999)). The Seventh Circuit rejected the contention that Illinois's independent review requirement constituted a forbidden "alternative remedy" under this Court's holding in Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987), and emphasized that § 4-10 does not authorize any particular form of relief in state courts; rather, with respect to any ERISA health plan, the judgment of the independent reviewer is only enforceable in an action brought under ERISA's civil enforcement scheme, 29 U.S.C. § 1132(a). 230 F.3d at 971.

Because the decision of the Court of Appeals conflicted with the Fifth Circuit's treatment of a similar provision of Texas law in Corporate Health Ins., Inc. v. Texas Dept. of Ins., 215 F.3d 526 (2000), we granted certiorari, 533 U.S. 948 (2001). We now affirm.

II

[***LEdHR3] [3] To "safeguard . . . the establishment, operation, and administration" of employee benefit plans, ERISA sets "minimum standards . . . assuring the equitable character of such plans and their financial soundness," 29 U.S.C. § 1001(a), and contains an express preemption provision that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." § 1144(a). A saving clause then claims a substantial amount of ground with its provision that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 1144(b)(2)(A). The "unhelpful" drafting of these antithetical clauses, New York State Conference [*365] of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995), occupies a substantial share of this Court's time, see, e.g., Egelhoff v. Egelhoff, 532 U.S. 141, 149 L. Ed. 2d 264, 121 S. Ct. 1322 (2001); UNUM Life [**2159] Ins. Co. of America
v. Ward, supra; California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc., 519 U.S. 316, 136 L. Ed. 2d 791, 117 S. Ct. 832 (1997); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985). In trying to extrapolate congressional intent in a case like this, when congressional language seems simultaneously to preempt everything and hardly anything, we "have no choice" but to temper the assumption that "the ordinary meaning . . . accurately expresses the legislative purpose," id., at 740 (quoting Park 'N Fly v. Dollar Park and Fly, Inc., 469 U.S. 189, 194, 83 L. Ed. 2d 582, 105 S. Ct. 658 (1985)), with the qualification "that the historic power forces of the States were not [meant] to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." Travelers, 514 U.S. at 655 [*389] (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 91 L. Ed. 1447, 67 S. Ct. 1146 (1947)).

[*LEdHR1B] [1B] [*LEdHR4] [4]It is beyond serious dispute that under existing precedent § 4-10 of the Illinois HMO Act "relates to" employee benefit plans within the meaning of § 1144(a). The state law bears "indirectly but substantially on all insured benefit plans," Metropolitan Life, 471 U.S. at 739, by requiring them to submit to an extra layer of review for certain benefit denials if they purchase medical coverage from any of the common types of health care organizations covered by the state law's definition of HMO. As a law that "relates to" ERISA plans under § 1144(a), § 4-10 is saved from preemption only if it also "regulates insurance" under § 1144(b)(2)(A). Rush insists that the Act is not such a law.

A

[*LEdHR5A] [5A]In Metropolitan Life, we said that in deciding whether a law "regulates insurance" under ERISA's saving clause, we start with a "common-sense view of the matter," 471 U.S. [*366] at 740, under which "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." Pilot Life Ins. Co. v. Dedeaux, supra, at 50. We then test the results of the common-sense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq. n4 Although this is not the place to plot the exact perimeter of the saving clause, it is generally fair to think of the combined "common-sense" and McCarran-Ferguson factors as parsing the "who" and the "what": when insurers are regulated with respect to their insurance practices, the state law survives ERISA. Cf. Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211, 59 L. Ed. 2d 261, 99 S. Ct. 1067 (1979) (explaining that the "business of insurance" is not coextensive with the "business of insurers").

n4 The McCarran-Ferguson Act requires that the business of insurance be subject to state regulation, and, subject to certain exceptions, mandates that "no Act of Congress shall be construed to invalidate . . . any law enacted by any State for the purpose of regulating the business of insurance . . . ." 15 U.S.C. § 1012(b).

1

The common-sense enquiry focuses on "primary elements of an insurance contract[, which] are the spreading and underwriting of a policyholder's risk." Id., at 211. The Illinois statute addresses these elements by defining "health maintenance organization" by reference to the risk that it bears. See 215 Ill. Comp. Stat., ch. 125, § 1-2(9) (2000) (an HMO "provides or arranges for . . . health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers"). [*2160]

Rush contends that seeing an HMO as an insurer distorts the nature of an HMO, which is, after all, a health care provider, too. This, Rush argues, should determine its characterization, with the consequence that regulation of an HMO is not insurance regulation within the meaning of ERISA. [*367]

[*390] [*LEdHR6] [6]The answer to Rush is, of course, that an HMO is both: it provides health care, and it does so as an insurer. Nothing in the saving clause requires an either-or choice between health care and insurance in deciding a preemption question, and as long as providing insurance fairly accounts for the application of state law, the saving clause may apply. There is no serious question about that here, for it would ignore the whole purpose of the HMO-style of organization to conceive of HMOs (even in the traditional sense, see n. 1, supra) without their insurance element.

"The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed." Pegram v. Herdrich, 530 U.S. 211, 218, 147 L. Ed. 2d 164, 120 S. Ct. 2143 (2000). "The HMO thus assumes the financial risk of providing the benefits promised: if a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes expensively ill, the HMO is responsible for the treatment . . . ." Id., at 218-219. The HMO design goes beyond the simple truism that all contracts are, in some sense, insurance against future fluctuations in price, R. Posner, Economic
Analysis of Law 104 (4th ed. 1992), because HMOs actually underwrite and spread risk among their participants, see, e.g., R. Shoullice, Introduction to Managed Care 450-462 (1991), a feature distinctive to insurance, see, e.g., SEC v. Variable Annuity Life Ins. Co. of America, 359 U.S. 65, 73-3 L. Ed. 2d 640, 79 S. Ct. 618 (1959) (underwriting of risk is an "earmark of insurance as it has commonly been conceived of in popular understanding and usage"); Royal Drug, 440 U.S. at 215, n. 12 ("Unless there is some element of spreading risk more widely, there is no underwriting of risk").

So Congress has understood from the start, when the phrase "Health Maintenance Organization" was established and defined in the HMO Act of 1973. The Act was intended to encourage the development of HMOs as a new form of health care delivery system, see S. Rep. No. 93-129, pp. 7-9 [*368] (1973), and when Congress set the standards that the new health delivery organizations would have to meet to get certain federal benefits, the terms included requirements that the organizations bear and manage risk. See, e.g., Health Maintenance Organization Act of 1973, § 1301(c), 87 Stat. 916, as amended, 42 U.S.C. § 300e(c) (1994 ed.); S. Rep. No. 93-129, at 14 (explaining that HMOs necessarily bear some of the risk of providing service, and requiring that a qualifying HMO "assume direct financial responsibility, without benefit of reinsurance, for care . . . in excess of the first five thousand dollars per enrollee per year"). The Senate Committee Report explained that federally qualified HMOs would be required to provide "a basic package of benefits, consistent with existing health insurance patterns," id., at 10, and the very text of the Act assumed that state insurance laws would apply to HMOs; it provided that to the extent state insurance capitalization and reserve requirements were too stringent to permit the formation of HMOs, "qualified" HMOs would be exempt from such limiting regulation. See § 1311, 42 U.S.C. § 300e-10. This congressional understanding [*391] that it was promoting a novel form of insurance was made explicit in the Senate Report's reference to the practices of "health insurers to charge premium rates based upon the actual claims experience of a particular group of subscribers," thus "raising costs and diminishing the availability of health insurance for those suffering from costly [*2161] illnesses," S. Rep. No. 93-129, at 29-30. The federal Act responded to this insurance practice by requiring qualifying HMOs to adopt uniform capitation rates, see § 1301(b), 42 U.S.C. § 300e(b), and it was because of that mandate "posing substantial competitive problems to newly emerging HMOs," S. Rep. No. 93-129, at 30, that Congress authorized funding subsidies, see § 1304, 42 U.S.C. § 300e-4. The Senate explanation left no doubt that it viewed an HMO as an insurer; the subsidy was justified because "the same stringent requirements do not apply to other indemnity or service benefits insurance plans." [*369] S. Rep. No. 93-129, at 30. In other words, one year before it passed ERISA, Congress itself defined HMOs in part by reference to risk, set minimum standards for managing the risk, showed awareness that States regulated HMOs as insurers, and compared HMOs to "indemnity or service benefits insurance plans."

This conception has not changed in the intervening years. Since passage of the federal Act, States have been adopting their own HMO enabling Acts, and today, at least 40 of them, including Illinois, regulate HMOs primarily through the States' insurance departments, see Aspen Health Law and Compliance Center, Managed Care Law Manual 31-32 (Supp. 6, Nov. 1997), although they may be treated differently from traditional insurers, owing to their additional role as health care providers, n5 see, e.g., Alaska Ins. Code § 21.86.010 (2000) (health department reviews HMO before insurance commissioner grants a certificate of authority); Ohio Rev. Code Ann. § 1742.21 (West 1994) (health department may inspect HMO). Finally, this view shared by Congress and the States has passed into common understanding. HMOs (broadly defined) have "grown explosively in the past decade and [are] now the dominant form of health plan coverage for privately insured individuals." Gold & Hurley, The Role of Managed Care "Products" in Managed Care "Plans," in Contemporary Managed Care 47 (M. Gold ed. 1998). While the original form of the HMO was a single corporation employing its own physicians, the 1980s saw a variety of other types of structures develop even as traditional insurers altered their own [*370] plans by adopting HMO-like cost-control measures. See Weiner & de Lisslovoy, Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans, 18 J. of Health Politics, Policy and Law 75, 83 (Spring 1993). The [*392] dominant feature is the combination of insurer and provider, see Gold & Hurley, supra, at 47, and "an observer may be hard pressed to uncover the differences among products that bill themselves as HMOs, [preferred provider organizations], or managed care overlays to health insurance." Managed Care Law Manual, supra, at 1. Thus, virtually all commentators on the American health care system describe HMOs as a combination of insurer and provider, and observe that in recent years, traditional "indemnity" insurance has fallen out of favor. See, e.g., Weiner & de Lisslovoy, supra, at 77 ("A common characteristic of the new managed care plans was the degree to which the roles of insurer and provider became integrated"); Gold, Understanding the Roots: Health Maintenance Organizations in Historical Context, in Contemporary Managed Care, supra, at [**2162] 7, 8, 13; Managed Care Law Manual, supra, at
HMOs may contract with third-party insurers to protect HMO at all. In a similar vein, Rush points out that arrangement, Rush claims, the risk is not borne by the physicians with a set fee for each HMO patient regardless of the treatment provided. Under such an arrangement, Rush claims, the risk is not borne by the HMO at all. In a similar vein, Rush points out that HMOs may contract with third-party insurers to protect themselves against large claims.

The problem with Rush's argument is simply that a reinsurant contract does not take the primary insurer out of the insurance business, cf. Hartford Fire Ins. Co. v. California, 509 U.S. 764, 125 L. Ed. 2d 612, 113 S. Ct. 772-773 ("Primary insurers . . . usually purchase insurance to cover a portion of the risk they assume from the consumer"), and capitation contracts do not relieve the HMO of its obligations to the beneficiary. The HMO is still bound to [***393] provide medical care to its members, and this is so regardless of the ability of physicians or third-party insurers to honor their contracts with the HMO.

