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COMMENTS

Regulation of Uninsured Multiple-Employer Trusts Under ERISA: An Open Question Again?

The term "uninsured multiple-employer trusts" (MET's) describes a large and complex field of entities that are established to offer employee benefits to employees of small employers. By banding together, these small employers generally pool their resources to provide more economical benefits, and in some cases, they purchase partial insurance coverage from insurance carriers at the lower rates given large employers. These uninsured¹ MET arrangements are typically organized and managed by third-party administrators who may be either independent entrepreneurs or insurance company representatives. Uninsured MET's assume a wide variety of legal forms including trusts,² unincorporated associations,³ and administrative service corporations.⁴ Collectively bargained multiemployer plans are not considered part of the uninsured MET field discussed here.⁵ The benefits provided through uninsured MET's are usually paid directly from trust assets derived from employers' and employees' contributions.

I. NATURE OF THE PROBLEM

Following the enactment of the Employee Retirement Income Security Act of 1974 (ERISA),⁶ controversy and alarm⁷ grew

1. The term "uninsured" adds an important distinction to the class of entities under discussion. Insured multiple-employer trusts pay their benefit obligations through duly licensed insurance carriers. The financial stability, marketing practices, investment policies, and claims payment procedures of the insurance carriers in turn are regulated by state insurance laws. Although in some cases uninsured MET's purchase limited insurance coverage, the benefits provided by uninsured MET's are predominantly self-funded. See Brummond, *The Legal Status of Uninsured Noncollectively-Bargained Multiple-Employer Welfare Trusts Under ERISA and State Insurance Laws*, 28 SYRACUSE L. REV. 701 (1977).

2. See *Hamberlin v. VIP Ins. Trust*, 434 F. Supp. 1196 (D. Ariz. 1977).

3. See *Bell v. Employee Security Benefit Ass'n*, 437 F. Supp. 382 (D. Kan. 1977).

4. See Brummond, *supra* note 1, at 701.

5. The "multiemployer" trusts or plans which are formed between a labor union and more than one employer pursuant to the provisions of a collective bargaining agreement are defined in the Employee Retirement Income Security Act of 1974 § 3(37), 29 U.S.C. § 1002(37) (1976).

6. Pub. L. No. 93-406, 88 Stat. 829 (codified at 29 U.S.C. §§ 1001-1381 (1976)) (also codified in scattered sections of 18, 19, 26 U.S.C.).

7. See David, *Employee Benefit Trusts' Growth Alarms Officials; More Failures*

as a rapidly expanding number of uninsured MET's claimed exemption from state insurance laws because of the preemption provisions of ERISA.⁸ These uninsured MET's were, for the most part, viewed by state insurance officials as purely entrepreneurial ventures,⁹ deliberately structured to fall within the so-called "regulatory void" beyond the jurisdiction of state insurance departments. Furthermore, the plan organizers assumed that ERISA's preemption provisions left the uninsured MET's apparently free from substantial federal regulation since ERISA's vesting and funding requirements do not apply to employee welfare benefit plans.¹⁰ The immediate question was whether state insurance officials could regulate the uninsured MET's, and if they could, to what extent. The urgency of the question was heightened by the insolvency of two large uninsured MET's. Additionally, several million citizens were believed to be enrolled in other MET programs for which there was no effective regulation.¹¹ Con-

Feared (pts. 1, 2), *Bus. Ins.*, Feb. 21, 1977, at 1, Mar. 7, 1977, at 1. A series of articles and editorials covering the uninsured multiple-employer trust question and related court cases appeared in *Business Insurance* between Feb. 21, 1977 and Jan. 23, 1978. See also H.R. REP. No. 1785, 94th Cong., 2d Sess. 33 (1977) [hereinafter cited as H.R. REP. 94-1785]. In a more recent update regarding the increasing magnitude of the uninsured MET problem, Herbert W. Anderson, Chairman, National Association of Insurance Commissioners (NAIC) ERISA Preemption Task Force, reported to the House Subcommittee on Labor Standards that the NAIC conservatively estimates that more than 600,000 employees and their beneficiaries are enrolled under "employee welfare benefit plans" of uninsured MET's. Anderson noted that other estimates range as high as three million people. Furthermore, approximately \$300 million in contributions are collected annually by promoters of uninsured MET's. At least 30 MET's or affiliated organizations were known to be operating in mid-1978. *Oversight on ERISA, 1978: Hearings on Public Law 93-406 Before the Subcomm. on Labor Standards of the House Comm. on Education and Labor, 95th Cong., 2d Sess. 650* (statement of National Association of Insurance Commissioners by Herbert W. Anderson, Chairman of NAIC ERISA Preemption Task Force) [hereinafter cited as *ERISA Oversight Hearings*].

8. ERISA supersedes any and all state laws relating to employee benefit plans. ERISA § 514, 29 U.S.C. § 1144 (1976). See text accompanying notes 20-28 *infra*.

9. The choice of language used here, which may have certain pejorative connotations, is not intended to imply that those individuals who administer or represent uninsured MET's are necessarily unscrupulous; rather, the assertion is that the business and legal structures provide incentive for conduct injurious to the working public.

10. ERISA §§ 201(1), 301(a)(1), 29 U.S.C. §§ 1051(1), 1081(a)(1) (1976). Employee welfare benefit plans need only comply with ERISA's reporting and disclosure provisions and abide by the Act's fiduciary standards. Employee pension benefit plans, however, are subject to all of ERISA's provisions.

11. On Feb. 2, 1977, the National Multiple Employers' Foundation, a California-based MET, filed a petition in bankruptcy. Approximately two months later, a second California-based MET, the Hospital Welfare Association Trust, filed an action seeking the appointment of a federal receiver because of its insolvent position. See David, *Employee Benefit Trusts' Growth Alarms Officials; More Failures Feared* (pt. 1), *Bus. Ins.*, Feb. 21,

sequently, state insurance departments mobilized their resources, went to the courts, and won important victories¹² involving uninsured MET's that were purportedly, but not in fact, established or maintained by employee organizations.¹³ These bogus employee-organization MET's, however, comprise only a segment of the much larger field of uninsured MET's.

The apparent judicial consensus permitting state insurance departments to regulate bogus employee-organization MET's did not resolve the jurisdictional question for all uninsured MET's. Although the Labor Department¹⁴ favors state control of bogus employee-organization MET's, it has been reluctant to relinquish jurisdiction over other portions of the uninsured MET field.¹⁵ The Labor Department's position has prompted some uninsured MET's to restructure their operations to conform with the judicial decisions to date.¹⁶

Another reason for the uncertainty regarding the regulation of uninsured MET's is that, until recently, no court had ruled whether an employee benefit plan allegedly established or maintained by an association of employers was a valid ERISA-covered plan. However, in January 1979 a federal district court in California determined that an uninsured MET established and maintained by an employer association was a valid ERISA-covered employee benefit plan.¹⁷ Interestingly, in spite of the federal

1977, at 1; David, *Court Case Could Set Self-funded Trust Rules*, BUS. INS., Apr. 18, 1977, at 1. It is also estimated that three million people are presently receiving welfare benefits from uninsured MET's. Between Jan. 1977 and June 1978 five major uninsured MET's went insolvent. The unpaid claims of just two of those insolvent MET's were estimated at in excess of \$7.5 million. See *ERISA Oversight Hearings*, supra note 7, at 659 (statement of NAIC by Herbert W. Anderson, Chairman of NAIC ERISA Preemption Task Force).

12. See *Bell v. Employee Security Benefit Ass'n*, 437 F. Supp. 382 (D. Kan. 1977); *Hamberlin v. VIP Ins. Trust*, 434 F. Supp. 1196 (D. Ariz. 1977).

13. An employee organization MET refers to an employee benefit plan established or maintained by an employee organization as defined in ERISA § 3(4), 29 U.S.C. § 1002(4) (1976). See text accompanying note 42 *infra*.

