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Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern

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Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern

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I. INTRODUCTION

Congress enacted the Employee Retirement Income Security Act (ERISA) in 1974¹ to address problems in the area of employee pensions and benefits, with which prior federal enactments and complementary

1. The Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified at 29 U.S.C. §§ 1001-1381 (1982)) [hereinafter ERISA]. President Ford signed ERISA into law on September 2, 1974. For a detailed guide to ERISA, see S. GOLDBERG, PENSION PLANS UNDER ERISA (1976).

state regulation had been unable to cope.² ERISA established a comprehensive scheme that placed the regulation of qualified employee benefit plans exclusively in federal hands.³ The drafters of ERISA also sought to reserve to the states the power to regulate areas in which they traditionally had primacy—most notably, insurance, banking, and securities.⁴ The drafters of ERISA thus attempted to carve out an area of

2. See *infra* notes 16-22 and accompanying text. In the introduction to the statute, Congress stated:

[T]he growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

ERISA, *supra* note 1, § 2(a), 29 U.S.C. § 1001(a) (1982).

3. See *infra* notes 24-29 and accompanying text. Congress declared:

[T]he policy of [ERISA is] to protect interstate commerce and the interests of 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 for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

ERISA, *supra* note 1, § 2(b), 29 U.S.C. § 1001(b) (1982). Congress further declared that ERISA is meant to:

[P]rotect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

ERISA, *supra* note 1, § 2(c), 29 U.S.C. § 1001(c) (1982).

4. ERISA, *supra* note 1, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982); see also S. GOLDBERG, *supra* note 1, at 151. The drafters of ERISA wanted the statute to be consistent with prior federal enactments that explicitly had established state regulation of these areas. In the field

“exclusive federal concern,”⁵ while preserving state regulation of tangential areas, so as not to create a regulatory void, nor to infringe on state police powers.⁶

In an attempt to achieve this goal, the drafters of ERISA constructed an express preemption provision. Section 514 of ERISA delineates the scope of the statute’s preemptive effect on state law.⁷ Section 514(a) states that ERISA supersedes any state laws⁸ to the extent that they “relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b).”⁹ Section 514(a), known as the “preemption clause,” is then qualified by a “savings clause,” section 514(b)(2)(A), which states that ERISA is not to be construed as exempting or relieving any person from any state law that regulates insurance, banking, or securities.¹⁰ The scope of the preemption and savings clauses is refined further by the “deemer clause,” section 514(b)(2)(B), which states that employee benefit plans, or any trusts established under such plans, will not be considered as engaging in the business of insurance or banking for purposes of any state’s law “purporting to regulate insurance companies [or] insurance contracts.”¹¹ Thus, through express legislative pronouncement, Congress attempted to define ERISA’s preemptive effect, giving the federal government broad regulatory authority over employee benefit plans, while reserving to the states the power to regulate insurance.¹²

of insurance regulation, the McCarran-Ferguson Act was the federal legislation that established this congressional intent. *See infra* notes 78-83 and accompanying text.

5. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981). One article has observed that “[s]ince state law had previously regulated many aspects of such plans, ERISA involved not only the creation of new law but the displacement of a large body of existing state law.” Hutchinson & Ishin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. CHI. L. REV. 23, 34 (1978).

6. *See Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977) (stating that there is a presumption that Congress does not intend to preempt areas of traditional state regulation), *cited in Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985). For an important early article that predicted many of the current interpretation problems and identified the complexities of employee benefit plan regulation under ERISA, see Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 IOWA L. REV. 57 (1976).

7. ERISA, *supra* note 1, § 514, 29 U.S.C. § 1144 (1982).

8. *Id.* § 514(c)(1), 29 U.S.C. § 1144(c)(1) (1982). “State law” includes “all laws, decisions, rules, regulations, or other State action having the effect of law.” *Id.*

9. *Id.* § 514(a), 29 U.S.C. § 1144(a) (1982).

10. *Id.* § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982).

11. *Id.* § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1982).