Nor do we see anything standing in the way of applying the saving clause if we assume that the general state definition of HMO would include a contractor that provides only administrative services for a self-funded plan. n6 Rush points [*372] out that the general definition of HMO under Illinois law includes not only organizations that "provide" health care plans, but those that "arrange for" them to be provided, so long as "any part of the risk of health care delivery" rests upon "the organization or its providers." Id., at 69.

n5 We have, in a limited number of cases, found certain contracts not to be part of the "business of insurance" under McCarran-Ferguson, notwithstanding their classification as such for the purpose of state regulation. See, e.g., SEC v. Variable Annuity Life Ins. Co. of America, 359 U.S. 65, 3 L. Ed. 2d 640, 79 S. Ct. 618 (1959). Even then, however, we recognized that such classifications are relevant to the enquiry, because Congress, in leaving the "business of insurance" to the States, "was legislating concerning a concept which had taken on its coloration and meaning largely from state law, from state practice, from state usage." Id., at 69.

2

On a second tack, Rush and its amici dispute that § 4-10 is aimed specifically at the insurance industry. They say the law sweeps too broadly with definitions capturing organizations that provide no insurance, and by regulating noninsurance activities of HMOs that do. Rush points out that Illinois law defines HMOs to include organizations that cause the risk of health care delivery to be borne by the organization itself, or by "its providers." 215 Ill. Comp. Stat., ch. 125, § 1-2(9) (2000). Rush's view, the reference to "its [*371] providers" suggests that an organization may be an HMO under state law (and subject to § 4-10) even if it does not bear risk itself, either because it has "devolved" the risk of health care delivery onto others, or because it has contracted only to provide "administrative" or other services for self-funded plans. Brief for Petitioner 38.

n6 ERISA's "deemer" clause provides an exception to its saving clause that forbids States from regulating self-funded plans as insurers. See 29 U.S.C. § 1144(b)(2)(B); FMC Corp. v. Holliday, 498 U.S. 52, 61, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990). Therefore, Illinois's Act would not be "saved" as an insurance law to the extent it applied to self-funded plans. This fact, however, does not bear on Rush's challenge to the law as one that is targeted toward non-risk-bearing organizations.

[***LEdHR1C] [1C] These arguments, however, are built on unsound assumptions. Rush's first contention assumes that an HMO is no longer an insurer when it arranges to limit its exposure, as when an HMO arranges for capitated contracts to compensate its affiliated physicians with a set fee for each HMO patient regardless of the treatment provided. Under such an arrangement, Rush claims, the risk is not borne by the HMO at all. In a similar vein, Rush points out that HMOs may contract with third-party insurers to protect themselves against large claims.

The problem with Rush's argument is simply that a reinsurant contract does not take the primary insurer out of the insurance business, cf. Hartford Fire Ins. Co. v. California, 509 U.S. 764, 125 L. Ed. 2d 612, 113 S. Ct. 2891 (1993) (applying McCarran-Ferguson to a dispute involving primary insurers and reinsurers); id., at 772-773 ("Primary insurers . . . usually purchase insurance to cover a portion of the risk they assume from the consumer"), and capitation contracts do not relieve the HMO of its obligations to the beneficiary. The HMO is still bound to [***393] provide medical care to its members, and this is so regardless of the ability of physicians or third-party insurers to honor their contracts with the HMO.

Nor do we see anything standing in the way of applying the saving clause if we assume that the general state definition of HMO would include a contractor that provides only administrative services for a self-funded plan. n6 Rush points [*372] out that the general definition of HMO under Illinois law includes not only organizations that "provide" health care plans, but those that "arrange for" them to be provided, so long as "any part of the risk of health care delivery" rests upon "the organization or its providers." 215 Ill. Comp. Stat., ch. 125, § 1-2(9) (2000). See Brief for Petitioner 38. Rush hypothesizes a sort of medical matchmaker, bringing together ERISA plans and medical care providers; even if the latter bear all the risks, the matchmaker would be an HMO under the Illinois definition. Rush would conclude from this that § 4-10 covers noninsurers, and so is not directed specifically to the insurance industry. Ergo, ERISA's saving clause would not apply.

n6 ERISA's "deemer" clause provides an exception to its saving clause that forbids States from regulating self-funded plans as insurers. See 29 U.S.C. § 1144(b)(2)(B); FMC Corp. v. Holliday, 498 U.S. 52, 61, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990). Therefore, Illinois's Act would not be "saved" as an insurance law to the extent it applied to self-funded plans. This fact, however, does not bear on Rush's challenge to the law as one that is targeted toward non-risk-bearing organizations.

[***2163]

It is far from clear, though, that the terms of § 4-10 would even theoretically apply to the matchmaker, for the requirement that the HMO "provide" the covered service if the independent reviewer finds it medically necessary seems to assume that the HMO in question is a provider, not the mere arranger mentioned in the general definition of an HMO. Even on the most generous reading of Rush's argument, however, it boils down to the bare possibility (not the likelihood) of some
overbreadth in the application of § 4-10 beyond orthodox HMOs, and there is no reason to think Congress would have meant such minimal application to noninsurers to remove a state law entirely from the category of insurance regulation saved from preemption.

In sum, prior to ERISA's passage, Congress demonstrated an awareness of HMOs as risk-bearing organizations subject to state insurance regulation, the state Act defines HMOs by reference to risk bearing, HMOs have taken over much business formerly performed by traditional indemnity insurers, and they are almost universally regulated as insurers under state law. That HMOs are not traditional "indemnity" insurers is no matter; "we would not undertake to freeze the concepts of 'insurance' . . . into the mold they fitted when these Federal Acts were passed." SEC v. Variable Annuity Life Ins. Co. of America, 359 U.S. at 71. Thus, the Illinois HMO Act is a law "directed toward" the insurance industry, and an "insurance regulation" under a "commonsense" view.

B

The McCarran-Ferguson factors confirm our conclusion. A law regulating insurance for McCarran-Ferguson purposes targets practices or provisions that "have the effect of transferring or spreading a policyholder's risk; . . . [that are] an integral part of the policy relationship between the insurer and the insured; and [are] limited to entities within the insurance industry." Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129, 73 L. Ed. 2d 647, 102 S. Ct. 3002 (1982). Because the factors are guideposts, a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption, see UNUM Life Ins. Co. v. Ward, 526 U.S. at 373, and so we follow our precedent and leave open whether the review mandated here may be described as going to a practice that "spreads a policyholder's risk." For in any event, the second and third factors are clearly satisfied by § 4-10.

It is obvious enough that the independent review requirement regulates "an integral part of the policy relationship between the insurer and the insured." Illinois adds an extra layer of review when there is internal disagreement about an HMO's denial of coverage. The reviewer applies both a standard of medical care (medical necessity) and characteristically, as in this case, construes policy terms. Cf. Pegram v. Herdrich, 530 U.S. at 228-229. The review affects the "policy relationship" between HMO and covered persons by translating the relationship under the HMO agreement into concrete terms of specific obligation or freedom from duty. Hence our repeated statements that the interpretation of insurance contracts is at the "core" of the business of insurance. E.g., SEC v. National Securities, Inc., 393 U.S. 453, 21 L. Ed. 2d 668, 89 S. Ct. 564 (1969).

Rush says otherwise, citing Union Labor Life Ins. Co. v. Pireno, supra, and insisting that that case holds external review of coverage decisions to be outside the "policy relationship." But Rush misreads Pireno. We held there that an insurer's use of a "peer review" committee to gauge the necessity of particular treatments was not a practice integral to the policy relationship for the purposes of McCarran-Ferguson. 458 U.S. at 131-132. We emphasized, however, [**2164] that the insurer's resort to peer review was simply the insurer's unilateral choice to seek advice if and when it cared to do so. The policy said nothing on the matter. The insurer's contract for advice from a third party was no concern of the insured, who was not bound by the peer review committee's recommendation any more, for that matter, than the insurer was. Thus it was not too much of an exaggeration to conclude that the practice was "a matter of indifference to the policyholder," id., at 132. Section 4-10, by contrast, is different on all counts, providing as it does a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMO's medical obligations.

The final factor, that the law be aimed at a "practice . . . limited to entities within the insurance industry," id., at 129, is satisfied for many of the same reasons that the law passes the commonsense test. The law regulates application of HMO contracts and provides for review of claim denials; once it is established that HMO contracts are, in fact, contracts for insurance (and not merely contracts for medical care), it is clear that § 4-10 does not apply to entities outside the insurance industry (although it does not, of course, apply to all entities within it).

Even if we accepted Rush's contention, rejected already, that the law regulates HMOs even when they act as pure administrators, we would still find the third factor satisfied. [*375] That factor requires the targets of the law to be limited to entities within the insurance industry, and even a matchmaking HMO would fall within the insurance industry. But the implausibility of Rush's hypothesis that the pure administrator would be bound by § 4-10 obviates any need to say more under this third factor. Cf. Barnett Bank of Marion Cty, N. A. v. Nelson, 517 U.S. 25, 39, 134 L. Ed. 2d 237, 116 S. Ct. 1103 (1996) (holding that a federal statute permitting banks to act as agents of insurance companies, although not insurers themselves, was a statute regulating the "business of insurance" for McCarran-Ferguson purposes).
III

[***LEdHR1F] [1F]Given that § 4-10 regulates insurance, ERISA's mandate that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance," 29 U.S.C. § 1144(b)(2)(A), ostensibly forecloses preemption. See Metropolitan Life, 471 U.S. at 746 ("If a state law 'regulates insurance,' . . . it is not pre-empted"). Rush, however, does not give up. It argues for preemption anyway, emphasizing that the question is ultimately one of congressional intent, which sometimes is so clear that it overrides a statutory provision designed to save state law from being preempted. See American Telephone & Telegraph Co. v. Central Office Telephone, Inc., 524 U.S. 214, 227, 141 L. Ed. 2d 222, 118 S. Ct. 1956 (1998) (AT&T) (clause in Communications Act of 1934 purporting to save "the remedies now existing at common law or by statute," 47 U.S.C. § 414 (1994 ed.), defeated by overriding policy of the filed-rate doctrine); Adams Express Co. v. Croninger, 226 U.S. 491, 507, 57 L. Ed. 314, 33 S. Ct. 148 (1913) (saving clause will not sanction state laws that would nullify policy expressed in federal statute; "the act cannot be said to destroy itself" (internal quotation marks omitted)).

In ERISA law, we have recognized one example of this sort of overpowering federal policy in the civil enforcement provisions, 29 U.S.C. § 1132(a), authorizing civil actions for [376] six specific types of relief. n7 [***2165] In Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 87 L. Ed. 2d 96, 105 S. Ct. 3085 [***396] (1985), we said those provisions amounted to an "interlocking, interrelated, and interdependent remedial scheme," id., at 146, which Pilot Life described as "representing a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans," 481 U.S. at 54. So, we have held, the civil enforcement provisions are of such extraordinarily preemptive power that they override even the "well-pleaded complaint" rule for establishing the conditions under which a cause of action may be removed to a federal forum. Metropolitan Life Ins. Co. v. Taylor, 481 U.S. at 63-64.

n7 Title 29 U.S.C. § 1132(a) provides in relevant part:

"(A) for the relief provided for in subsection (c) of this section [concerning requests to the administrator for information], or

"(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

"(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [breach of fiduciary duty];

"(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

"(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title [information to be furnished to participants];

"(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

"(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (l) of this section."