14. Although the Secretary of Labor and the Secretary of the Treasury jointly administer ERISA according to the provisions of 29 U.S.C. §§ 1201-1204 (1976), direct supervision of uninsured MET's originates from the Administrator of Pension and Welfare Benefit Programs at the Labor Department.

15. Letter from James D. Hutchinson, Labor Department Administrator, to Willie R. Barnes, California Commissioner of Corporations (Jul. 4, 1976), reprinted in [1976] PENS. REP. (BNA) No. 96, at R-1 (Jul. 26, 1976).

16. David, *Trusts Retrench in Wake of Court Decisions*, BUS. INS., Oct. 17, 1977, at 1.

17. *Insurance & Prepaid Benefits Trust v. Security Health Plan*, No. 78-1926 RMT (GX) (C.D. Cal. Jan. 29, 1979).

court determination, the Labor Department has nonetheless taken the position that the plan in question is not a legitimate ERISA plan.¹⁸

This recent turn of events intensifies the uncertainty surrounding the jurisdictional issue of uninsured MET's. The question persists whether state insurance officials can regulate uninsured MET's, and if so, to what extent.

This Comment focuses on past and present judicial, legislative, and regulatory efforts to define the respective roles of the state and federal governments in regulating uninsured MET's. First, a brief overview¹⁹ summarizing ERISA's preemption provisions and the two conflicting interpretations of those provisions will be presented. The focus will then shift to an analysis of court decisions in the uninsured MET field that have attempted to define employee benefit plans. Subsequently, the central importance of the substantive/definitional conflict in defining an employee benefit plan will be considered. Finally, alternatives will be presented for resolving the uninsured MET regulatory controversy.

II. ERISA'S PREEMPTION PROVISIONS AND CONFLICTING INTERPRETATIONS

Section 514 of ERISA expressly declares Congress' intent to occupy the field of employee benefit plans.²⁰ The general preemptive language of section 514(a), the "relation clause," states in broad terms that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan."²¹

18. Letter from Ian D. Lanoff, Labor Department Administrator, to Thomas J. Wilkie, Administrator of Insurance and Prepaid Benefits Trust (Jul. 23, 1979), reprinted in [1979] PENS. REP. (BNA) No. 250, at R-26 (Jul. 30, 1979).

19. For a more detailed analysis of the larger question of ERISA's preemption of state laws generally, see Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. CHI. L. REV. 23 (1978); Turza & Holloway, *Preemption of State Laws Under the Employee Retirement Income Security Act of 1974*, 28 CATH. U.L. REV. 163 (1979). For a discussion of ERISA preemption of state insurance regulation, see Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 IOWA L. REV. 57 (1976); Okin, *Preemption of State Insurance Regulation by ERISA*, 13 FORUM 652 (1978).

20. ERISA's preemption provisions are codified at 29 U.S.C. § 1144(a)-(d) (1976).

21. ERISA § 514(a), 29 U.S.C. 1144(a) (1976). The term "state law" as used in the preemption provisions includes "all laws, decisions, rules, regulations, or other state action having the effect of law, of any state." *Id.* § 514(c)(1), 29 U.S.C. § 1144(c)(1). Moreover, the term "state" is defined to include "a state, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly,

The "savings clause," section 514(b)(2)(A), reserves or saves the states' regulatory power over insurance matters by clarifying 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."²² Congress, in an apparent attempt to reinforce the broad preemptive language of the relation clause and simultaneously circumscribe the scope of the savings clause,²³ included section 514(b)(2)(B), the "deemer clause." The deemer clause provides in relevant part: "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" ²⁴ The extent to which the deemer clause qualifies the savings clause has been the focal point of much of the preemption-related litigation.²⁵ Finally, section 514(d) states that ERISA shall neither supplant nor impinge upon other existing federal laws.²⁶ In the

the terms and conditions of employee benefit plans" *Id.* § 514(c)(2), 29 U.S.C. § 1144(c)(2).

22. *Id.* § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

23. Both the original House and Senate versions of ERISA provided for limited preemption of state law. A broader preemption provision was subsequently drafted and adopted in conference committee. Senator Jacob Javits explained the reasoning behind the change in these words:

Both 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.

120 CONG. REC. 29,942 (1974).

24. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1976).

25. See *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978); *Bell v. Employee Security Benefit Ass'n*, 437 F. Supp. 382 (D. Kan. 1977); *Hamberlin v. VIP Ins. Trust*, 434 F. Supp. 1196 (D. Ariz. 1977); *Wayne Chem., Inc. v. Columbus Agency Serv. Corp.*, 426 F. Supp. 316 (N.D. Ind.), *aff'd as modified*, 567 F.2d 692 (7th Cir. 1977); *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal.), *aff'd*, 571 F.2d 502 (9th Cir. 1977), *cert. denied*, 439 U.S. 831 (1978).

26. ERISA § 514(d), 29 U.S.C. § 1144(d) (1976). The subsection states: "Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law."

insurance context, section 514(d) is frequently referred to as recognizing the validity of the McCarran-Ferguson Act,²⁷ which established the national policy of state primacy in insurance regulation.²⁸

In the application of ERISA's preemption provisions to the vast array of entities allegedly operating as employee benefit plans, two conflicting interpretations of section 514 have emerged: a broad view and a narrow view of preemption.

A. *Broad Interpretation of Preemption*

One of the strongest and most frequently cited judicial pronouncements in favor of total preemption is *Hewlett-Packard Co. v. Barnes*.²⁹ In *Hewlett-Packard* the administrators of various ERISA health benefit plans challenged the authority of the defendant Commissioner of Corporations to regulate their programs under the California Knox-Keene Health Care Service Plan Act of 1975³⁰ on the ground that the Act had been preempted by ERISA. The commissioner contended that neither the language of ERISA's preemption provisions nor the Act's legislative history mandated the preemption of state legislation, such as the Knox-Keene Act, that regulates health services. He further argued that because the Knox-Keene Act regulates the business of insurance, it was precluded from preemption by virtue of the savings clause.³¹ Following a careful analysis of section 514's plain language,³² and the statute's legislative history,³³ the court sided with

27. 15 U.S.C. §§ 1011-1015 (1976).

28. The McCarran-Ferguson Act further provides that "[n]o 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 . . . unless such Act specifically relates to the business of insurance." *Id.*

29. 425 F. Supp. 1294 (N.D. Cal.), *aff'd*, 571 F.2d 502 (9th Cir. 1977), *cert. denied*, 439 U.S. 831 (1978).

30. Knox-Keene Act, CAL. HEALTH & SAFETY CODE §§ 1340-1345 (West Cum. Supp. 1971-1977).

31. A third argument raised by the defendant commissioner was that if ERISA were to be construed so broadly as to preempt state regulation of health care services, then § 514(a) would be violative of the tenth amendment of the Constitution. The court disposed of this argument by noting that other courts have repeatedly held that the tenth amendment does not limit Congress' application of the commerce power to private activity. 425 F. Supp. at 1301.

32. The court rejected the defendant's argument that the words "relate to" as contained in § 514(a) of ERISA were "vague and ambiguous." On the contrary, the court concluded that Congress could not have "chosen any more precise language to express its intent to preempt a state statute such as Knox-Keene insofar as it seeks to regulate ERISA-covered employee benefit plans . . ." *Id.* at 1297.

33. The district court judge relied primarily on statements from conference commit-

the plan administrators and ruled that the Knox-Keene Act was preempted to the extent that it applied to ERISA-covered employee welfare benefit plans. The court stated:

In seeking to regulate plaintiff's plans pursuant to Knox-Keene under the theory that the statute applies to and that such plans constitute "insurance," defendant contravenes the clear intent of Section 514(a) and (b) of ERISA that employee benefit plans, so dubbed or under any other name, be free of state regulation.³⁴

Thus, the *Hewlett-Packard* preemption test requires that a state insurance statute be preempted whenever it relates to a valid ERISA employee benefit plan.