12. Although ERISA’s preemption provision appears on its face to be crafted carefully, courts have had enormous difficulty interpreting its language ever since its enactment. At least one commentator has argued that ERISA’s preemption provision needs clarification through amendment. *See Manno, ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action*, 52 TEMP. L.Q. 51, 51 (1979) (arguing that the result of the uncertainties existing with regard to whether employee benefits are provided through self-insured plans or by the purchase of group insurance policies could be the complete termination of such plans, which would clearly

Despite congressional attempts to elucidate an ERISA preemption standard, it has been the courts that have been called upon to interpret ERISA's preemption provision.¹³ This has led to wide debate regarding the intent of the drafters, the underlying purpose of the legislation, and ultimately, the essence of federalism. This Note will explore the scope of ERISA's preemption provision as it conflicts with state efforts to regulate insurance, especially in light of the recent United States Supreme Court decisions in *Pilot Life Insurance Co. v. Dedeaux*¹⁴ and *Metropolitan Life Insurance Co. v. Massachusetts*.¹⁵ Part II provides a brief history of employee benefit plan regulation by the federal government before ERISA. Part III examines the legislative history of ERISA and its drafters' attempt to construct an express preemption provision. Part IV explores in detail the three parts of ERISA's preemption provision and discusses several important cases interpreting the preemptive scope of ERISA. Part V concludes that the Supreme Court has interpreted fairly ERISA's preemption provision thus far, despite a lack of legislative guidance, by attempting to give meaning to all of its component parts, while keeping in mind the fundamental purpose behind the legislation. In order to bring uniformity and certainty to the field of employee benefit plan regulation, courts should not find a state insurance regulation saved from preemption unless it is directed at the insurance industry and regulates the activities of insurance companies acting uniquely as insurance companies, but not as administrators or underwriters of ERISA plans. This approach will maintain ERISA's integrity, by following the plain language of the statute, while furthering Congress's goal in enacting ERISA: bringing uniformity to the regulation of employee benefit plans by making them exclusively a federal concern.

II. PRE-ERISA REGULATION OF EMPLOYEE BENEFIT PLANS

Prior to the enactment of ERISA, attempts at federal regulation of administrative abuses of employee benefit plans had been largely unsuccessful. The common law of trusts was inadequate to cover the complexities of employee benefit plans.¹⁶ The initial federal statutory

frustrate congressional intent).

13. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life*, 471 U.S. 724; *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).

14. 481 U.S. 41 (1987).

15. 471 U.S. 724 (1985).

16. See *Hutchinson & Ifshin*, *supra* note 5, at 25-26. The common law of trusts possesses both strengths and weaknesses in handling pension problems. ERISA's prudent business judgment rule, for example, is really a common law trust rule that has been incorporated into the federal statute. See ERISA, *supra* note 1, § 404(a), 29 U.S.C. § 1104(a) (1982). The section provides, in part, that an ERISA fiduciary "shall discharge his duties . . . solely in the interest of the participants and beneficiaries . . . with the care, skill, prudence, and diligence under the circumstances

response to employee benefit plan abuses was to regulate through the use of the tax laws. Beginning in 1921, and culminating in section 401(a) of the Internal Revenue Code of 1954, Congress set forth a series of requirements for plan qualification.¹⁷ This provision and others, however, could be avoided by employers who could afford to forego the tax benefits of a "qualified" plan.¹⁸ The Labor-Management Relations Act of 1947 (LMRA), although primarily concerned with labor-management problems not directly related to pensions, set forth requirements that affected employee benefit plans set up by unions.¹⁹ The LMRA's provi-

then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character." *Id.* The "prudent man" approach provides flexibility, while holding an ERISA fiduciary to the highest standard of care. The common law of trusts approach is inadequate on its own, however, due to its shortcomings. *See* Hutchinson & Ifshin, *supra* note 5, at 25-26. For example, while ERISA provides that a participant or beneficiary may bring a civil action for enforcement of the statute's fiduciary obligations, beneficiaries suing under the common law of trusts often had difficulty establishing the requisite interest and injury to accord them standing to sue for breach of fiduciary duty. *See* ERISA, *supra* note 1, § 502(a), 29 U.S.C. § 1132(a) (1982).