[*377]

A

Although we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the "reservation of the business of insurance to the States," Metropolitan Life, 471 U.S. at 744, n. 21, we have anticipated such a conflict, with the state insurance regulation losing out if it allows plan participants "to obtain remedies . . . that Congress rejected in ERISA," Pilot Life, 481 U.S. at 54.

In Pilot Life, an ERISA plan participant who had been denied benefits sued in a state court on state tort and contract claims. He sought not merely damages for breach of contract, but also damages for emotional distress and punitive damages, both of which we had held unavailable under relevant ERISA provisions. Russell, supra, at 148. We not only rejected the notion that these common-law contract claims "regulated insurance," Pilot Life, 481 U.S. at 50-51, but went on to say that, regardless, Congress intended a "federal
common law of rights and obligations' to develop under ERISA, \textit{id.}, at 56, without embellishment by independent state remedies. As in \textit{AT&T}, we said the saving clause had to stop short of subverting congressional intent, clearly expressed "through the structure and legislative history[,] that the federal remedy . . . displace state causes of action." 481 U.S. at 57. n8

n8 Rush and its \textit{amici} interpret \textit{Pilot Life} to have gone a step further to hold that any law that presents such a conflict with federal goals is simply not a law that "regulates insurance." however else the "insurance" test comes out. We believe the point is largely academic. As will be discussed further, even under Rush's approach, a court must still determine whether the state law at issue does, in fact, create such a conflict. Thus, we believe that it is more logical to proceed as we have done here.

Rush says that the day has come [***397] to turn dictum into holding by declaring that the state insurance regulation, § 4-10, is preempted for creating just the kind of "alternative remedy" we disparaged in \textit{Pilot Life}. As Rush sees it, the independent [***2166] [***378] review procedure is a form of binding arbitration that allows an ERISA beneficiary to submit claims to a new decisionmaker to examine Rush's determination de novo, supplanting judicial review under the "arbitrary and capricious" standard ordinarily applied when discretionary plan interpretations are challenged. \textit{Firestone Tire & Rubber Co. v. Bruch}, 489 U.S. 101, 110-112, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989). Rush says that the beneficiary's option falls within \textit{Pilot Life}'s notion of a remedy that "supplements or supplants" the remedies available under ERISA. 481 U.S. at 56.

We think, however, that Rush overstates the rule expressed in \textit{Pilot Life}. The enquiry into state processes alleged to "supplement or supplant" the federal scheme by allowing beneficiaries "to obtain remedies under state law that Congress rejected in ERISA," \textit{id.}, at 54, has, up to now, been far more straightforward than it is here. The first case touching on the point did not involve preemption at all; it arose from an ERISA beneficiary's reliance on ERISA's own enforcement scheme to claim a private right of action for types of damages beyond those expressly provided. \textit{Russell}, 473 U.S. at 145. We concluded that Congress had not intended causes of action under ERISA itself beyond those specified in § 1132(a). \textit{Id.}, at 148. Two years later we determined in \textit{Metropolitan Life Ins. Co. v. Taylor, supra}, that Congress had so completely preempted the field of benefits law that an ostensibly state cause of action for benefits was necessarily a "creature of federal law" removable to federal court. 481 U.S. at 64 (internal quotation marks omitted). \textit{Russell} and \textit{Taylor} naturally led to the holding in \textit{Pilot Life} that ERISA would not tolerate a diversity action seeking monetary damages for breach generally and for consequential emotional distress, neither of which Congress had authorized in § 1132(a). These monetary awards were claimed as remedies to be provided at the ultimate step of plan enforcement, and even if they could have been characterized as products of "insurance regulation," they would have significantly [***379] expanded the potential scope of ultimate liability imposed upon employers by the ERISA scheme.

[***LEdHR8] [8]Since \textit{Pilot Life}, we have found only one other state law to "conflict" with § 1132(a) in providing a prohibited alternative remedy. In \textit{Ingersoll-Rand Co. v. McClendon}, 498 U.S. 133, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990), we had no trouble finding that Texas's tort of wrongful discharge, turning on an employer's motivation to avoid paying pension benefits, conflicted with ERISA enforcement; while state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under § 1132(a)(3) (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal). Thus, \textit{Ingersoll-Rand} fit within the category of state laws \textit{Pilot Life} had held to be incompatible with ERISA's enforcement [***398] scheme; the law provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA. Any such provision patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred. See \textit{Pilot Life}, \textit{supra}, at 56 ("The uniformity of decision . . . will help administrators . . . predict the legality of proposed actions without the necessity of reference to varying state laws.") (quoting H. R. Rep. No. 93-533, p. 12 (1973))); 481 U.S. at 56 ("The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop . . . would make little sense if the remedies available to ERISA participants and beneficiaries under [ § 1132(a)] could be supplemented or supplanted by varying state laws"). [***2167]

[***LEdHR1G] [1G]But this case addresses a state regulatory scheme that provides no new cause of action under state law and authorizes no new form of ultimate relief. While independent review under § 4-10 may well settle the fate of a benefit claim under a particular contract, the state statute does not enlarge [*380] the
claim beyond the benefits available in any action brought under § 1132(a). And although the reviewer's determination would presumably replace that of the HMO as to what is "medically necessary" under this contract, n9 the relief ultimately available would still be what ERISA authorizes in a suit for benefits under § 1132(a). n10 This case therefore does not involve the sort of additional claim or remedy exemplified in Pilot Life, Russell, and Ingersoll-Rand, but instead bears a resemblance to the claims-procedure rule that we sustained in UNUM Life Ins. Co. v. Ward, 526 U.S. 358, 119 S. Ct. 1380 (1999), holding that a state law barring enforcement of a policy's time limitation on submitting claims did not conflict with § 1132(a), even though the state "rule of decision," id., at 377, could mean the difference between success and failure for a beneficiary. The procedure provided by § 4-10 does not fall within Pilot Life's categorical preemption.

n9 The parties do not dispute that § 4-10, as a matter of state law, purports to make the independent reviewer's judgment dispositive as to what is "medically necessary." We accept this interpretation of the meaning of the statute for the purposes of our opinion.

n10 This is not to say that the court would have no role beyond ordering compliance with the reviewer's determination. The court would have the responsibility, for example, to fashion appropriate relief, or to determine whether other aspects of the plan (beyond the "medical necessity" of a particular treatment) affect the relative rights of the parties. Rush, for example, has chosen to guarantee medically necessary services to plan participants. For that reason, to the extent § 4-10 may render the independent reviewer the final word on what is necessary, see n. 9, supra, Rush is obligated to provide the service. But insurance contracts do not have to contain such guarantees, and not all do. Some, for instance, guarantee medically necessary care, but then modify that obligation by excluding experimental procedures from coverage. See, e.g., Tillery v. Hoffman Enclosures, Inc., 280 F.3d 1192 (CA8 2002). Obviously, § 4-10 does not have anything to say about whether a proposed procedure is experimental. There is also the possibility, though we do not decide the issue today, that a reviewer's judgment could be challenged as inaccurate or biased, just as the decision of a plan fiduciary might be so challenged.

[*381]

B

[***LEdHR1H] [1H]Rush still argues for going beyond [***399] Pilot Life, making the preemption issue here one of degree, whether the state procedural imposition interferes unreasonably with Congress's intention to provide a uniform federal regime of "rights and obligations" under ERISA. However, "such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." Metropolitan Life, 471 U.S. at 747. n11 Although we have recognized a limited exception from the saving clause for alternative causes of action and alternative remedies [**2168] in the sense described above, we have never indicated that there might be additional justifications for qualifying the clause's application. Rush's arguments today convince us that further limits on insurance regulation preserved by ERISA are unlikely to deserve recognition.

[***LEdHR1I] [1I]

n11 Thus, we do not believe that the mere fact that state independent review laws are likely to entail different procedures will impose burdens on plan administration that would threaten the object of 29 U.S.C. § 1132(a); it is the HMO contracting with a plan, and not the plan itself, that will be subject to these regulations, and every HMO will have to establish procedures for conforming with the local laws, regardless of what this Court may think ERISA forbids. This means that there will be no special burden of compliance upon an ERISA plan beyond what the HMO has already provided for. And although the added compliance cost to the HMO may ultimately be passed on to the ERISA plan, we have said that such "indirect economic effects," New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 659, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995), are not enough to preempt state regulation even outside of the insurance context. We recognize, of course, that a State might enact an independent review requirement with procedures so elaborate, and burdens so onerous, that they might undermine § 1132(a). No such system is before us.

To be sure, a State might provide for a type of "review" that would so resemble an adjudication as to fall within Pilot Life's categorical bar. Rush, and the dissent, post, at 8, contend that § 4-10 fills that bill by
imposing an alternative scheme of arbitral adjudication at [*382] odds with the manifest congressional purpose to confine adjudication of disputes to the courts. It does not turn out to be this simple, however, and a closer look at the state law reveals a scheme significantly different from common arbitration as a way of construing and applying contract terms.


Section 4-10 does resemble an arbitration provision, then, to the extent that the independent reviewer considers disputes about the meaning of the HMO contract n12 and receives "evidence" in the form of medical records, statements from [*383] physicians, and the like. But this is as far as the resemblance to arbitration goes, for the other features of review under § 4-10 give the proceeding a different character, one not at all at odds with the policy behind § 1132(a). The Act does not give the independent reviewer a free-ranging power to construe contract terms, but instead, confines review to a single term: the phrase "medical necessity," used to define the services covered under the contract. This limitation, in turn, implicates a feature of HMO benefit determinations that we described in *Pegram v. Herdrich*, 530 U.S. 211, 147 L. Ed. 2d 164, 120 S. Ct. 2143 (2000). We explained that when an HMO guarantees medically necessary care, determinations of coverage "cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* , at 229. This is just how the Illinois Act operates; the independent examiner must be a physician with credentials similar to those of the primary care physician, 215 Ill. Comp. Stat., ch. 125, § 4-10 (2000), and is expected to exercise independent medical judgment in deciding what medical necessity requires. Accordingly, the reviewer in this case did not hold the kind of conventional evidentiary hearing common in arbitration, but simply received medical records submitted by the parties, and ultimately came to a professional [*2169] judgment of his own. Tr. of Oral Arg. 30-32.

n12 Nothing in the Act states that the reviewer should refer to the definitions of medical necessity contained in the contract, but the reviewer did, in this case, refer to that definition. Thus, we will assume that some degree of contract interpretation is required under the Act. Were no interpretation required, there would be a real question as to whether § 4-10 is properly characterized as a species of mandated-benefit law of the type we approved in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985).


The practice of obtaining a second opinion, however, is far removed from any notion of an enforcement scheme, and [*384] once § 4-10 is seen as something akin to a mandate for second-opinion practice in order to ensure sound medical judgments, the preemption argument that arbitration under § 4-10 supplants judicial enforcement runs out of steam.