B. *Narrow Interpretation of Preemption*

In contrast to the expansive approach taken by the court in *Hewlett-Packard*, the court in *Wadsworth v. Whaland*³⁵ adopted a narrow view of preemption. In *Wadsworth* representatives of several health and welfare funds objected to a New Hampshire law³⁶ that required all insurers issuing group health insurance policies in the state to include coverage for mental illness and emotional disorders. Since ERISA does not impose a similar requirement and because the benefit plans involved were ERISA-covered, the plan representatives sought to enjoin the defendant Commissioner of Insurance from enforcing the requirement.³⁷ The plaintiffs argued that to directly regulate group insurance policies by imposing mandatory coverages is to exercise indirect control over the benefits an employee receives from his employee welfare benefit plan. Hence, they contended that a state insurance statute that indirectly relates to an ERISA employee benefit plan

tee members as to the legislation's purpose. Congressman John Dent, Chairman of the Subcommittee on Labor of the House Labor and Education Committee, was quoted as stating in part:

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 state and local regulations.

120 CONG. REC. 29,197 (1974). See also *id.* at 29,933 (remarks of Senator Harrison Williams, Jr.).

34. 425 F. Supp. at 1300.

35. 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

36. N.H. REV. STAT. ANN. § 415:18-a (Supp. 1977).

37. *Cf. Insurer's Action Council, Inc. v. Heaton*, 423 F. Supp. 921, 926 (D. Minn. 1976) (injunction denied because no clear conflict existed between challenged state insurance law and ERISA).

should trigger the preemption provision. The trial court disagreed.

The First Circuit affirmed the lower court decision by concluding that the deemer clause did not forbid states from indirectly affecting employee benefit plans by regulating group insurance policies. The court reasoned that a contrary holding would completely emasculate the savings clause and contravene the express objective of the McCarran-Ferguson Act to uphold state primacy in the regulation of insurance.

III. DEFINING AN EMPLOYEE BENEFIT PLAN

The *Hewlett-Packard* court's decision that a state insurance law is preempted whenever it relates to a valid ERISA employee benefit plan naturally requires that the first determination be whether the plan in question is a valid ERISA-defined plan. In cases involving uninsured MET's, the courts have concerned themselves primarily with ascertaining whether specific plans qualify as legitimate ERISA employee benefit plans. These courts have encountered complex definitional questions because of the complicating role played by third-party administrators or entrepreneurs who substantially minimize or eliminate the participation of employers and employees in the operation of the plan. Employer or employee participation in the establishment or maintenance of a plan, however, is a prerequisite for qualification as an employee benefit plan.

A. ERISA Definitions

Specifically, ERISA defines an employee benefit plan as an employee welfare benefit plan, an employee pension benefit plan,³⁸ or a plan that combines the two.³⁹ 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 . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise [any of a number of enumerated benefits]."⁴⁰ Further-

38. Employee pension benefit plans are beyond the scope of this Comment. They are defined in ERISA § 3(2), 29 U.S.C. § 1002(2) (1976).

39. *Id.* § 3(3), 29 U.S.C. § 1002(3).

40. *Id.* § 3(1), 29 U.S.C. § 1002(1) (emphasis added). The benefits specified by the statute include "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

more, "[t]he term 'employer' means any person acting directly as an employer, or indirectly in the interest of employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity."⁴¹ Finally, regarding "employee organization," ERISA states:

The term "employee organization" means 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.⁴²

B. Wayne Chemical—*First Purported Plan Held Outside of ERISA's Scope*

One of the first courts to examine the ERISA definitions and conclude that an alleged ERISA plan was not a valid employee benefit plan was the Seventh Circuit in *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*⁴³ The suit was brought in behalf of a plan beneficiary who had become severely paralyzed in an accident when he was eighteen years old and still covered by a group medical insurance policy purchased by his father's employer. Shortly before the mishap, the defendant service corporation had formally transferred the policy from a conventional insurance carrier to National Multiple Employers Foundation (NMEF), alleged to be a multiple-employer welfare trust. The quadriplegic son was later notified that, according to the terms of the NMEF policy, his benefits would end on his twentieth birthday, a result contrary to Indiana law.⁴⁴ The district court found the NMEF plan to be a legitimate ERISA plan and ruled that the state law that would have permitted recovery was

services" *Id.* § 3(1)(A), 29 U.S.C. § 1002(1)(A).

It should be noted that this Comment primarily focuses upon uninsured MET's that provide benefits to their participants or beneficiaries through means *other* than insurance.

41. *Id.* § 3(5), 29 U.S.C. § 1002(5).

42. *Id.* § 3(4), 29 U.S.C. § 1002(4).

43. 567 F.2d 692 (7th Cir. 1977).

44. IND. CODE § 27-8-5-10(B)(4) (1976). This statute requires that any group hospital and medical policy which permits termination of coverage once a dependent reaches a given age must also provide that the coverage cannot be terminated "while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the employee or member for support and maintenance." *Id.*

preempted; nevertheless, the court granted relief under its power to fashion federal common law.⁴⁵

On interlocutory appeal the Seventh Circuit affirmed the lower court decision, but on different grounds. The court held that NMEF was not a valid ERISA plan because the employer, Wayne Chemical, had neither transacted business with any trust or plan⁴⁶ nor participated in any employee benefit plan.⁴⁷ On the contrary, Wayne Chemical had only contracted with the defendant service corporation for the procurement of insurance. Consequently, NMEF, which had been selling insurance without a certificate of authority, and the agent service corporation were held subject to Indiana law.⁴⁸

The Seventh Circuit also stated that the question of "employer" or "employee organization" establishment, maintenance, and participation requirements was apparently not addressed in the reports and debates of ERISA.⁴⁹ The court, therefore, chose to forego any discussion of the legislative history. Ironically, the court then proceeded to base its opinion upon an unusual retroactive declaration of legislative intent contained in an activity report issued by the House Committee on Education and Labor.⁵⁰ The report notes that "certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA-covered plans." The report continues:

To the extent that such programs fail to meet the definition of an "employee benefit plan," state regulation of them is not preempted by section 514, even though such state action is

45. The district court adopted the appropriate Indiana statute as federal common law based upon *Zdanok v. Glidden Co.*, 327 F.2d 944 (2d Cir.), *cert. denied*, 377 U.S. 934 (1964) (state law may be resorted to and adopted as a federal rule of decision if compatible with national policy).

46. The court found no indication from the record that any trust or plan had been created. Importantly, the communications from the defendant service corporation to the plaintiff/employer stated that Wayne Chemical was the former's policyholder. 567 F.2d at 694-99.

47. The court reasoned that Wayne Chemical could not have been a participating employer even if a trust or plan had existed because Wayne Chemical neither knew of the existence of such a plan until long after the formal transfer of insurance carriers nor did Wayne Chemical enter into an agreement to establish a plan. *Id.* at 699.

48. See IND. CODE § 27-4-5-2(c)(2) (1976). Indiana's unauthorized insurer's act provides that if any unauthorized insurer defaults on an insurance contract governed by Indiana law, then any person who assisted in the procurement of the insurance is personally liable on the coverage.

49. 567 F.2d at 699 n.11.

50. H.R. REP. 94-1785, *supra* note 7, at 33.

barred with respect to the plans which purchase these "products."

We are mindful of the potentially harmful effects of an overly broad interpretation of the term employee benefit plan when coupled with the policy of section 514. As we have already noted, we do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the definition. Where a plan is, in effect, an entrepreneurial venture, it is outside the policy of section 514 for reasons we have already stated. In short, to be properly characterized as an ERISA employee benefit plan, a plan must satisfy the definitional requirement of section 3(3) in both form and substance⁵¹

In view of the similarity of the wording in the activity report to the fact situation in *Wayne Chemical*, the court found it unnecessary to more rigorously analyze "employer" or "employee organization" establishment, maintenance, and participation requirements.