17. I.R.C. § 401(a) (1982) (repealed 1986); Hutchinson & Ifshin, *supra* note 5, at 26-27. From 1921 to 1942, Congress passed several pieces of legislation that deferred taxation of employer contributions to pension plans until benefits under the plan were finally distributed to its beneficiaries. Section 401(a) of the Internal Revenue Code of 1954 required that a "qualified" plan be intended exclusively for the benefit of employees and their beneficiaries, that it not discriminate in favor of shareholders, officers, or highly compensated employees, that it cover a minimum percentage of all employees, and that it meet minimum vesting and termination rules. Hutchinson & Ifshin, *supra* note 5, at 26-27. A qualified plan entitled an employer to take immediate deductions for contributions to it, while the recipient of benefits under the plan could defer taxation of the plan's proceeds until they were actually received. *Id.* at 27; *see also* M. BERNSTEIN, *THE FUTURE OF PRIVATE PENSIONS* 197-223 (1964).

18. Hutchinson & Ifshin, *supra* note 5, at 27.

19. Labor-Management Relations Act of 1947, Pub. L. No. 80-101, § 302, 61 Stat. 136, 157 (codified at 29 U.S.C. § 186 (1982)) [hereinafter LMRA]; *see also* Hutchinson & Ifshin, *supra* note 5, at 27. The Act prohibited the payment of money, by an employer to a union or employee trust, for the sole and exclusive benefit of the employees of such employer, and their families and dependents [unless] such payments are held in trust for the purpose of paying, either from principal or income or both, for the benefit of employees, their families and dependents, 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; (B) the detailed basis on which such payments are to be made is specified in a written agreement with the employer, and employees and employers are equally represented in the administration of such fund, together with such neutral persons as the representatives of the employers and the representatives of employees may agree upon and in the event the employer and employee groups deadlock on the administration of such fund and there are no neutral persons empowered to break such deadlock, such agreement provides that the two groups shall agree on an impartial umpire to decide such dispute, or in event of their failure to agree within a reasonable length of time, an impartial umpire to decide such dispute shall, on petition of either group, be appointed by the district court of the United States for the district where the trust fund has its principal office, and shall also contain provisions for an annual audit of the trust fund, a statement of the results of which shall be available for inspection by interested persons at the principal office of the trust fund and at such other

sions, however, only applied to plans set up by certain unionized industries. Neither the tax laws nor the LMRA had the breadth necessary to enforce fiduciary obligations imposed on persons in control of the plans.²⁰

Congress enacted the Welfare and Pension Plans Disclosure Act (WPPDA) in 1958,²¹ requiring employee benefit plan disclosure and filing information. States, however, maintained their dominance in the regulation of pension plans, insurance, and trusts.²² Thus, the WPPDA did not go far enough in placing the job of regulating employee benefit plans into the hands of the federal government.

In 1974 Congress sought to remedy employee benefit plan abuses through an extensive regulatory scheme, ERISA. The congressional purpose behind the new law was to ensure that benefits from private pension plans were distributed to participating employees in accordance with their credited years of service with their employers.²³ ERISA protected participants in employee benefit plans by establishing fiduciary standards,²⁴ requiring reporting of financial information,²⁵ imposing minimum funding and vesting standards,²⁶ requiring plan termination

places as may be designated in such written agreement; and (C) such payments as are intended to be used for the purpose of providing pensions or annuities for employees are made to a separate trust which provides that the funds held therein cannot be used for any purpose other than paying such pensions or annuities

LMRA, *supra*, § 302(c)(5), 29 U.S.C. § 186(c)(5) (1982).

20. Hutchinson & Ifshin, *supra* note 5, at 27.

21. Pub. L. No. 85-836, 72 Stat. 997 (1958) (codified at 29 U.S.C. § 301 (1958) (repealed 1976)); *see* Hutchinson & Ifshin, *supra* note 5, at 27-30.

22. Hutchinson & Ifshin, *supra* note 5, at 28-29; *see also* M. BERNSTEIN, *supra* note 17, at 47-48. Professor Bernstein noted that "[t]he diversion of funds by speculation, overly generous commissions to favored companies (some in collusion with plan administrators), and other such questionable activities were the evils to which the Act was directed." *Id.* at 47. Professor Bernstein recognized, however, the shortcomings of the WPPDA:

[The WPPDA's] method was compulsory disclosure and, initially, policing of practices by those interested in the plans. But even effective disclosure was difficult to achieve because of limitations placed in the law by the House committee. After a few years of frustration, amendments were enacted giving greater powers to the Secretary of Labor to compel disclosure and to check on the accuracy of the reports. . . . [T]he 1961 amendments added criminal penalties for embezzlement, kickbacks, and conflicts of interest by plan administrators, who must be bonded. However, the Act does not prescribe proper plan practices or provisions to enhance the effectiveness of plans other than the protection afforded against criminal conduct.