Next, Rush argues that § 4-10 clashes with a substantive rule intended to be preserved by the system of uniform enforcement, stressing a feature of judicial review highly prized by benefit plans: a deferential standard for reviewing benefit denials. Whereas *Firestone Tire & Rubber* [*401] Co. v. Bruch,
U.S. at 115, recognized that an ERISA plan could be designed to grant "discretion" to a plan fiduciary, deserving deference from a court reviewing a discretionary judgment, § 4-10 provides that when a plan purchases medical services and insurance from an HMO, benefit denials are subject to apparently de novo review. If a plan should continue to balk at providing a service the reviewer has found medically necessary, the reviewer's determination could carry great weight in a subsequent suit for benefits under § 1132(a), n14 depriving the plan of the judicial deference a fiduciary's medical judgment might have obtained if judicial review of the plan's decision had been immediate. n15

n14 See n. 10, supra.

n15 An issue implicated by this case but requiring no resolution is the degree to which a plan provision for unfettered discretion in benefit determinations guarantees truly deferential review. In Firestone Tire itself, we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised. That last observation was underscored only two Terms ago in Pegram v. Herdrich, 530 U.S. 211, 147 L. Ed. 2d 164, 120 S. Ct. 2143 (2000), when we again noted the potential for conflict when an HMO makes decisions about appropriate treatment, see id., at 219-220. It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest. Moreover, as we explained in Pegram, "it is at least questionable whether Congress would have had mixed eligibility decisions in mind when it provided that decisions administering a plan were fiduciary in nature." id., at 232. Our decision today does not require us to resolve these questions.

n16 Rush presents the alternative argument that § 4-10 is preempted as conflicting with ERISA's requirement that a benefit denial be reviewed by a named fiduciary, 29 U.S.C. § 1133(2). Rush contends that § 4-10 interferes with fiduciary discretion by forcing the provision of benefits over a fiduciary's objection. Happily, we need not decide today whether § 1133(2) carries the same preemptive force of § 1132(a) such that it overrides even the express saving clause for insurance regulation, because we see no conflict. Section 1133 merely requires that plans provide internal appeals of benefits denials; § 4-10 plays no role in this process, instead providing for extra review once the internal process is complete. Nor is there any conflict in the removal of fiduciary "discretion"; as described below, ERISA does not require that such decisions be discretionary, and insurance regulation is not preempted merely because it conflicts with substantive plan terms. See UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 376, 143 L. Ed. 2d 462, 119 S. Ct. 1380 (1999) ("Under [Petitioner's] interpretation . . . insurers could displace any state regulation simply by inserting a contrary term in plan documents. This interpretation would virtually read the saving clause out of ERISA." (internal quotation marks omitted)).
designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract's terms. As such, it does not implicate ERISA's enforcement scheme at all, and is no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption, such as mandated-benefit statutes and statutes prohibiting the denial of claims solely on the ground of untimeliness. n17 See Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985); UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 143 L. Ed. 2d 462, 119 S. Ct. 1380 (1999).

n17 We do not mean to imply that States are free to create other forms of binding arbitration to provide de novo review of any terms of insurance contracts; as discussed above, our decision rests in part on our recognition that the disuniformity Congress hoped to avoid is not implicated by decisions that are so heavily imbued with expert medical judgments. Rather, we hold that the feature of § 4-10 that provides a different standard of review with respect to mixed eligibility decisions from what would be available in court is not enough to create a conflict that undermines congressional policy in favor of uniformity of remedies.

In sum, § 4-10 imposes no new obligation or remedy like the causes of action considered in Russell, Pilot Life, and Ingersoll-Rand. Even in its formal guise, the state Act bears a closer resemblance to second-opinion requirements than to arbitration schemes. Deferential review in the HMO context is not a settled matter. § 4-10 operates before the stage of judicial review; the independent reviewer's de novo examination of the benefit claim mirrors the general or default rule we have ourselves recognized; and its effect is no greater than that of mandated-benefit regulation.

In deciding what to make of these facts and conclusions, it helps to go back to where we started and recall the ways States regulate insurance in looking out for the welfare of their citizens. Illinois has chosen to regulate insurance as one way to regulate the practice of medicine, which we have previously held to be permissible [*2171] under ERISA, see Metropolitan Life 471 U.S. at 741. While the statute designed to do this undeniably eliminates whatever may have remained of a plan sponsor's option to minimize scrutiny of benefit denials, this effect of eliminating an insurer's autonomy to guarantee terms congenial to its own interests is the stuff of garden variety insurance regulation through the imposition of standard policy terms. See id., at 742 ("State [*403] laws regulating the substantive terms of insurance contracts were commonplace well before the mid-70's"). It is therefore hard to imagine a reservation of state power to regulate insurance that would not be meant to cover restrictions of the insurer's advantage in this kind of way. And any lingering doubt about the reasonableness of § 4-10 in affecting the application of § 1132(a) may be put to rest by recalling that regulating insurance tied to what is medically necessary is probably inseparable from enforcing the quintessentially state-law standards of reasonable medical care. See Pem根源 v. Herdrich, 530 U.S. at 236. "In the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." Id., at 237. To the extent that benefits litigation in some federal courts may have to account for the effects of § 4-10, it would be an exaggeration to hold that the objectives of § 1132(a) are undermined. The saving clause is entitled to prevail here, and we affirm the judgment.

It is so ordered.

DISSENT: THOMAS

|[*388] | JUSTICE THOMAS, with whom THE CHIEF JUSTICE, JUSTICE SCALIA, and JUSTICE KENNEDY join, dissenting. |

This Court has repeatedly recognized that ERISA's civil enforcement provision, § 502 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132, provides the exclusive vehicle for actions asserting a claim for benefits under health plans governed by ERISA, and therefore that state laws that create additional remedies are pre-empted. See, e.g., Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987); Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146-147, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985). Such exclusivity of remedies is necessary to further Congress' interest in establishing a uniform federal law of employee benefits so that employers are encouraged to provide benefits to their employees: "To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits." FMC Corp. v. Holliday, 498 U.S. 52, 60, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990).
Of course, the "expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop . . . would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws." Pilot Life, supra, at 56. Therefore, as the Court concedes, see ante, at 19, even a state law that "regulates insurance" may be preempted if it supplements the remedies provided by ERISA, despite ERISA's saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). See Silkwood v. Kerr-McGee Corp., 464 U.S. 238, 248, 78 L. Ed. 2d 443, 104 S. Ct. 615 (1984) (noting that state laws that stand as an obstacle to the accomplishment of the full purposes and objectives of Congress are pre-empted). n1 Today, however, [*389] the Court takes the unprecedented step of allowing respondent [**2172]

Debra Moran to short circuit ERISA's remedial scheme by allowing her claim for benefits to be determined in the first instance through an arbitral-like procedure provided under Illinois law, and by a decisionmaker other than a court. See 215 Ill. Comp. Stat., ch.125, § 4-10 (2000). This decision not only conflicts with our precedents, it also eviscerates the uniformity of ERISA remedies Congress deemed integral to the "careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." Pilot Life, supra, at 54. I would reverse the Court of Appeals' judgment and remand for a determination of whether Moran was entitled to reimbursement absent the independent review conducted under § 4-10.

n1 I would assume without deciding that 215 Ill. Comp. Stat., ch. 125, § 4-10 (2000) is a law that "regulates insurance." We can begin and end the pre-emption analysis by asking if § 4-10 conflicts with the provisions of ERISA or operates to frustrate its objects. See, e.g., Boggs v. Boggs, 520 U.S. 833, 841, 138 L. Ed. 2d 45, 117 S. Ct. 1754 (1997).

I

From the facts of this case one can readily understand why Moran sought recourse under § 4-10. Moran is covered by a medical benefits plan sponsored by her husband's employer and governed by ERISA. Petitioner Rush Prudential HMO, Inc., is the employer's health maintenance organization (HMO) provider for the plan. Petitioner's Member Certificate of Coverage (Certificate) details the scope of coverage under the plan and provides petitioner with "the broadest possible discretion" to interpret the terms of the plan and to determine participants' entitlement to benefits. 1 Record, Exh. A, p. 8. The Certificate specifically excludes from coverage services that are not "medically necessary." Id., at 21. As the Court describes, ante, at 2-3, Moran underwent a nonstandard surgical procedure. n2 Prior to [*390] Moran's surgery, which was performed by an unaffiliated doctor, petitioner denied coverage for the procedure on at least three separate occasions, concluding that this surgery was not "medically necessary." For the same reason, petitioner denied Moran's request for post-surgery reimbursement in the amount of $94,841.27. Before finally determining that the specific treatment sought by Moran was not "medically necessary," petitioner consulted no fewer than six doctors, reviewed Moran's medical records, and consulted peer-reviewed medical literature. n3

n2 While the Court characterizes it as an "unconventional treatment," the Court of Appeals described this surgery more clinically as "rib resection, extensive scale-nectomy," and "microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification." 230 F.3d 959, 963 (CA7 2000). The standard procedure for Moran's condition, as described by the Court of Appeals, involves (like the nonstandard surgery) rib resection with scale-nectomy, but it does not include "microneurolysis of the brachial plexus," which is the procedure Moran wanted and her primary care physician recommended. See id., at 963-964. In any event, no one disputes that the procedure was not the standard surgical procedure for Moran's condition or that the Certificate covers even nonstandard surgery if it is "medically necessary."

n3 Petitioner thus appears to have complied with § 503 of ERISA, which requires every employee benefit plan to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied," and to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133.

[***405] In the course of its review, petitioner informed Moran that "there is no prevailing opinion within the appropriate specialty of the United States medical profession that the procedure proposed [by Moran] is safe and effective for its intended use and that
the omission of the procedure would adversely affect [her] medical condition." 1 Record, Exh. E, p. 2.
Petitioner did agree to cover the standard treatment for Moran's ailment, see n. 2, supra; n. 4, infra, concluding that peer-reviewed literature "demonstrates that [the standard surgery] is effective therapy in the treatment of [Moran's condition]." 1 Record, Exh. E, at 3. [**2173]

Moran, however, was not satisfied with this option. After exhausting the plan's internal review mechanism, Moran [*391] chose to bypass the relief provided by ERISA. She invoked § 4-10 of the Illinois HMO Act, which requires HMOs to provide a mechanism for review by an independent physician when the patient's primary care physician and HMO disagree about the medical necessity of a treatment proposed by the primary care physician. See 215 Ill. Comp. Stat., ch.125, § 4-10 (2000). While Moran's primary care physician acknowledged that petitioner's affiliated surgeons had not recommended the unconventional surgery and that he was not "an expert in this or any other area of surgery," 1 Record, Exh. C, he nonetheless opined, without explanation, that Moran would be "best served" by having that surgery, ibid.

Dr. A. Lee Dellon, an unaffiliated physician who served as the independent medical reviewer, concluded that the surgery for which petitioner denied coverage "was appropriate," that it was "the same type of surgery" he would have done, and that Moran "had all of the indications and therefore the medical necessity to carry out" the nonstandard surgery. Appellant's Separate App. (CA7), pp. A42-A43. n4 Under § 4-10, Dr. Dellon's determination conclusively established Moran's right to benefits under Illinois law. See 215 Ill. Comp. Stat., ch.125, § 4-10 ("In the event that the reviewing physician determines the covered service to be medically necessary, the [HMO] shall provide the covered service" (emphasis added)). 230 F.3d 959, 972-973 (CA7 2000).

n4 Even Dr. Dellon acknowledged, however, both that "there is no particular research study" to determine whether failure to perform the nonstandard surgery would adversely affect Moran's medical condition and that the most common operation for Moran's condition in the United States was the standard surgery that petitioner had agreed to cover. Appellant's Separate App. (CA7), p. A43.