C. Hamberlin—*Circumstances Dictate Result*

In *Hamberlin v. VIP Insurance Trust*,⁵² the United States District Court in Arizona was presented with a fact situation that it considered to be so clearly repugnant to ERISA's purposes that it offered only a conclusory analysis with supporting quotes from the activity report to support its holding. The beneficiaries of a group health and accident policy brought suit against the defendant insurance trust and defendant trustees for alleged violations of ERISA. Although the parties agreed that the defendant insurance trust was a valid ERISA plan, the defendants moved for dismissal on the ground that the alleged violations involved a simple contract action that should properly be tried in state court. The State Insurance Commissioner filed an amicus brief arguing that control had not been preempted because the defendant trust did not qualify as an ERISA-covered employee benefit plan. Hence, the threshold and dispositive question was whether the federal court possessed subject matter jurisdiction in the case. The court concluded that it did not.

In reaching its decision, the court placed considerable weight

51. *Id.* at 48, quoted in *Wayne Chem., Inc. v. Columbus Agency Serv. Corp.*, 567 F.2d at 699, 700.

52. 434 F. Supp. 1196 (D. Ariz. 1977).

on the apparent motives of the plan organizers and also on the circumstances surrounding the formation of the VIP Insurance Trust.⁵³ Although the trust organizers sought the endorsement of various unrelated employers and groups, they marketed the policies directly to individual employees who financed their own policies. The employers played no meaningful role in the creation or maintenance of the trust. The court characterized the plan as an entrepreneurial scheme put together to protect business commissions, maintain business relations, and escape state insurance department supervision and auditing.⁵⁴ The court observed: "[The defendant trustees] were simply not acting as agents of or on behalf of the employers or employer groups as contemplated by 29 U.S.C. § 1002(5). They were acting in the interest of and on behalf of the business of Galbraith & Green, their employer."⁵⁵ Moreover, the court perceived the conduct of the VIP trustees as deliberate self-dealing, which it would not countenance. Therefore, in much the same manner as the *Wayne Chemical* court, the *Hamberlin* court anchored its conclusion upon the language of the activity report that suggests that entrepreneurial ventures are outside the scope of ERISA.⁵⁶

D. Bell—Emergence of Judicial Criteria

In a third case, *Bell v. Employee Security Benefit Association*,⁵⁷ an unusual factual setting again arguably mandated the court's conclusion. For instance, the defendant uninsured MET was consuming seventy-two percent of each dollar collected for payment of commissions and administrative expenses.⁵⁸ Furthermore, the defendant never presented a defense, thereby allowing a default judgment to be entered.⁵⁹ In other

53. The original VIP Trust was a MET insured by Old Republic Life Insurance Co.. After Old Republic cancelled VIP Trust's group coverage, the insurance brokers established a new self-funded trust with itself acting as administrator for a 15% commission rather than replacing Old Republic with an authorized insurer. The court found that the trustees of the newly formed VIP Trust, while acting in that capacity, negotiated with themselves as corporate officers of the insurance brokerage an administration and management agreement. The trustees, the court concluded, were acting solely in the interest of the insurance brokerage. *Id.* at 1198.

54. *Id.*

55. *Id.*

56. *Id.* at 1199 (quoting H.R. REP. 94-1785, *supra* note 7, at 48). See text accompanying note 51 *supra*.

57. 437 F. Supp. 382 (D. Kan. 1977).

58. *Id.* at 384-85. See also note 61 and accompanying text *infra*.

59. Because Employee Security Benefit Association (ESBA) was doing a minimal

words, in light of the unique fact situation in *Bell*, the court had no reasonable alternative but to conclude that the defendant MET was not a valid employee benefit plan. The defendant Employee Security Benefit Association (ESBA), an unincorporated association, was soliciting agents in numerous states, including Kansas, to offer its medical and death benefits plan, which it advertised as a "self-funded, self-adjusting Employee Benefit Plan established under Public Law 93-406."⁶⁰ Upon learning that ESBA was paying excessive commission rates to its marketing representatives, disbursing substantial plan funds for administrative expenses,⁶¹ and enrolling as plan members individuals from a wide spectrum of unrelated occupations,⁶² the plaintiff insurance commissioner commenced suit to enjoin ESBA's business activities until it conformed to the state's various insurance statutes and regulations. Unlike the superficial analyses applied by the *Wayne Chemical* and *Hamberlin* courts, the *Bell* court set forth a two-pronged analytical approach to, first, determine the scope of the preemption provisions and, second, ascertain whether ESBA's program was "insurance" or an "employee benefit plan."⁶³

After a review of the language in section 514 and its legislative history, the court subscribed to the expansive view of preemption announced by the *Hewlett-Packard* court. Concerning the more difficult question whether ESBA's program was "insurance" or an "employee benefit plan," the court began its analysis by acknowledging that most employee benefit plans comply with the criteria of a general definition of insurance.⁶⁴ The

amount of business in Kansas as compared with other states, ESBA's counsel decided to default in *Bell* and focus full attention to litigation involving ESBA in Nevada. Letter from Curtis Lee Brooke, Counsel for ESBA, to the author (Oct. 3, 1979).

60. 437 F. Supp. at 384.

61. D.M.A., Inc., an agency organized by two of ESBA's officers to market ESBA's program, received 50% of first year member contributions and 17 ½% on renewal contributions. Benefit Services Corp., a corporation organized by individuals with substantial ties to ESBA's organizers, provided administrative services to ESBA in exchange for a 22% commission on all contributions received. *Id.* at 384-85.

62. A sampling of ESBA's members in Kansas included a contractor, a self-employed carpenter, a teacher's aide, a self-employed truck driver, and a sewer department employee. *Id.* at 385.

63. *Id.*

64. The court referred to the conclusion of one author who proposed that a general description of insurance would ensure the following: (a) consideration (premium), (b) fortuitous event, (c) a group of people with identical interests more or less equally exposed to the same risks, (d) a shifting of that risk to the insurer, and (e) a distribution of the risk to others similarly exposed. *Id.* at 389.

court then succinctly inquired: "Given that most employee benefit plans meet standard definitions of insurance, and that Congress meant to preempt state regulation of employee benefit plans without otherwise affecting state regulation of insurance, how are we to tell exactly what Congress meant to preempt?"⁶⁵

Several factors led the court to the conclusion that just as a state cannot regulate an employee benefit plan by calling it insurance, neither could ESBA merchandise an insurance program simply by terming it an employee benefit plan.⁶⁶ The two principal factors shaping the court's decision were the program's substantive nature and the program's technical nonconformity with the ERISA definition of an employee benefit plan. First, from a substantive standpoint, the court surveyed pre-ERISA literature and determined that the "pre-ERISA concept of an 'employee benefit plan' was easily distinguished from the concept of 'insurance.'"⁶⁷ Moreover, employee benefit plans before 1974 were considered to be nonprofit, nonadvertising programs provided by already existing employee groups rather than by employers.⁶⁸ The court then identified five general standards typifying the employee benefit plan concept as it existed when Congress adopted ERISA's preemption provisions.⁶⁹ Based upon those standards, the court determined that it was "clear" that ESBA's program was not an employee benefit plan but was instead "disguised insurance."⁷⁰

After examining the specific wording of the ERISA provisions, the *Bell* court also concluded that ESBA's program did not qualify as an employee benefit plan as that term is defined in

65. *Id.*

66. *Id.* at 390.

67. One pre-ERISA article listed the following characteristics as distinguishing employee benefit plans from insurance: (1) funds not open to the public, (2) no advertising or solicitation, (3) voluntary membership, and (4) a non-profit operation. *Id.* See 28 *ARK. L. REV.* 515, 516 (1975).

68. 437 F. Supp. at 390.

69. The court stated:

Clearly, the [employer benefit plan] concept as it existed when Congress passed the preemption provisions of ERISA involved the following characteristics: (1) it was provided by an employer or homogeneous employee organization, such as a union; (b) it was non-commercial in nature; (c) it did not involve solicitation; (d) it was not intended to be actuarially sound; (e) because the employees could look only to the fund, and not to the provider of that fund, the rates were substantially lower than insurance rates.

Id. at 391.