Id.

23. *Highlights of the New Pension Reform Law*, Collective Bargaining Negot. & Cont. (BNA) No. 763, at 5 (Aug. 29, 1974). *See generally* M. BERNSTEIN, *supra* note 17 (a seminal treatise in which the author discusses the inadequacies of the pre-ERISA regime and proposes ways in which its shortcomings could be addressed).

24. ERISA, *supra* note 1, §§ 401-414, 29 U.S.C. §§ 1101-1114 (1982); *see also* Brummond, *supra* note 6, at 61-64 (discussing ERISA's provisions and summarizing their contents).

25. ERISA, *supra* note 1, §§ 101-111, 29 U.S.C. §§ 1021-1031 (1982).

26. *Id.* §§ 201-306, 29 U.S.C. §§ 1051-1086 (1982).

insurance,²⁷ and setting forth exclusive federal remedies for enforcement.²⁸ Because ERISA was the most far-reaching attempt at federal regulation of employee benefit plans to date, and because the regulation of employee benefit plans previously had been left largely to the states, ERISA's enactment inevitably meant the displacement of a large body of state law.²⁹

III. GENESIS OF ERISA'S PREEMPTION PROVISION

A. Legislative History

Congress engaged in extensive debate over the scope of the preemptive effect ERISA should have on competing state regulation. The Conference Committee, in its report, considered but ultimately rejected a preemption provision narrower than section 514,³⁰ expressly stating that section 514(a) was drafted intentionally to have a broad preemptive scope.³¹ Proponents trumpeted ERISA's intended broad preemptive effect in both houses of Congress. Representative John H. Dent, House sponsor of ERISA, stated that "the reservation to Federal authority the *sole* power to regulate the field of employee benefit plans" is the statute's "crowning achievement."³² Senator Harrison A. Williams, Chairman of the Senate Labor & Public Welfare Committee, echoed these sentiments, stating that ERISA's provisions were intended to preempt the entire field of employee benefit plans for federal regulation.³³

27. *Id.* §§ 4001-4402, 29 U.S.C. §§ 1301-1461 (1982).

28. *Id.* §§ 501-515, 29 U.S.C. §§ 1131-1145 (1982).

29. See Hutchinson & Ifshin, *supra* note 5, at 30.

30. See *supra* text accompanying note 9. A more limited preemption provision stated:

It is hereby declared to be the express intent of Congress that . . . the provisions of this Act or the [WPPDA] shall supersede any and all laws of the States . . . insofar as they may now or hereafter relate to the *subject matters* regulated by this Act or the [WPPDA] . . .

S. 4, 93d Cong., 1st Sess. § 609, 119 CONG. REC. 141-42 (1973) (emphasis added); see also H.R. REP. No. 533, 93d Cong., 2d Sess., reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 4639, 4666 (setting forth another early and more limited preemption provision).

31. H.R. CONF. REP. No. 1280, 93d Cong., 2d Sess., reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 5038, 5162. The Conference Committee report stated that "the provisions of title I are to supersede all State laws that relate to any employee benefit plan that is established by an employer engaged in or affecting interstate commerce or by an employee organization that represents employees engaged in or affecting interstate commerce." *Id.*

32. 120 CONG. REC. 29,197 (1974) (remarks of Rep. Dent) (emphasis added).

33. *Id.* at 29,933. Senator Williams stated:

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 preempt 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. (emphasis added).