Nevertheless, petitioner again denied benefits, steadfastly maintaining that the unconventional surgery was not medically necessary. While the Court of Appeals recharacterized Moran's claim for reimbursement under § 4-10 as a claim for benefits under ERISA § 502(a)(1)(B), it reversed the judgment [*392] of the District Court based solely on Dr. Dellon's judgment that the surgery was "medically necessary."

II

Section 514(a)'s broad language [***406] provides that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan," except as provided in § 514(b). 29 U.S.C. § 1144(a). This language demonstrates "Congress's intent to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.'" New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656, 112 L. Ed. 2d 695, 115 S. Ct. 1671 (1995) (quoting Alesi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523, 68 L. Ed. 2d 402, 101 S. Ct. 1895 (1981)). It was intended to "ensure that plans and plan sponsors would be subject to a uniform body of benefits law" so as to "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government" and to prevent "the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990). See also Egelhoff v. Egelhoff, 532 U.S. 141, 148, 149 L. Ed. 2d 264, 121 S. Ct. 1322 (2001).

To be sure, this broad goal of uniformity is in some tension with the so-called "saving clause," which provides that ERISA does not "exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A). [**2174] As the Court has suggested on more than one occasion, the pre-emption and saving clauses are almost antithetically broad and "are not a model of legislative drafting." John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 99, 126 L. Ed. 2d 524, 114 S. Ct. 517 (1993) (quoting Pilot Life, 481 U.S. at 46). But because there is "no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional pre-emption analysis," the Court has concluded [*393] that federal pre-emption occurs where state law governing insurance "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress." Harris Trust, 510 U.S. at 99 (quoting Silkwood, 464 U.S. at 248).

Consequently, the Court until today had consistently held that state laws that seek to supplant or add to the exclusive remedies in § 502(a) of ERISA, 29 U.S.C. § 1132(a), are pre-empted because they conflict with Congress' objective that rights under ERISA plans are to
be enforced under a uniform national system. See, e.g., 
Ingersoll-Rand Co., 498 U.S. at 142-145; Metropolitan 
The Court has explained that § 502(a) creates an 
"interlocking, interrelated, and interdependent remedial 
scheme," and that a beneficiary who claims that he was 
wrongfully denied benefits has "a panoply of remedial 
devices" at his disposal. Russell, 473 U.S. at 146. It is 
effectively this enforcement scheme that Pilot Life described 
as "representing a careful balancing of the need for 
prompt and fair claims [***407] settlement procedures 
against the public interest in encouraging the formation of 
employee benefit plans," 481 U.S. at 54. Central to 
that balance is the development of "a federal common 
law of rights and obligations under ERISA-regulated 
plans." Id., at 56.

In addressing the relationship between ERISA's 
remedies under § 502(a) and a state law regulating 
insurance, the Court has observed that "the policy 
choices reflected in the inclusion of certain remedies and 
the exclusion of others under the federal scheme would 
be completely undermined if ERISA-plan participants 
and beneficiaries were free to obtain remedies under 
state law that Congress rejected in ERISA." Id., at 54. 
Thus, while the preeminent federal interest in the 
uniform administration of employee benefit plans yields 
in some instances to varying state regulation of the 
business of insurance, the exclusivity and uniformity of 
[*394] ERISA's enforcement scheme remains 
paramount. "Congress intended § 502(a) to be the 
exclusive remedy for rights guaranteed under ERISA." 
Ingersoll-Rand Co., 498 U.S. at 144. In accordance with 
ordinary principles of conflict pre-emption, therefore, 
even a state law "regulating insurance" will be pre-
empted if it provides a separate vehicle to assert a claim 
for benefits outside of, or in addition to, ERISA's 
remedial scheme. See, e.g., Pilot Life, supra, at 54 (citing 
Russell, 473 U.S. at 146); Harris Trust, 510 U.S. at 99 
(citing Silkwood, 464 U.S. at 248).

III

The question for the Court, therefore, is whether § 
4-10 provides such a vehicle. Without question, Moran 
had a "panoply of remedial devices," Russell, 473 U.S. at 
146, available under § 502 of ERISA when petitioner 
denied her claim for benefits. n5 Section 502(a)(1)(B) of 
[**2175] ERISA provided the most obvious remedy: a 
civil suit to recover benefits due under the terms of the 
such a suit, Moran sought to have her right to benefits 
determined outside of ERISA's remedial scheme through 
the arbitral-like mechanism available under § 4-10.

n5 Commonly included in the panoply 
constituting part of this enforcement scheme are: 
suits under § 502(a)(1)(B) (authorizing an action 
to recover benefits, obtain a declaratory judgment 
that one is entitled to benefits, and to enjoin an 
improper refusal to pay benefits); suits under § § 
502(a)(2) and 409 (authorizing suit to seek 
removal of the fiduciary); and a claim for 
attorney's fees under § 502(g). See Russell, 473 
U.S. at 146-147; Pilot Life Ins. Co. v. Dedeaux, 
481 U.S. 41, 53, 95 L. Ed. 2d 39, 107 S. Ct. 1549 

Section 4-10 cannot be characterized as anything 
other than an alternative state-law remedy or vehicle for 
seeking benefits. In the first place, § 4-10 comes into 
play only if the HMO and the claimant dispute the 
claimant's entitlement to benefits; the purpose of the 
review is to determine whether a claimant is entitled to 
benefits. Contrary to the majority's characterization of § 
4-10 as nothing more than a state law [*395] regarding 
medical standards, ante, at 26-27, it is in fact a binding 
determination of whether benefits are [***408] due: "In 
the event that the reviewing physician determines the 
covered service to be medically necessary, the [HMO] 
shall provide the covered service." 215 Ill. Comp. Stat., 
ch. 125, § 4-10 (2000) (emphasis added). Section 4-10 is 
thus most precisely characterized as an arbitration-like 
mechanism to settle benefits disputes. See Brief for 
United States as Amicus Curiae 23 (conceding as much).

There is no question that arbitration constitutes an 
alternative remedy to litigation. See, e.g., Air Line Pilots 
v. Miller, 523 U.S. 866, 876, 880, 140 L. Ed. 2d 1070, 
118 S. Ct. 1761 (1998) (referring to "arbitral remedy" 
and "arbitration remedy"); DelCostello v. Teamsters, 462 
U.S. 151, 163, 76 L. Ed. 2d 476, 103 S. Ct. 2281 (1983) 
(referring to "arbitration remedies"); Great American 
Fed. Sav. & Loan Assn. v. Novotny, 442 U.S. 366, 377-
378, 60 L. Ed. 2d 957, 99 S. Ct. 2345 (1979) (noting that 
arbitration and litigation are "alternative remedies"); 3 D. 
Dobbs, Law of Remedies § 12.23 (2d. ed. 1993) 
(explaining that arbitration "is itself a remedy"). 
Consequently, although a contractual agreement to 
arbitrate -- which does not constitute a "State law" 
relating to "any employee benefit plan" -- is outside § 
514(a) of ERISA's pre-emptive scope, States may not 
circumvent ERISA pre-emption by mandating an 
alternative arbitral-like remedy as a plan term 
enforceable through an ERISA action.

To be sure, the majority is correct that § 4-10 does 
not mirror all procedural and evidentiary aspects of 
decision on the merits of the controversy the § 4-10 
review resembles nothing so closely as arbitration. See
generally 1 I. MacNeil, R. Spediel, & T. Stipanowich, Federal Arbitration Law § 2.1.1 (1995). That the decision of the § 4-10 medical reviewer is ultimately enforceable through a suit under § 502(a) of ERISA further supports the proposition that it tracks the arbitral remedy. Like the decision of any arbitrator, it is enforceable through a subsequent judicial action, but judicial [*396] review of an arbitration award is very limited, as was the Court of Appeals' review in this case. See, e.g., Paperworkers v. Misco, Inc., 484 U.S. 29, 36-37, 98 L. Ed. 2d 286, 108 S. Ct. 364 (1987) (quoting Steelworkers v. American Mfg. Co., 363 U.S. 564, 567-568, 4 L. Ed. 2d 1403, 80 S. Ct. 1343 (1960)). Although the Court of Appeals recharacterized Moran's claim for reimbursement under § 4-10 as a claim for benefits under § 502(a)(1)(B) of ERISA, the Court of Appeals did not interpret the plan terms or purport to analyze whether the plan fiduciary had engaged in the "full and fair review" of Moran's claim for benefits that § 503(2) of ERISA, 29 U.S.C. § 1133(2), requires. Rather, it rubberstamped the independent medical reviewer's judgment that Moran's surgery was "medically necessary," granting summary judgment to Moran on her claim for benefits solely on that basis. Thus, as Judge [**2176] Posner aptly noted in his dissent from the denial of rehearing en banc below, § 4-10 "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans." 230 F.3d at 973.

IV

The Court of Appeals attempted to [***409] evade the pre-emptive force of ERISA's exclusive remedial scheme primarily by characterizing the alternative enforcement mechanism created by § 4-10 as a "contract term" under state law. n6 Id., at 972. The Court saves § 4-10 from pre-emption in a somewhat different manner, distinguishing it from an alternative enforcement mechanism because it does not "enlarge the [*397] claim beyond the benefits available in any action brought under § 1132(a)," and characterizing it as "something akin to a mandate for second-opinion practice in order to ensure sound medical judgments." Ante, at 22, 27. Neither approach is sound.

n6 The Court of Appeals concluded that § 4-10 is saved from pre-emption because it is a law that "regulates insurance," and that it does not conflict with the exclusive enforcement mechanism of § 502 because § 4-10's independent review mechanism is a state-mandated contractual term of the sort that survived ERISA pre-emption in UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 375-376, 143 L. Ed. 2d 462, 119 S. Ct. 1380 (1999). In the Court of Appeals' view, the independent review provision, like any other mandatory contract term, can be enforced through an action brought under § 502(a) of ERISA, 29 U.S.C. § 1132(a), pursuant to state law. 230 F.3d at 972.

The Court of Appeals' approach assumes that a State may impose an alternative enforcement mechanism through mandated contract terms even though it could not otherwise impose such an enforcement mechanism on a health plan governed by ERISA. No party cites any authority for that novel proposition, and I am aware of none. Cf. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 16-17, 96 L. Ed. 2d 1, 107 S. Ct. 1211 (1987) (noting that a State cannot avoid ERISA pre-emption on the ground that its regulation only mandates a benefit plan; such an approach would "permit States to circumvent ERISA's pre-emption provision, by allowing them to require directly what they are forbidden to regulate"). To hold otherwise would be to eviscerate ERISA's comprehensive and exclusive remedial scheme because a claim to benefits under an employee benefits plan could be determined under each State's particular remedial devices so long as they were made contract terms. Such formalist tricks cannot be sufficient to bypass ERISA's exclusive remedies; we should not interpret ERISA in such a way as to destroy it.

With respect to the Court's position, Congress' intention that § 502(a) be the exclusive remedy for rights guaranteed under ERISA has informed this Court's weighing of the pre-emption and saving clauses. While the Court has previously focused on ERISA's overall enforcement mechanism and remedial scheme, see infra, at 6-7, the Court today ignores the "interlocking, interrelated, and interdependent" nature of that remedial scheme and announces that the relevant inquiry is whether a state regulatory scheme "provides [a] new cause of action" or authorizes a "new form of ultimate relief." Ante, at 23. These newly created principles have no roots in the precedents of this Court. That § 4-10 also [***398] effectively provides for a second opinion to better ensure sound medical practice is simply irrelevant to the question whether it, in fact, provides a binding mechanism for a participant or beneficiary to pursue a claim for benefits because it is on this latter basis that § 4-10 is pre-empted.