70. *Id.* at 392.

section 3(3) of ERISA.⁷¹ Although ESBA's program indisputably qualified under the medical, surgical, or hospital care benefits provision,⁷² the court found that the program failed to qualify as having been established or maintained by either an employer⁷³ or an employee organization.⁷⁴ In finding that ESBA's program was neither established nor maintained by an employee organization, the court relied primarily on reasoning supplied by the Labor Department in its amicus brief.⁷⁵

IV. SHAPING THE SUBSTANTIVE/DEFINITIONAL CONFLICT

The holding in *Bell* that ESBA was not a valid ERISA employee benefit plan was based on dual lines of analysis—substantive and definitional. Fortunately, both lines of analysis when applied to that particular fact setting compelled the same conclusion. In other words, the substantive analysis in *Bell* led to the conclusion that ESBA was doing the business of insurance.

71. 29 U.S.C. § 1002(3) (1976).

72. See note 40 and accompanying text *supra*.

73. See note 41 and accompanying text *supra*. The court summarily concluded that ESBA was not established or maintained by employers since ESBA did not employ those persons who purchased its benefits coverage. In addition, ESBA did not act directly or indirectly for the benefit of employers who hired ESBA plan members. 437 F. Supp. at 393.

74. See note 42 and accompanying text *supra*. The court had some difficulty in determining that the ESBA plan was not established or maintained by an employee organization because of the circular definition in § 3(4) of ERISA. Specifically, the term "employee organization" is defined in terms of the plan provided. The term "plan" is defined in terms of who provides it. Because of the ruling in *Stamps v. Michigan Teamsters Joint Council No. 43*, 431 F. Supp. 745 (E.D. Mich. 1977), which states that no statute may be construed in a manner so as to render a portion superfluous, the court felt constrained to define the term "employees' beneficiary association." Based upon an examination of legislation preceding ERISA and portions of the Internal Revenue Code, the court identified the "commonality of interest" element as being a necessary requisite for an employees' benefit association. Since ESBA enrolled virtually anyone in its program who was employed, the court found no commonality of interest in ESBA's program. 437 F. Supp. at 393-96.

75. Memorandum of Secretary of Labor, Amicus Curiae, *Bell v. Employee Security Benefit Ass'n*, 437 F. Supp. 382 (D. Kan. 1977), reprinted in [1977] PENS. REP. (BNA) No. 150, at R-1 (Aug. 15, 1977). Because ESBA did not claim to be an employer, employer association, or labor union, the Labor Department's brief examined whether ESBA qualified as an employee organization. The Department first argued that ESBA was not an employee representation committee or similar organization in which employees participate and which deals with employers. Second, the Department contended that ESBA was not an employee beneficiary association because the program's members lacked any kind of employment "commonality of interest." The commonality requirement was adopted because of its use in similarly worded sections of ERISA's predecessor, the Welfare and Pension Plans Disclosure Act. See Welfare and Pension Plan Disclosure Act, Pub. L. No. 85-836, § 3, 72 Stat. 997 (1958) (repealed 1976).

The definitional analysis also precluded ESBA's classification as an employee benefit plan because ESBA did not comply with ERISA's definitions of employer or employee organization. Perhaps because the circumstances of the case did not require a more detailed analysis, the *Bell* court failed to consider that fact settings may arise in which the two lines of analysis would lead to opposite results. For example, based on the *Bell* opinion, at least two types of cases would merit further inspection by the court: (1) an uninsured MET established or maintained by a definitionally conforming employee organization or (2) an uninsured MET established or maintained by an association of employers. Either type of case, if accompanied by the appropriate fact setting, would pose the classic conflict: a valid employee benefit plan (measured by definitional standards) that is transacting insurance business (measured by substantive standards). Such a case would create a direct conflict between the McCarran-Ferguson Act mandate that the business of insurance be regulated by the states and ERISA's broad preemption provisions that exclusively reserve to the federal government supervision over all employee benefit plans. In none of the cases considered thus far did the fact situations pose such a conflict; rather, those cases involved transparent attempts to circumvent state insurance laws for the sole purpose of furthering individuals' self-interest at the expense of the public.

The recent case of *Insurance & Prepaid Benefits Trust v. Security Health Plan (IPBT (I))*,⁷⁶ with its pending sequel (*IPBT (II)*),⁷⁷ presents a fact setting in which the substantive/definitional conflict is clear and inescapable. In *IPBT (I)* the plaintiff trust sued the defendant health-care provider and others in a contract dispute.⁷⁸ The defendants moved to have the action dismissed on the ground that the plaintiff trust was not a valid ERISA employee benefit plan. Relying primarily upon *Hamberlin* and *Bell*, the defendants attempted to characterize Insurance and Prepaid Benefits Trust's (IPBT) origin and mode of operation as essentially the same as those prior plans, which were declared invalid employee benefit plans. The defendants

76. No. 78-1926 RMT (GX) (C.D. Cal. Jan. 29, 1979).

77. *Insurance & Prepaid Benefits Trust v. Marshall*, No. CV 7903029 RMT (PX) (C.D. Cal., filed Aug. 9, 1979).

78. The plaintiff trust alleged that the defendants violated their fiduciary duties by mishandling funds. Contrary to the provisions of the agreement entered into by the two parties, the defendants allegedly wrongfully appropriated plan funds for their own purposes rather than providing benefits to the plan's participants and beneficiaries.

also argued, adopting precisely the same substantive analysis used by the *Bell* court, that IPBT complied with no more than one of the five general standards that typified the employee benefit plan concept as it existed when Congress adopted ERISA.⁷⁹ Moreover, the defendants alleged that: (1) the IPBT plan was entirely commercial in nature, (2) IPBT "products" were marketed directly to the public in the same manner that insurance is solicited, (3) the IPBT plan was intended to be actuarially sound,⁸⁰ and (4) IPBT's coverage rates were lower than insurance rates. The fifth criterion that the plan be provided by an employer or homogeneous employee organization was concededly a debatable issue.⁸¹

The plaintiff trust successfully countered the defendants' allegations and reasoning, that is its substantive analysis, by arguing that IPBT was "an employee benefit plan as *defined* under ERISA."⁸² The IPBT counsel explained that in December 1977 the single trust (IPBT) was divided into five successor trusts under the control of a benefit committee that was empowered to organize and manage the trusts.⁸³ Each trust is allegedly an organization of employers within a specific industry. Participating employers are chosen from the ranks of the five individual trusts to serve as members of the benefit committee.⁸⁴ Thus, the plaintiff trust contended that it complied with the definition of an employee benefit plan formed by an association of employers.⁸⁵

Having reviewed the extensive memoranda of points and

79. See note 69 and accompanying text *supra*.

80. The absurd implication here is that actuarial soundness is not desirable for employee benefit plans. Although it may be true that insurance carriers are required to remain actuarially sound and that employee benefit plans are not, the *Bell* court could not reasonably have meant that an employee benefit plan's intention to be actuarially sound could defeat its ERISA status.

81. Defendant's Memorandum of Points and Authorities at 17-20, Insurance & Prepaid Benefits Trust v. Security Health Plan, No. 78-1926 RMT (GX) (C.D. Cal. Jan. 29, 1979).

82. Plaintiff's Memorandum of Points and Authorities at 4, Insurance & Prepaid Benefits Trust v. Security Health Plan, No. 78-1926 RMT (GX) (C.D. Cal. Jan. 29, 1979) (emphasis added).

83. *Id.* at 6.

84. Complaint for Plaintiff at 2, Insurance & Prepaid Benefits Trust v. Marshall, No. CV 7903029 RMT (PX) (C.D. Cal., filed Aug. 9, 1979).