The Conference Committee's report, however, merely paraphrased the exceptions to ERISA's preemptive scope explicitly enumerated in the text of section 514 itself,³⁴ stating that "[t]he preemption provisions of title I are not to exempt any person from any State law that regulates insurance, banking or securities."³⁵ Thus, despite Senator Williams's characterization of these exceptions as "narrow,"³⁶ the report provides little more guidance than already is present in the text of the statute, which could account in part for the early confusion of courts faced with the task of construing ERISA's preemption provision.³⁷

B. *Judicial Interpretation: The Preemption Problem*

In light of the dearth of legislative guidance³⁸ as to how the words of section 514 should be read, courts could only look to the words of the statute themselves.³⁹ Although Congress had expressed its intent in making the area of employee benefits a federal concern, it also had been unmistakably clear in stating that certain state laws were to be saved from preemption.⁴⁰ Thus, there were limits to the scope of preemption already embodied in the statute.

The supremacy clause of the United States Constitution authorizes federal preemption of conflicting state law.⁴¹ Courts inevitably fell back on fundamental preemption principles embodied in this clause to develop a sounder doctrinal approach to ERISA preemption questions be-

34. Compare text accompanying note 9 with source cited *supra* note 20.

35. H.R. CONF. REP. No. 1280, 93d Cong., 2d Sess., reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 5038, 5162. The report goes on to paraphrase the deemer clause as well, stating: [T]he [statute] generally provides that 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.

Id.

36. See *supra* note 33.

37. Compare *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) with *Insurers' Action Council v. Heaton*, 423 F. Supp. 921 (D. Minn. 1976). See *infra* notes 54-66 and accompanying text.

38. See *supra* notes 34-37 and accompanying text; see also *Brummond*, *supra* note 6, at 64-65 (forecasting that because of the uncertainty as to the meaning of ERISA's preemption provision, extensive litigation would be sure to ensue before the exact scope of preemption could be ascertained). See generally *Hirsch, Toward a New View of Federal Preemption*, 1972 U. ILL. L.F. 515.

39. The plain language of a statute is always a good starting point, so good that the United States Supreme Court has adopted a dictionary's definition of the phrase "relates to" in ERISA's preemption clause. See *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 n.16 (1983) (citing *Black's Law Dictionary* in stating that "relates to" means "having a connection with or reference to"); see also *infra* notes 72-77 and accompanying text.

40. ERISA, *supra* note 1, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982).

41. U.S. CONST. art. VI.

cause of the lack of congressional guidance in interpreting ERISA's preemption provision.⁴² The initial judicial debate on the preemption question centered on whether ERISA preempted all state law in the area of employee benefits, or only those state laws that came into direct conflict with one of ERISA's substantive provisions.⁴³ Some courts took the approach that because there was some doubt as to the scope of ERISA's preemptive reach, only those state laws that came into direct conflict with one of ERISA's substantive provisions would be preempted.⁴⁴ They declared that the presumption is always against preemption.⁴⁵ Other courts looked to the statute's legislative history and to its wording and concluded that Congress intended for the federal government to oversee totally employee benefit plan regulation, leaving no room even for state regulation that did not conflict with ERISA.⁴⁶ Thus, although courts initially attempted to apply broader and more theoretical preemption doctrines, they were faced ultimately with a matter of statutory construction: how should ERISA's preemption provision be read based on its wording and on its legislative history.

IV. STATUTORY CONSTRUCTION AND CURRENT INTERPRETATION PROBLEMS

A. Preemption Clause

1. Background

The first problem of statutory interpretation is the phrase "relates to" in section 514(a).⁴⁷ The preemption clause states that state laws that relate to an "employee benefit plan," as defined in section 3 of

42. See, e.g., *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977) (stating that when a field is traditionally occupied by state law, a court should assume no preemption unless it is the clear and manifest purpose of Congress); *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142 (1963) (stating that "federal regulation of a field of commerce should not be deemed preemptive of state regulatory power in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained"). *Contra Hines v. Davidowitz*, 312 U.S. 52, 67 (1941) (framing the inquiry as whether the state statute subject to possible preemption obstructs "the accomplishment and execution of the full purposes and objectives of Congress"). See generally *Brummond*, *supra* note 6, at 93-97 (providing an overview of the preemption doctrine in general and laying the foundation for its possible application in the context of § 514 of ERISA).

43. See, e.g., *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) (discussed *infra* notes 84-88 and accompanying text); see also *supra* note 30 and accompanying text.