The Court's attempt to diminish [***410] § 4-10's effect by characterizing it as one where "the reviewer's determination would presumably replace that of the HMO," ante, at 23 (emphasis added), is puzzling [**2177] given that the statute makes such a determination conclusive and the Court of Appeals
treated it as a binding adjudication. For these same reasons, it is troubling that the Court views the review under § 4-10 as nothing more than a practice "of obtaining a second [medical] opinion." Ante, at 27. The independent reviewer may, like most arbitrators, possess special expertise or knowledge in the area subject to arbitration. But while a second medical opinion is nothing more than that -- an opinion -- a determination under § 4-10 is a conclusive determination with respect to the award of benefits. And the Court's reference to Pegram v. Herdrich, 530 U.S. 211, 147 L. Ed. 2d 164, 120 S. Ct. 2143 (2000), as support for its Alice in Wonderland-like claim that the § 4-10 proceeding is "far removed from any notion of an enforcement scheme," ante, at 27, is equally perplexing, given that the treatment is long over and the issue presented is purely an eligibility decision with respect to reimbursement. n7

n7 I also disagree with the Court's suggestion that, following Pegram v. Herdrich, 530 U.S. 211, 147 L. Ed. 2d 164, 120 S. Ct. 2143 (2000), HMOs are exempted from ERISA whenever a coverage or reimbursement decision relies in any respect on medical judgment. Ante, at 26, 30, n. 17. Pegram decided the limited question whether relief was available under § 1109 for claims of fiduciary breach against HMOs based on its physicians' medical decisions. Quite sensibly, in my view, that question was answered in the negative because otherwise, "for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians." 530 U.S. at 235.

[*399]

As we held in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985), a State may, of course, require that employee health plans provide certain substantive benefits. See id., at 746 (holding that a state law mandating mental health benefits was not within ERISA's pre-emptive reach). Indeed, were a State to require that insurance companies provide all "medically necessary care" or even that it must provide a second opinion before denying benefits, I have little doubt that such substantive requirements would withstand ERISA's pre-emptive force. But recourse to those benefits, like all others, could be sought only through an action under § 502 and not, as is the case here, through an arbitration-like remedial device. Section 4-10 does not, in any event, purport to extend a new substantive benefit. Rather, it merely sets up a procedure to conclusively determine whether the HMO's decision to deny benefits was correct when the parties disagree, a task that lies within the exclusive province of the courts through an action under § 502(a).

By contrast, a state law regulating insurance that merely affects whether a plan participant or beneficiary may pursue the remedies available under ERISA's remedial scheme, such as California's notice-prejudice rule, is not pre-empted because it has nothing to do with § 502(a)'s exclusive enforcement scheme. In UNUM Life Ins. Co. of [***411] America v. Ward, 526 U.S. 358, 143 L. Ed. 2d 462, 119 S. Ct. 1380 (1999), the Court evaluated California's so-called notice-prejudice rule, which provides that an insurer cannot avoid liability in cases where a claim is not filed in a timely fashion absent proof that the insurer was actually prejudiced because of the delay. In holding that it was not pre-empted, the Court did not suggest that this rule provided a substantive plan term. The Court expressly declined to address the Solicitor General's argument that the saving clause saves even state law "conferring causes of action or affecting remedies that regulate insurance." See id., at 376-377, n. 7 (internal quotation marks omitted). While [*400] a law may "effectively create a mandatory contract term," id., at 374 (internal quotation marks omitted), and even provide the rule of decision with respect to whether a claim is out of time, and thus whether benefits will [***2178] ultimately be received, such laws do not create an alternative enforcement mechanism with respect to recovery of plan benefits. They merely allow the participant to proceed via ERISA's enforcement scheme. To my mind, neither Metropolitan Life nor UNUM addresses, let alone purports to answer, the question before us today.

***

Section 4-10 constitutes an arbitral-like state remedy through which plan members may seek to resolve conclusively a disputed right to benefits. Some 40 other States have similar laws, though these vary as to applicability, procedures, standards, deadlines, and consequences of independent review. See Brief for Respondent State of Illinois 12, n. 4 (citing state independent review statutes); see also Kaiser Family Foundation, K. Politz, J. Crowley, K. Lucia, & E. Bangit, Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation (May 2002) (comparing state program features). Allowing disparate state laws that provide inconsistent external review requirements to govern a participant's or beneficiary's claim to benefits under an employee benefit plan is wholly destructive of Congress' expressly stated goal of uniformity in this area. Moreover, it is inimical to a scheme for furthering and protecting the "careful
balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans," given that the development of a federal common law under ERISA-regulated plans has consistently been deemed central to that balance. n8 The Court suggests that a state law's impact on cost is not relevant after New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 662, 131 L. Ed. 2d 695, 115 S. Ct. 1671 (1995), which holds that a state law providing for surcharges on hospital rates did not, based solely on their indirect economic effect, "bear the requisite 'connection with' ERISA plans to trigger pre-emption." But Travelers addressed only the question whether a state law "relates to" an ERISA plan so as to fall within § 514(a)'s broad preemptive scope in the first place and is not relevant to the inquiry here. The Court holds that "it is beyond serious dispute," ante, at 7-8, that § 4-10 does "relate to" an ERISA plan; § 4-10's economic effects are necessarily relevant to the extent that they upset the object of § 1132(a). See Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990) ("Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries").

n8 The Court isolates the "plan" from the HMO and then concludes that the independent review provision "does not threaten the object of 29 U.S.C. § 1132" because it does not affect the plan, but only the HMO. Ante, at 24, n. 11. To my knowledge such a distinction is novel. Cf. Pegram, 530 U.S. at 223 (recognizing that the agreement between an HMO and an employer may provide elements of a plan by setting out the rules under which care is provided). Its application is particularly novel here, where the Court appears to view the HMO as the plan administrator, leaving one to wonder how the myriad state independent review procedures can help but have an impact on plan administration. Ante, at 5-6, n. 3.

n9 The Court isolates the "plan" from the HMO and then concludes that the independent
L Ed Digest, Insurance 1; States, Territories, and Possessions 38.2

L Ed Index, Accident and Health Insurance; Health Maintenance Organizations; Pensions and Retirement

Annotation References:
Supreme Court's views as to validity, construction and application of McCarran-Ferguson Act (15 USCS 1011-1015), concerning regulation of business of insurance by state or federal law. 125 L Ed 2d 879.

When is state or local law pre-empted by Employee Retirement Income Security Act of 1974, as amended (ERISA) (29 USCS 1001 et seq.)-- Supreme Court cases. 121 L Ed 2d 783.

Construction and application of pre-emption exemption, under Employee Retirement Income Security Act (29 USCS 1001 et seq.), for state laws regulating insurance, banking, or securities (29 USCS 1144(b)(2)). 87 ALR Fed 797.
LEXSEE 123 S CT 1471

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL., PETITIONERS v. JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

No. 00-1471

SUPREME COURT OF THE UNITED STATES


January 14, 2003, Argued
April 2, 2003, Decided


DISPOSITION: Affirmed.

CASE SUMMARY:

PROCEDURAL POSTURE: Petitioner health maintenance organizations (HMOs) sued respondent state insurance commissioner, alleging that Ky. Rev. Stat. Ann. § § 304.17A-171(2), 304.17A-270, which precluded the HMOs from limiting their network providers, were preempted by the Employee Retirement Income Security Act of 1974 (ERISA). Upon a grant of certiorari, the HMOs appealed the judgment of the U.S. Court of Appeals for the Sixth Circuit which upheld the state statutes.

OVERVIEW: The state statutes required a health insurer to acknowledge the services of any healthcare provider willing to abide by the insurer's plan, thus precluding the HMOs from limiting their provider networks as necessary to reduce patient costs. The HMOs contended that the statutes were preempted as laws which related to ERISA plans, but the commissioner asserted that the statutes were saved from preemption under 29 U.S.C.S. § 1144(b)(2)(A) since they were laws which regulated insurance. The U.S. Supreme Court unanimously held that the state statutes in fact regulated insurance and thus were not preempted by ERISA. The statutes were specifically directed toward entities engaged in insurance, regardless of the fact that the statutes also had the effect of prohibiting providers from entering into limited network contracts with the HMOs. Further, despite the statutory focus upon the relationship between the HMOs and third-party providers, the statutory prohibition substantially affected the type of risk pooling arrangements that the HMOs could offer and thus constituted regulation of the business of insurance.

OUTCOME: The judgment upholding the state statutes was affirmed.

CORE TERMS: insurer, provider, state law, business of insurance, insured, insurance industry, regulate insurance, savings clause, network, saved, directed toward, pre-emption, pooling, health-care, entities, substantially affect, health benefit, chiropractic, regulated, regulation, self-insured, third-party, employee benefit plan, employee benefit, interpreting, pre-empts, insurance policies, right to engage, integral part, notice-prejudice

LexisNexis(R) Headnotes

Healthcare Law > Business Organization & Administration > Employment Discrimination
Healthcare Law > Business Organization & Administration > Employment Discrimination


Insurance Law > Regulation of Insurance > ERISA Preemption

[HN3] The Employee Retirement Income Security Act of 1974 pre-empts all state laws insofar as they may now or hereafter relate to any employee benefit plan, 29 U.S.C.S. § 1144(a), but state laws which regulate insurance, banking, or securities are saved from pre-emption, § 1144(b)(2)(A).


Insurance Law > Regulation of Insurance > ERISA Preemption

[HN4] A state law must be "specifically directed toward" the insurance industry in order to fall under 29 U.S.C.S. § 1144(b)(2)(A), the savings clause of the Employee Retirement Income Security Act of 1974; laws of general application that have some bearing on insurers do not qualify. At the same time, not all state laws "specifically directed toward" the insurance industry will be covered by § 1144(b)(2)(A), which saves laws that regulate insurance, not insurers. Insurers must be regulated with respect to their insurance practices.


Insurance Law > Regulation of Insurance > ERISA Preemption

[HN5] Regulations "directed toward" certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such regulation outside the scope of 29 U.S.C.S. § 1144(b)(2)(A), the savings clause of the Employee Retirement Income Security Act of 1974.


Insurance Law > Regulation of Insurance > ERISA Preemption

[HN6] 29 U.S.C.S. § 1144(b)(2)(A), the savings clause of the Employee Retirement Income Security Act of 1974 (ERISA), does not require that a state law regulate "insurance companies" or even "the business of insurance" to be saved from pre-emption; it need only be a law which regulates insurance, and self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan. Any contrary view would render superfluous ERISA's "deemer clause," § 1144(b)(2)(B), which provides that an employee benefit plan covered by ERISA may not 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. That clause has effect only on state laws saved from pre-emption by § 1144(b)(2)(A) that would, in the absence of § 1144(b)(2)(B), be allowed to regulate self-insured employee benefit plans.

Insurance Law > Regulation of Insurance > Limitations on Federal Regulation


Insurance Law > Regulation of Insurance > ERISA Preemption


Insurance Law > Regulation of Insurance > Limitations on Federal Regulation

[HN9] In determining whether certain practices constitute "the business of insurance" under the McCarran-Ferguson Act, courts look to three factors: first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.