85. According to the trust agreements under which IPBT is organized, the governing board or "benefit committee" is comprised of participating employers in the trust. The benefit committee is authorized and empowered to adopt benefit plans, set rates, establish rules for participation, and contract for services with outside organizations. Benefit committee members may be removed by the vote of a majority of the participating employers. *Id.* at 7-8.

authorities from both sides, the court ruled that IPBT was an employee benefit plan under section 3(3) of ERISA⁸⁶ and therefore subject to the provisions of ERISA. Although the court chose to rule from the bench and not to write an opinion, it did adopt findings of fact and conclusions of law.⁸⁷ It is unfortunate that the court did not prepare an opinion explaining its holding since *IPBT (I)* is the first case of an adjudication of an employer association uninsured MET.⁸⁸

To further add to the uncertainty created by *IPBT (I)*, the Labor Department in July of 1979—six months after *IPBT (I)*—sent the administrator of IPBT an advisory opinion. The opinion stated that in spite of the holding in *IPBT (I)*, the Department did not consider IPBT to be a valid ERISA-covered employee benefit plan.⁸⁹ IPBT filed an action on August 9, 1979, against the Secretary of Labor seeking declaratory relief and a court mandate ordering the Labor Department to recognize IPBT under ERISA.

In its advisory opinion, the Labor Department states that a multiple-employer plan exists where a “cognizable” group or association of employers establishes a benefit program for their employees, where the employees jointly establish a program with an employee organization, or where the employers subscribe to a plan established by an employee association.⁹⁰ According to the

86. 29 U.S.C. § 1002(3) (1976).

87. Settlement negotiations between the two parties commenced before the court's decree was entered. Although the plaintiff trust was apparently willing to settle when it became apprised of the defendant health-care provider's unstable financial condition, both parties submitted complete memoranda of points and authorities and requested that the judge rule on the trust's ERISA status. Only after the court's decision on that issue was announced did the parties present the court with a consent judgment for its approval. Telephone interview with Claude J. Dorias, Counsel for Insurance and Prepaid Benefits Trust (Aug. 16, 1979).

88. Although *IPBT (I)* was the first judicially resolved uninsured MET case involving an “employer association,” at least two other cases were settled out of court. The case of *California v. Aid Fringe Benefits Group Trust*, No. C 77-2296 AJZ (N.D. Cal. 1979), was removed to federal court where a stipulated final judgment and permanent injunction were entered. *California v. 3/33 Group Benefit Trust*, No. 243.15B (San Francisco, Cal. Super. Ct., filed Sept. 6, 1977), was brought in state court before being settled.

89. Letter from Ian D. Lanoff, Labor Department Administrator, to Thomas J. Wilkie, Insurance and Prepaid Benefits Trust Administrator (July 23, 1979), reprinted in [1979] PENS. REP. (BNA) No. 250, at R-26 (Jul. 30, 1979).

90. The last paragraph of the Department's advisory opinion states:

It is the Department of Labor's view, based on the definitional provisions of ERISA as well as the overall statutory scheme, that a multiple employer plan exists where a cognizable group or association of employers establishes a benefit program for the employees of member employers, or where several employers

Department, each of the above situations involves an "organizational relationship" among the employers, employees, or both. This reasoning is rooted in the "commonality of interest" argument presented by the Department in *Bell*,⁹¹ an argument that the *Bell* court had some difficulty in adopting.⁹² It is troubling that the Department now reasons that when several unrelated employers execute identical trust agreements with an independent third party as a means of funding welfare benefits and there is no "concerted 'sponsor' or 'settlor' activity," the resulting trust is not an employee benefit plan under ERISA. The flaw in the Department's reasoning arises because of its failure to consider the conjunction "or" in ERISA's definition of an employee benefit plan as any plan, fund, or program "established *or maintained* by an employer or by an employee organization."⁹³ It may be argued that when an independent third party seeks out and brings together employers from unrelated areas to "establish" a multiple-employer plan, the formation process is initiated and directed by the third party rather than by the employers themselves. Accordingly, the arrangement supposedly does not qualify as an ERISA plan under the "established" language. However, the disjunctive language, "*or maintained by*," provides another avenue whereby a third-party administrator scheme may qualify as a valid ERISA plan. The statutory language does not appear

and one or more employee organizations jointly establish such a program, or where several employers contribute to a plan established by an employee organization. In each of these contexts there is some organizational relationship among the employers, or the employees, or both in coming together and establishing a single plan. But where several unrelated employers, in establishing benefit programs for their unrelated employees, without any concerted "sponsor" or "settlor" activity, merely execute identically worded "trust agreements," "subscription agreements," or similar documents offered by an independent third party as a means to fund benefits, no multiple employer plan can be recognized. In such a situation, each employer (or each bona fide employer association) establishes its own plan, and the entity contracted with to provide benefits is not itself an employee benefit plan, but the provider of a funding vehicle to the various plans. We believe that this description fits IBT. Accordingly, we have determined that IBT, as an entity, is not a multiple employer plan subject to ERISA. This, of course, does not mean that individual employers or bona fide employer associations which have associated themselves with IBT have not established individual employee welfare benefit plans subject to the coverage of ERISA or that persons who act in fiduciary capacities with respect to those plans are not subject to the fiduciary obligations imposed by part 4 of Title 1 of ERISA, 29 U.S.C. § 1101 *et seq.*

Id.

91. See note 75 *supra*.

92. See note 74 and accompanying text *supra*.

93. ERISA § 3(1), 29 U.S.C. § 1002(1) (1976) (emphasis added).

to prohibit an independent third party from organizing the MET by deliberately aligning the unrelated employers' interests such that the employers thereafter "maintain" the plan as a "cognizable" group adhering to a definite "organizational relationship." It would seem improper, therefore, for the Department to focus on the "established" language of the ERISA definition to the complete exclusion of the "maintenance" language.

A second difficulty with the Labor Department's interpretation of multiple-employer plans results from its apparent policy against third-party administrators. The Department's position that third-party administration arrangements are only a funding vehicle is at cross purposes with the congressional objective of increasing the availability of cost-efficient employee benefit plans to small employers. For example, the General Accounting Office reports that ERISA was a major factor in the decision to terminate in the case of about forty-one percent of the employee benefit plans with fewer than 100 participants that terminated between mid-1975 and mid-1977.⁹⁴ The desire to eliminate or reduce high administrative costs was cited as the most predominate ERISA factor that affected decisions to terminate. The Department's exclusion of third-party administrators in effect eliminates the most economical method for small employers to distribute their administrative costs among a larger pool of participants. Thus, by excluding entrepreneurial schemes from federal regulation and placing them under the more stringent regulation of state insurance departments, the Labor Department, in large measure, would destroy the incentives behind the very administrative and financial arrangement that makes adoption of cost-viable MET plans attractive to small employers.⁹⁵ The Labor Department should carefully evaluate the ramifications of its latest position before fully implementing it.

In any event, the Department's earlier support for state regulation of bogus employee organization MET's that is now being extended to include state regulation of alleged bogus employer association uninsured MET's implicitly denotes a more accommodating view by federal officials toward state insurance departments.⁹⁶ Although this is by no means an indefensible position,

94. See [1979] PENS. REP. (BNA) No. 236, at A-13 (Apr. 23, 1979).

95. It should be acknowledged, on the other hand, that the establishment of a third-party administrator arrangement does not necessarily guarantee cost efficiency. As has been seen in cases such as *Bell*, entrepreneurial schemes also present enticing opportunities for abuse and exploitation if effective controls are not employed.

96. The Labor Department would probably dispute any suggestion that it is accomo-

it nevertheless could be argued that the Department has reversed its earlier stance and abdicated a portion of its congressionally mandated position of total preemption.

In summary, although it is impossible to predict the outcome of *IPBT (II)* and its resulting impact upon the whole field of uninsured MET's, it is hoped that the court will seize this opportunity to squarely confront the issues and reach a definitive determination.

V. ALTERNATIVES FOR RESOLVING THE UNINSURED MET REGULATORY CONTROVERSY

In order to resolve the uninsured MET regulatory controversy, two questions must be answered: (1) Where should the line be drawn between state and federal regulation of uninsured MET's, and (2) who should draw the line—the Congress, the Labor Department, or the judiciary?

A. *Where to Draw the Line?*

The question of where the line between state and federal regulation of uninsured MET's should be drawn can be stated more precisely: Should ERISA's definition of employee benefit plans be interpreted to encompass more of the field of uninsured MET's? Whereas a move to bring more of the field of uninsured MET's within the definition of an ERISA employee welfare benefit plan would strengthen ERISA's preemption provisions, a move to define more uninsured MET's as not qualifying as employee benefit plans would enlarge the regulatory powers of state insurance departments.⁹⁷

Some observers have noted that while it is not at all clear that ERISA's preemption provisions will be clarified or revised,⁹⁸ no consensus exists, even among those who favor revision of the section 514 language, as to whether the preemptive language

dating state regulation within the employee benefit field; rather, it would likely point out that the "bogus" nature of the alleged "employee organization" or "employer association" uninsured MET's confirms the fact that such entities were never properly considered to be within the definitional confines of an employee benefit plan.

97. Four public policy considerations favoring state regulations of uninsured multiple-employer welfare trusts (UMEWT's) are: (1) disparity in bargaining power between participating employers and the UMEWT's; (2) the soliciting and advertising of employee benefit "plans" to the public; (3) the very real potential for UMEWT insolvencies; and (4) the administrative incapacity of the Department of Labor to properly supervise UMEWT activities. See Brummond, *supra* note 1, at 713.

98. Turza & Halloway, *supra* note 19, at 212.

should be expanded or restricted.⁹⁹ This lack of agreement suggests that policy considerations will play an increasingly important role in the final outcome. Two factors argue particularly persuasively in favor of total preemption: (1) Congress' intent to occupy the field of employee benefit plans, thereby displacing all state regulations,¹⁰⁰ and (2) the national interest in uniformity with respect to interstate plans.¹⁰¹ Support for these two factors is found in the plain language of section 514.¹⁰²

Conversely, several factors argue with equal force in behalf of greater state participation in the regulation of uninsured MET's. First is the existing expertise and enforcement machinery of the state insurance departments as compared with that of the Labor Department.¹⁰³ Second, there is a national interest in leaving regulation of insurance matters to the individual states.¹⁰⁴ The third factor is the need for prompt and decisive action in the public interest. Finally, the federal government has failed to adopt minimum standards for uninsured MET's or to refine ERISA definitions.

B. Who Draws the Line?

The lack of consensus concerning revision of the language in ERISA's preemption provisions explains in part why no one has

99. Compare *ERISA Oversight Hearings*, *supra* note 7, at 535 (statement of ERISA Industry Committee) (supporting current broad preemptive language) and H.R. REP. 94-1785, *supra* note 7, at 46-49 (recommending strengthening of broad preemptive language) with *ERISA Oversight Hearings*, *supra* note 7, at 650 (statement of NAIC by Herbert W. Anderson, Chairman of NAIC ERISA Preemption Task Force) (advocating amendments to restrict preemptive language).

100. See ERISA § 2, 29 U.S.C. § 1001 (1976) (Congressional declaration of policy); H.R. REP. 94-1785, *supra* note 7, at 46-49.

101. See H.R. REP. 94-1785, *supra* note 7, at 46-49. See also note 23 *supra*.

102. See *Banks v. Chicago Grain Trimmers Ass'n*, 390 U.S. 459, 465 (1968) (absent persuasive reasons to the contrary, the words of a statute are given their ordinary meaning).

103. During 1977 the Labor Department received 1.5 million ERISA reports and 230,000 inquiries regarding ERISA compliance. Consequently, on the average, every employee in the Plans Benefit Security Division of the Labor Department would have had to review 2680 ERISA filings and respond to 412 ERISA inquiries. *ERISA Oversight Hearings*, *supra* note 7, at 670 (statement of NAIC by Herbert W. Anderson, Chairman of NAIC ERISA Preemption Task Force). NAIC also points out that in the field of "welfare" benefits, unlike the field of employee pension benefits, the types of benefits offered are quite diverse in nature; therefore, the increased complexity in handling claims raises administrative costs. *Id.* at 669. See also *Complaint for Plaintiff at 2, Insurance & Prepaid Benefits Trust v. Marshall*, No. CV 7903029 RMT (PX) (C.D. Cal., filed Aug. 9, 1979) (an employee welfare benefit plan administrator allegedly waited for over three years for an answer to his status inquiry).

104. See text accompanying notes 27, 28 *supra*.

taken decisive action to resolve the matter. With respect to uninsured MET's specifically, three groups are in a position to offer a remedy: the Congress, the Labor Department, and the judiciary.

1. Congress—remedial legislation

When Congress decided to adopt the joint committee's recommendation for a much broader preemption provision than had been earlier proposed by either house,¹⁰⁵ it anticipated that modifications and improvements would necessarily follow; hence, provision was made for the establishment of a Pension Task Force¹⁰⁶ to study the consequences of ERISA's implementation and to report its findings back to Congress.¹⁰⁷ Although the Pension Task Force has conducted hearings on the subject, no legislative refinement affecting uninsured MET's has occurred to date.¹⁰⁸ The chances of legislation in the near future appear to be growing slimmer.¹⁰⁹ The present pessimism stems in part from the changing provisions of remedial legislation introduced by two of ERISA's original sponsors, Senators Williams and Javits.¹¹⁰ These two influential Senators have twice introduced versions of remedial legislation—S. 3017¹¹¹ and S. 209,¹¹² with the latter currently pending. Both versions of the proposed legislation would amend portions of section 514 to reinforce the federal government's claim to full preemption with only limited exceptions.¹¹³ The earlier

105. See note 23 *supra*.

106. ERISA §§ 3021, 3022, 29 U.S.C. §§ 1221, 1222 (1976) (establishment and duties).

107. Senator Javits of the Conference Committee explained:

The conferees—recognizing the dimensions of such a policy—also agreed to assign the Congressional Pension Task Force the responsibility of studying and evaluating preemption in connection with State authorities and reporting its findings to the Congress. If it is determined that the preemption policy devised has the effect of precluding essential legislation at either the State or Federal level, appropriate modifications can be made.

120 CONG. REC. 29,942 (1974).

108. A number of specific amendments to restrict the preemptive scope of ERISA's § 514 language have been offered by NAIC. Important recommended changes affecting uninsured MET's would redefine the terms "employee organization" and "employer." See *ERISA Oversight Hearings*, *supra* note 7, at 672-76 (statement of NAIC by Herbert W. Anderson, Chairman of NAIC ERISA Preemption Task Force).

109. See [1979] PENS. REP. (BNA) No. 221, at A-20 (Jan. 8, 1979).

110. Senator Harrison Williams is the Chairman of the Senate Committee on Labor and Public Welfare. Senator Jacob Javits is the ranking minority member of the same committee.

111. 95th Cong., 2d Sess., 124 CONG. REC. S 6592 (daily ed. May 1, 1978).

112. 96th Cong., 1st Sess. (1979).

113. The pending legislation, S. 209, would underscore ERISA's broad preemptive powers by adding to the end of subsection (b)(2)(B) of § 514 the following:

version, S. 3017, as introduced in the 95th Congress, suggested two major refinements concerning uninsured MET's that have particular application here. First, section 201(b)(1) provided a definitional clarification of the term "employee organization."¹¹⁴ Second, section 266 authorized the Secretary of Labor to promulgate solvency and reserve standard regulations for uninsured welfare trusts.¹¹⁵ In surprising contrast, S. 209, as introduced, apparently emasculates one provision¹¹⁶ and deletes the other.¹¹⁷ Unless changes occur, the probable result will be that Congress, in time, will underscore the broad preemptive language of section 514,¹¹⁸ leaving the unwanted task of precise line-drawing to the Labor Department or the judiciary.