Insurance Law > Regulation of Insurance > ERISA Preemption

[HN10] For a state law to be deemed a law which regulates insurance under 29 U.S.C.S. § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

SYLLABUS: Petitioner health maintenance organizations (HMOs) maintain exclusive "provider networks" with selected doctors, hospitals, and other health-care providers. Kentucky has enacted two "Any Willing Provider" (AWP) statutes, which prohibit [a]
health insurer [from] discriminating against any provider who is . . . willing to meet the terms and conditions for participation established by the . . . insurer," and require a "health benefit plan that includes chiropractic benefits [to] . . . permit any licensed chiropractor who agrees to abide by the terms [and] conditions . . . of the . . . plan to serve as a participating primary chiropractic provider." Petitioners filed this suit against respondent, the Commissioner of Kentucky's Department of Insurance, asserting that the AWP laws are pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA), which pre-empts all state laws "inssofar as they . . . relate to any employee benefit plan," 29 U.S.C. § 1144(a), but saves from pre-emption state "laws . . . which regulate insurance . . . ." § 1144(b)(2)(A). The District Court concluded that although both AWP statutes "relate to" employee benefit plans under § 1144(a), each law "regulates insurance" and is therefore saved from pre-emption by § 1144(b)(2)(A). The Sixth Circuit affirmed.

_Held:_ Kentucky's AWP statutes are "laws . . . which regulate insurance" under § 1144(b)(2)(A). Pp. 3-12.

(a) For these statutes to be "laws . . . which regulate insurance," they must be "specifically directed toward" the insurance industry; laws of general application that have some bearing on insurers do not qualify. E.g., _Pilot Life Ins. Co. v. Dedeaux_, 481 U.S. 41, 50, 95 L. Ed. 2d 39, 107 S. Ct. 1549. However, not all state laws "specifically directed toward" the insurance industry will be covered by § 1144(b)(2)(A), which saves laws that regulate insurance, not insurers. Insurers must be regulated "with respect to their insurance practices." _Rush Prudential HMO, Inc. v. Moran_, 536 U.S. 355, 366, 153 L. Ed. 2d 375, 122 S. Ct. 2151. Pp. 3-4.

(b) Petitioners argue that the AWP laws are not "specifically directed" towards the insurance industry. The Court disagrees. Neither of these statutes, by its terms, imposes any prohibitions or requirements on providers, who may still enter exclusive networks with insurers who conduct business outside the Commonwealth or who are otherwise not covered by the AWP laws. The statutes are transgressed only when a "health insurer," or a "health benefit plan that includes chiropractic benefits," excludes from its network a provider who is willing and able to meet its terms. Pp. 4-6.

(c) Also unavailing is petitioners' contention that Kentucky's AWP laws fall outside § 1144(b)(2)(A)'s scope because they do not regulate an insurance practice but focus upon the relationship between an insurer and third-party providers. Petitioners rely on _Group Life & Health Ins. Co. v. Royal Drug Co._, 440 U.S. 205, 210, 59 L. Ed. 2d 261, 99 S. Ct. 1067, which held that third-party provider arrangements between insurers and pharmacies were not "the 'business of insurance'" under § 2(b) of the McCarran-Ferguson Act. ERISA's savings clause, however, is not concerned (as is the McCarran-Ferguson Act provision) with how to characterize conduct undertaken by private actors, but with how to characterize state laws in regard to what they "regulate." Kentucky's laws "regulate" insurance by imposing conditions on the right to engage in the business of insurance. To come within ERISA's savings clause those conditions must also substantially affect the risk pooling arrangement between insurer and insured. Kentucky's AWP statutes pass this test by altering the scope of permissible bargains between insurers and insureds in a manner similar to the laws we upheld in _Metropolitan Life, UNUM_, and _Rush Prudential_. Pp. 6-9.

(d) The Court's prior use, to varying degrees, of its cases interpreting § 2(a) and 2(b) of the McCarran-Ferguson Act in the ERISA savings clause context has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis. The Court has never held that the McCarran-Ferguson factors are an essential component of the § 1144(b)(2)(A) inquiry. Today the Court makes a clean break from the McCarran-Ferguson factors in interpreting ERISA's savings clause. Pp. 9-12.

227 F.3d 352, affirmed.

COUNSEL: Robert N. Eccles argued the cause for petitioners.

Elizabeth A. Johnson argued the cause for respondent.

James A. Feldman argued the cause for the United States, as amicus curiae, by special leave of court.

JUDGES: SCALIA, J., delivered the opinion for a unanimous Court.

OPINIONBY: SCALIA

OPINION:

[**331] [***474] [***1473] JUSTICE SCALIA

delivered the opinion of the Court.

[***LEdHR1A] [1A]Kentucky law provides that [HN1] "[a] health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms [***1474] and conditions for participation [***332] established by the health insurer,
including the Kentucky state Medicaid program and Medicaid partnerships." Ky. Rev. Stat. Ann. § 304.17A-270 (West 2001). Moreover, [HN2] any "health benefit plan that includes chiropractic [***475] benefits shall . . . permit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan." § 304.17A-171(2). We granted certiorari to decide whether the Employee Retirement Income Security Act of 1974 (ERISA) pre-empts either, or both, of these "Any Willing Provider" (AWP) statutes.

I

Petitioners include several health maintenance organizations (HMOs) and a Kentucky-based association of HMOs. In order to control the quality and cost of health-care delivery, these HMOs have contracted with selected doctors, hospitals, and other health-care providers to create exclusive "provider networks." Providers in such networks agree to render health-care services to the HMOs' subscribers at discounted rates and to comply with other contractual requirements. In return, they receive the benefit of patient volume higher than that achieved by nonnetwork providers who lack access to petitioners' subscribers.

Kentucky's AWP statutes impair petitioners' ability to limit the number of providers with access to their networks, and thus their ability to use the assurance of high patient volume as the quid pro quo for the discounted rates that network membership entails. Petitioners believe that AWP laws will frustrate their efforts at cost and quality control, and will ultimately deny consumers the benefit of their cost-reducing arrangements with providers.

[***LEDHR2A] [2A] In April 1997, petitioners filed suit against respondent, the Commissioner of Kentucky's Department of Insurance, in the United States District Court for the Eastern District [*333] of Kentucky, asserting that ERISA, 88 Stat. 832, as amended, pre-empts Kentucky's AWP laws. [HN3] ERISA pre-empts all state laws "insofar as they may now or hereafter relate to any employee benefit plan," 29 U.S.C. § 1144(a), but state "laws . . . which regulate insurance, banking, or securities" are saved from pre-emption, § 1144(b)(2)(A). The District Court concluded that although both AWP statutes "relate to" employee benefit plans under § 1144(a), each law "regulates insurance" and is therefore saved from pre-emption by § 1144(b)(2)(A). App. to Pet. for Cert. 64a- 84a. In affirming the District Court, the Sixth Circuit also concluded that the AWP laws "regulate insurance" and fall within ERISA's savings clause. Kentucky Assn. of Health Plans, Inc. v. Nichols, 227 F.3d 352, 363-372 (2000). Relying on UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 119 S. Ct. 1380 (1999), the Sixth Circuit first held that Kentucky's AWP laws regulate insurance "as a matter of common sense," 227 F.3d at 364, because they are "specifically directed toward 'insurers' and the insurance industry . . .," id., at 366. The Sixth Circuit then considered, as "checking points or guideposts" in its analysis, the three factors used to determine whether a practice fits within "the business of health insurance" in our cases interpreting the McCarran-Ferguson Act. Id., at 364. These factors are: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral [***476] part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129, 102 S. Ct. 3002 (1982). The Sixth Circuit found all three factors satisfied. 227 F.3d at 368-371. Notwithstanding its analysis of the McCarran-Ferguson [**1475] factors, the Sixth Circuit reiterated that the "basic test" under ERISA's savings clause is whether, from a common-sense view, the Kentucky AWP laws regulate insurance. Id., at 372. Finding that the laws passed both the "common sense" test and the [*334] McCarran-Ferguson "checking points," the Sixth Circuit upheld Kentucky's AWP statutes. Ibid.

We granted certiorari, 536 U.S. 956 (2002).

II

To determine whether Kentucky's AWP statutes are saved from preemption, we must ascertain whether they are "laws . . . which regulate insurance" under § 1144(b)(2)(A).

[***LEDHR1B] [1B] [***LEDHR3A] [3A] It is well established in our case law that [HN4] a state law must be "specifically directed toward" the insurance industry in order to fall under ERISA's savings clause; laws of general application that have some bearing on insurers do not qualify. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987); see also Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 366, 153 L. Ed. 2d 375, 122 S. Ct. 2151 (2002); FMC Corp. v. Holliday, 498 U.S. 52, 61, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990). At the same time, not all state laws "specifically directed toward" the insurance industry will be covered by § 1144(b)(2)(A), which saves laws that regulate insurance, not insurers. As we explained in Rush Prudential, insurers must be regulated "with respect to their insurance practices," 536 U.S., at 366. Petitioners contend that Kentucky's AWP laws fall outside the scope of § 1144(b)(2)(A) for two reasons. First, because Kentucky has failed to "specifically direct"
its AWP laws towards the insurance industry; and second, because the AWP laws do not regulate an insurance practice. We find neither contention persuasive.

A

[***LEdHR1C] [1C]Petitioners claim that Kentucky's statutes are not "specifically directed toward" insurers because they regulate not only the insurance industry but also doctors who seek to form and maintain limited provider networks with HMOs. That is to say, the AWP laws equally prevent providers from entering into limited network contracts with insurers, just as they prevent insurers from creating exclusive networks in the first place. We do not think it follows that Kentucky [*335] has failed to specifically direct its AWP laws at the insurance industry.

Neither of Kentucky's AWP statutes, by its terms, imposes any prohibitions or requirements on health-care providers. See 


Neither of Kentucky's AWP statutes, by its terms, imposes any prohibitions or requirements on health-care providers. See Ky. Rev. Stat. Ann. § 304.17A-270 (West 2001) (imposing obligations only on "health insurers" not to discriminate against any willing provider); § 304.17A-171 (imposing obligations only on "health benefit plans that include chiropractic benefits"). And Kentucky health-care providers are still capable of entering exclusive networks with insurers who conduct business outside the Commonwealth of Kentucky or who are otherwise not covered by §§ 304.17A-270 or 304.17A-171. Kentucky's statutes are transgressed only when a "health insurer," or a "health benefit plan that includes chiropractic benefits," excludes from its network a provider who is willing and able to meet its terms.