2. Labor Department regulation

The Department of Labor has assumed an increasingly active role in resolving the uninsured MET controversy through the use of amicus curiae briefs, press releases, and advisory opinions.¹¹⁹ Nevertheless, the Department's efforts have fallen far

A State insurance law which provides that a specific benefit or benefits must be provided or made available by a contract or policy of insurance issued to an employee benefit plan is a law which relates to an employee benefit plan within the meaning of subsection (a) and is not a law which regulates insurance within the meaning of subparagraph (A)

Id. § 155. The pending legislation includes exceptions for "State domestic relations law" and the "Hawaii Prepaid Health Care Law." *Id.*

114. The proposed amendment stated in part: "For purposes of this paragraph, the term 'employees' beneficiary association' shall mean an association in which employees participate as members and in which eligibility for membership is based on a commonality of interest with respect to the members' employment relationships." S. 3017, 95th Cong., 2d Sess., 124 CONG. REC. S 6592 (daily ed. May 1, 1978). Compare *id.* with *ERISA Oversight Hearings*, *supra* note 7, at 675 (statement of NAIC by Herbert W. Anderson, Chairman of NAIC ERISA Preemption Task Force).

115. S. 3017, 95th Cong., 2d Sess., 124 CONG. REC. S 6594 (daily ed. May 1, 1978).

116. S. 209, 96th Cong., 1st Sess. § 131 (1979).

117. *Id.* § 102.

118. If passed in its present or similar form, S. 209 would have the effect of overruling the First Circuit's decision in *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). *ERISA Improvements Act of 1979: Hearings on S. 209 Before the Comm. on Labor and Human Resources*, 96th Cong., 1st Sess. 97 (opening statement of Senator Jacob K. Javits) [hereinafter cited as *Improvements Act Hearings, 1979*]. Furthermore, the bill would overrule the holding in *Standard Oil v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), in which the Hawaii Prepaid Health Care Act, HAWAII REV. STAT. §§ 393-1 to -51 (1976), was preempted. Compare *Improvements Act Hearings, 1979, supra*, at 642 (statement of Hon. Daniel K. Inouye and Hon. Spark Matsunaga, Senators from the State of Hawaii) (favoring passage of Hawaii Prepaid Health Care Act exception) with *id.* at 1053 (statement of H.P. Kneen, Jr., Director of Employee Benefits for IBM) (opposing passage of Hawaii Prepaid Health Care Act exception).

119. See, e.g., Letter from Ian D. Lanoff, Labor Department Administrator, to Ed-

short of concretely defining a valid ERISA-covered employee welfare benefit plan. The Department does not presently contemplate issuing any official regulations regarding uninsured MET's¹²⁰ despite a resolution from one state¹²¹ urging such a formulation. Whether the reason for the Department's reticence be caution to ensure the development of foolproof regulations, deference to Congress' anticipated remedial legislation, an election to attack the problem on a case-by-case basis, or simply indecision, the Department's inaction has created a number of serious problems. For instance, it has caused a rift between the Labor Department and state insurance departments that have been forced to expend substantial time and money in litigation.¹²² This apparent schism in governmental regulation of uninsured MET's is unfortunate in view of the fact that the Secretary of Labor is authorized to make "arrangements or agreements for cooperation or mutual assistance in the performance of his functions" on a reimbursable or other basis with state departments and agencies, such as state insurance departments.¹²³ Congress granted the Secretary this authorization for the express purpose of avoiding "unnecessary expense and duplication of functions among Government agencies."¹²⁴ In addition, the Department's inaction has produced a cloud of uncertainty over uninsured MET administrators and organizers who are genuinely attempting to bring their operations into conformity with ERISA's provisions.

3. *Judicial determination*

Although several federal courts have justifiably expressed the view that the resolution of ERISA-related controversies should be handled by Congress rather than by the courts,¹²⁵ it now appears that a judicial determination of the uninsured MET

ward N. Getoor, President, Multiple Fund Administrators, Inc. (June 29, 1979), *reprinted in* [1979] PENS. REP. (BNA) No. 250, at R-28, 29 (Jul. 30, 1979).

120. Telephone interview with Wayland B. Coe, Acting Assistant Administrator for Reporting and Plan Standards, Pension and Welfare Benefits Program, Dep't of Labor (Nov. 15, 1979).

121. *Improvements Act Hearings, 1979, supra* note 118, at 1314 (California Joint Resolution No. 43). *See* [1978] PENS. REP. (BNA) No. 199, at A-18 (July 31, 1978).

122. *ERISA Oversight Hearings, supra* note 7, at 660 (statement of NAIC by Herbert W. Anderson, Chairman of NAIC ERISA Preemption Task Force).

123. ERISA § 506, 29 U.S.C. § 1136 (1976).

124. *Id.*

125. *See* *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978); *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal.), *aff'd*, 571 F.2d 502 (9th Cir. 1977), *cert. denied*, 439 U.S. 831 (1978).

question is both desirable and necessary. Until a consensus is achieved in Congress, some protection must be afforded to the public against abuses in the uninsured MET field.

In anticipation of the judicial determination to come, several factors indicate that the courts may be inclined to increase the state's regulatory role over uninsured MET's. First is the emerging conservative disposition of the Burger Court to allow the accommodation of state regulation that does not conflict with or impinge upon federal regulation.¹²⁶ Second, the Labor Department has apparently deferred to state insurance departments in the regulation of "bogus employer association" uninsured MET's. Third, there is a vital public interest in sealing off any regulatory void that might cause injury to the working public. Fourth is the recognition that if Congress is opposed to a constriction on absolute preemption, remedial legislation can rectify the situation.

Although a judicial determination to permit increased state regulatory power over uninsured MET's may provide short term relief, any move in that direction will necessarily require further judicial entanglement in the complex line-drawing controversy. Perhaps the more prudent approach for the courts to pursue is that advocated by the plaintiff in *IPBT (II)*. The plaintiff requested a court mandate directing the Labor Department to recognize IPBT as a valid employee benefit plan under ERISA. Since the Labor Department is charged with the supervision of ERISA plans generally and possesses the power to promulgate definitive regulations, the court may be well-advised to order the Department to assume regulatory jurisdiction over IPBT and other uninsured MET's—a duty arguably mandated by the plain wording of ERISA's preemption provisions.

VI. CONCLUSION

Recent events have again called into question the jurisdictional bounds between state insurance departments and federal regulators in the field of uninsured MET's. The judicial consensus that emerged from *Hamberlin* and *Bell*, permitting state regulation of certain plans, may be of limited application because of the unusual fact settings involved. The principal question now pending before the courts is whether an alleged employee benefit plan's definitional qualification under ERISA provisions or the

126. See generally Hirsch, *Toward a New View of Federal Preemption*, 1972 U. ILL. L.F. 515; Note, *The Preemption Doctrine: Shifting Perspectives on Federalism and the Burger Court*, 75 COLUM. L. REV. 623 (1975).

plan's substantive nature should be controlling in determining a plan's ERISA status. The difficulty of the line-drawing procedure is compounded because of Congress' and the Labor Department's failure to act affirmatively and decisively in resolving the matter. Clearly, primary responsibility to clarify ERISA's preemption provisions rests upon Congress—the originator of the legislation. Nevertheless, given the weight of the competing policy issues—none of which is apparently capable of commanding a congressional majority at present—it does not reasonably appear that remedial legislation can be expected in the immediate future.

Although the congressional stalemate is perhaps understandable, the Labor Department's minimal efforts are inexcusable. The Labor Department received a direct congressional mandate to implement and administer ERISA. That mandate included the power to promulgate official regulations as the need arises. Yet despite the magnitude of the existing problem and the pervasive uncertainty regarding regulatory jurisdiction over uninsured MET's, the Labor Department continues to refrain from promulgating regulations.

Because of both the Labor Department's reluctance to act and the Congress' division over preemption questions, the judiciary by default has inherited the unenviable task of providing an interim solution. Although the courts in the past have engaged in the uninsured MET line-drawing controversy, and may elect to continue to do so now, the better approach would be for the judiciary to place the responsibility where it belongs: on the Congress and the Labor Department. The courts are powerless to compel Congress to act in this situation; the same is not true, however, with regard to the Labor Department. The courts should exercise their powers of mandate to order the Labor Department to recognize under ERISA those parties in litigation that qualify as valid ERISA employee benefit plans. Perhaps this judicial leverage will induce the Labor Department to promulgate needed regulations or stimulate Congress to consider and enact sorely needed remedial legislation.

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