[***LEdHR1D] [1D]It is of course true that as a consequence of Kentucky's AWP laws, entities outside the insurance industry (such as health-care providers) will be unable to enter into certain agreements with Kentucky insurers. But the same could be said about the state laws we held saved from pre-emption in FMC Corp. and Rush Prudential. Pennsylvania's law prohibiting insurers from exercising subrogation rights against an insured's tort recovery, see FMC Corp., supra, at 55, n. 1, also prevented insureds from entering into enforceable contracts with insurers allowing subrogation. Illinois' requirement that HMOs provide independent review of whether services are "medically necessary," Rush Prudential, supra, at 372, likewise excluded insureds from joining an HMO that would have withheld the right to independent review in exchange for a lower premium. Yet neither case found the effects of these laws on noninsurers, significant though they may have been, inconsistent with the requirement that laws saved from pre-emption by § 1144(b)(2)(A) be "specifically directed toward" the insurance industry. [HN5] Regulations "directed toward" certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such regulation outside the scope of ERISA's savings clause. n1

[***LEdHR1E] [1E]

n1 Petitioners also contend that Ky. Rev. Stat. Ann. § 304.17A-270 (West 2001) is not "specifically directed toward" insurers because it applies to "self-insurer or multiple employer welfare arrangements not exempt from state regulation by ERISA." § 304.17A-005(23). We do not think § 304.17A-270's application to self-insured non-ERISA plans forfeits its status as a "law . . . which regulates insurance" under 29 U.S.C. § 1144(b)(2)(A). [HN6] ERISA's savings clause does not require that a state law regulate "insurance companies" or even "the business of insurance" to be saved from pre-emption; it need only be a "law . . . which regulates insurance," ibid. (emphasis added), and self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan. Any contrary view would render superfluous ERISA's "deemer clause," § 1144(b)(2)(B), which provides that an employee benefit plan covered by ERISA may not "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 . . ." That clause has effect only on state laws saved from pre-emption by § 1144(b)(2)(A) that would, in the absence of § 1144(b)(2)(B), be allowed to regulate self-insured employee benefit plans. Under petitioners' view, such laws would never be saved from pre-emption in the first place. (The deemer clause presents no obstacle to Kentucky's law, which reaches only those employee benefit plans "not exempt from state regulation by ERISA").

Both of Kentucky's AWP laws apply to all HMOs, including HMOs that do not act as insurers but instead provide only administrative services to self-insured plans. Petitioners maintain that the application to noninsuring HMOs forfeits the laws' status as "laws . . . which regulate insurance." § 1144(b)(2)(A). We disagree. To begin with, these noninsuring HMOs...
would be administering self-insured plans, which
we think suffices to bring them within the activity
of insurance for purposes of § 1144(b)(2)(A).
Moreover, we think petitioners' argument is
foreclosed by Rush Prudential HMO, Inc. v.
Moran, 536 U.S. 355, 372, 153 L. Ed. 2d 375,
122 S. Ct. 2151 (2002), where we noted that
Illinois' independent-review laws contained
"some overbreadth in the application of [215 Ill.
Comp. Stat., ch. 125.] § 4-10 [(2000)] beyond
orthodox HMOs," yet held that "there is no
reason to think Congress would have meant such
minimal application to noninsurers to remove a
state law entirely from the category of insurance
regulation saved from preemption."

[*337] B

[***478] [***LedHR1F] [1F]Petitioners claim
that the AWP laws do not regulate insurers with respect
to an insurance practice because, unlike the state laws
we held saved from pre-emption in Metropolitan Life Ins.
Co. v. Massachusetts, 471 U.S. 724, 83 L. Ed. 2d 728,
105 S. Ct. 2380 (1985), UNUM, and Rush Prudential,
they do not control the actual terms of insurance policies.
Rather, they focus upon the relationship between an
insurer and third-party providers -- which in petitioners'
view does not constitute an "insurance practice."

In support of their contention, petitioners rely on
Group Life & Health Ins. Co. v. Royal Drug Co., 440
U.S. 205, 210, 59 L. Ed. 2d 261, 99 S. Ct. 1067 (1979),
which held that third-party provider arrangements
between insurers and pharmacies were not "the 'business
of insurance" under § 2(b) of the McCarran-Ferguson
Act. n2 ERISA's savings clause, however, is not
concerned (as is the McCarran-Ferguson Act provision)
with how to characterize conduct undertaken by private actors, but with how to characterize state laws
in regard to what they "regulate. " It does not follow from
Royal Drug that a law mandating certain insurer-provider
relationships fails to "regulate insurance. " Suppose a
state law required all licensed attorneys to participate in
10 hours of continuing legal education (CLE) each year.
This statute "regulates" the practice of law -- [*338]
even though sitting through 10 hours of CLE classes
does not constitute the practice of law -- because the
state has conditioned the right to practice law on certain
requirements, which substantially affect the product
delivered by lawyers to their clients. Kentucky's AWP
laws operate in a similar manner with respect to the
insurance industry: Those who wish to provide health
insurance in Kentucky (any "health insurer") may not
discriminate against any willing provider. This
"regulates" insurance by imposing conditions on the right
to engage in the business of insurance; whether or not an
HMO's contracts with providers constitute "the business
of insurance" under Royal Drug is beside the point.

n2 Section 2 of the McCarran-Ferguson Act
provides:

[HN7] "(a) 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) 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, 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, shall be
applicable to the business of insurance to the
extent that such business is not regulated by State
added).

[***LedHR1G] [1G] [***LedHR3B] [3B]
[***LedHR4A] [4A]We emphasize that [HN8]
conditions on the right to engage in the business of
insurance must also substantially affect the risk pooling
arrangement between the insurer and the insured to be
covered by ERISA's savings clause. Otherwise, any state
law aimed at insurance companies [***479] could be
deemed a law that "regulates insurance," contrary to our
interpretation of § 1144(b)(2)(A) in Rush Prudential,
536 U.S., at 364. A state law requiring all insurance
companies to pay their janitors twice the minimum wage
would not "regulate insurance," even though it would be
a prerequisite to engaging in the business of insurance,
because it does not substantially affect the risk pooling
arrangement undertaken by insurer and insured.

Petitioners contend that Kentucky's AWP statutes fail
this test as well, since they do not alter or affect the terms
of insurance policies, but concern only the relationship
between insureds and third-party providers, Brief for
Petitioners 29. We disagree. We have never held that
state laws must alter or control the actual terms of
insurance policies to be deemed "laws... which regulate
insurance" under § 1144(b)(2)(A); it suffices that they
substantially affect the risk pooling arrangement between
insurer and insured. By expanding the number of
providers from whom an insured may receive health
services, AWP laws alter the scope [*339] of permissible bargains between insurers and insureds in a manner similar to the mandated-benefit laws we upheld in Metropolitan Life, the notice-prejudice rule we sustained in UNUM, n3 and the independent-review provisions we approved in [*1478] Rush Prudential. No longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium. The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer.

n3 While the Ninth Circuit concluded in Cisneros v. UNUM Life Insurance Co., 134 F.3d 939, 945-946 (1998), aff'd in part, rev'd and remanded in part, UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 143 L. Ed. 2d 462, 119 S. Ct. 1380 (1999), that "the notice-prejudice rule does not spread the policyholder's risk within the meaning of the first McCarran-Ferguson factor," our test requires only that the state law substantially affect the risk pooling arrangement between the insurer and insured; it does not require that the state law actually spread risk. See ante, at 8-9. The notice-prejudice rule governs whether or not an insurance company must cover claims submitted late, which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed. This certainly qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured.

III

Our prior decisions construing § 1144(b)(2)(A) have relied, to varying degrees, on our cases interpreting § § 2(a) and 2(b) of the McCarran-Ferguson Act. [HN9] In determining whether certain practices constitute "the business of insurance" under the McCarran-Ferguson Act (emphasis added), our cases have looked to three factors: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." Pireno, 458 U.S., at 129.

We believe that our use of the McCarran-Ferguson case law in the ERISA context has misdirected attention, failed [*340] to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis. That is unsurprising, since the statutory language of § 1144(b)(2)(A) differs [*480] substantially from that of the McCarran-Ferguson Act. Rather than concerning itself with whether certain practices constitute "the business of insurance," 15 U.S.C. § 1012(a), or whether a state law was "enacted . . . for the purpose of regulating the business of insurance," § 1012(b) (emphasis added), 29 U.S.C. § 1144(b)(2)(A) asks merely whether a state law is a "law . . . which regulates insurance, banking, or securities." What is more, the McCarran-Ferguson factors were developed in cases that characterized conduct by private actors, not state laws. See Pireno, supra, at 126 ("The only issue before us is whether petitioners' peer review practices are exempt from antitrust scrutiny as part of the 'business of insurance'" (emphasis added)); Royal Drug, 440 U.S., at 210 ("The only issue before us is whether the Court of Appeals was correct in concluding that these Pharmacy Agreements are not the 'business of insurance' within the meaning of § 2(b) of the McCarran-Ferguson Act" (emphasis added)).

Our holdings in UNUM and Rush Prudential -- that a state law may fail the first McCarran-Ferguson factor yet still be saved from pre-emption under § 1144(b)(2)(A) -- raise more questions than they answer and provide wide opportunities for divergent outcomes. May a state law satisfy any two of the three McCarran-Ferguson factors and still fall under the savings clause? Just one? What happens if two of three factors are satisfied, but not "securely satisfied" or "clearly satisfied," as they were in UNUM and Rush Prudential? 526 U.S., at 374; 536 U.S., at 373. Further confusion arises from the question whether the state law itself or the conduct regulated by that law is the proper subject to which one applies the McCarran-Ferguson factors. In Pilot Life, we inquired whether Mississippi's law of bad faith has the effect of transferring or spreading risk, 481 U.S., at 50, [*341] whether that law is integral to the insurer-insured relationship, id., at 51, and whether that law is limited to the insurance industry, ibid. n4 Rush Prudential, by contrast, focused the McCarran-Ferguson inquiry on the conduct regulated by the state law, rather than the state law itself. 536 U.S., at 373 [*1479] ("It is obvious enough that the independent review requirement regulates an integral part of the policy relationship between the insurer and insured" (emphasis added)); id., at 374 ("The final factor, that the law be aimed at a 'practice . . . limited to entities within the insurance industry' is satisfied . . ." (emphasis added; citation omitted)).
This approach rendered the third McCarran-Ferguson factor a mere repetition of the prior inquiry into whether a state law is "specifically directed toward" the insurance industry under the "common-sense view." UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358, 143 L. Ed. 2d 462, 119 S. Ct. 1380 (1999); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987).

We have never held that the McCarran-Ferguson factors are an essential component of the § 1144(b)(2)(A) inquiry. Metropolitan Life initially used these factors only to buttress its previously reached conclusion that Massachusetts' mandated-benefit statute was a "law . . . which regulates insurance" under § 1144(b)(2)(A). 471 U.S., at 742-743. Pilot Life referred to them as mere "considerations [to be] weighed" in determining whether a state law falls under the savings clause. 481 U.S., at 49. UNUM emphasized that the McCarran-Ferguson factors were not "required" in the savings clause analysis, and were only "checking points" to be used after determining whether the state law regulates insurance from a "common-sense" understanding. 526 U.S., at 374. And Rush Prudential called the factors "guideposts," using them only to "confirm our conclusion" that Illinois' statute regulated insurance under § 1144(b)(2)(A). 536 U.S., at 373.

Today we make a clean break from the McCarran-Ferguson factors and hold that a state law to be deemed a "law . . . which regulates insurance" under § 1144(b)(2)(A), [*342] it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. See Pilot Life, supra, at 50. UNUM, supra, at 368; Rush Prudential, supra, at 366. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky's law satisfies each of these requirements.

***

For these reasons, we affirm the judgment of the Sixth Circuit.

It is so ordered.

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Supreme Court's views as to validity, construction, and application of McCarran-Ferguson Act (15 USCS 1011-1015), concerning regulation of business of insurance by state or federal law. 125 L Ed 2d 879.

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