44. See, e.g., *Insurers' Action Council v. Heaton*, 423 F. Supp. 921 (D. Minn. 1976).

45. *Id.* at 924.

46. See, e.g., *Hewlett-Packard*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978).

47. ERISA, *supra* note 1, § 514(a), 29 U.S.C. § 1144(a) (1982).

ERISA, are superseded.⁴⁸ Although some courts have struggled with the question of whether the plan involved is an employee benefit plan⁴⁹ to which ERISA applies, the more frequently litigated question has been whether the state statute involved relates to what presumably qualifies as an employee benefit plan under ERISA.⁵⁰ The meaning to be given the phrase "relates to" is significant because it defines the initial preemptive reach of the legislation, answering the question of how much state law ERISA could displace. If read narrowly, the clause could preempt only state laws that were targeted directly at employee benefit plans and came into direct conflict with one of ERISA's substantive provisions.⁵¹ Some early interpretations of the preemption clause sup-

48. *Id.* § 3(1)-(3), 29 U.S.C. § 1002(1)-(3). Section 3 reads:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean 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 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean 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 by its express terms or as a result of surrounding circumstances such plan, fund, or program—

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

...

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

Id.

49. See *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211 (1987) (holding that a state statute requiring an employer, in event of plant closing, to furnish a one-time severance payment to employees not covered by a contract expressly providing severance pay is not preempted by ERISA, because it does not relate to an employee benefit plan, but to employee benefits); *Bell v. Employee Sec. Benefit Ass'n*, 437 F. Supp. 382 (D. Kan. 1977) (stating that a trust set up by employer was not an employee benefit plan, and therefore was not governed by ERISA); Kilberg & Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex. L. Rev. 1313, 1319 n.27 (1984); Turza & Halloway, *Preemption of State Laws Under the Employee Retirement Income Security Act of 1974*, 28 CATH. U.L. Rev. 163, 187 n.136 (1979); see also *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).

50. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983); *Hewlett-Packard*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978).

51. See, e.g., *supra* notes 44-45 and accompanying text.

ported this reading.⁵² If read broadly, however, the preemption clause could preempt any state law that had any effect on an employee benefit plan, whether or not it conflicted with a substantive provision of ERISA.⁵³

The reasoning behind these approaches, as well as more moderate ones, centered around congressional intent in enacting ERISA, and general principles of preemption, which control any federal intrusion into a traditionally state-dominated field. Proponents of broad preemption argued that Congress intended to preempt totally the field of employee benefit plans for federal regulation and that it would be inconsistent with such intent to read the preemption clause narrowly.⁵⁴ Their statutory construction argument was that the term "relates to" should be given a common sense meaning and that if Congress had meant to limit the preemptive reach of ERISA, it would have done so with more limiting language. An early case adopting this view was *Hewlett-Packard Co. v. Barnes*.⁵⁵ In *Hewlett-Packard* the Ninth Circuit Court of Appeals found California's Knox-Keene Health Care Service Plan Act of 1975⁵⁶ preempted by ERISA.⁵⁷ The court looked to the wording of the statute, buttressed by its legislative history, and concluded that preemption was indisputable.⁵⁸

At the other end of the spectrum, in *Insurers' Action Council v. Heaton*,⁵⁹ the Insurers' Action Council sought an injunction in federal

52. *Id.*

53. See *supra* note 46 and accompanying text.

54. See *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*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) (holding that employee benefit plans could not be regulated by California's Knox-Keene Act, which purported to regulate insurance, because of clear wording of deemer clause); see also *Standard Oil Co. of Cal. v. Agsalud*, 442 F. Supp. 695, 711 (N.D. Cal. 1977) (stating that "[b]y enacting ERISA, Congress created a moratorium of indefinite length on the passage of health insurance laws").

55. 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978).

56. CAL. HEALTH & SAFETY CODE §§ 1340-1399.5 (West 1979). The act regulated funding, disclosure, sales practices, and quality of services and required that California health care service plans be licensed by the state Commissioner of Corporations. *Hewlett-Packard*, 425 F. Supp. at 1297. The statute also sought to regulate self-funded plans. *Id.* See also *infra* text accompanying notes 160-78.

57. *Hewlett-Packard*, 571 F.2d at 505.

58. *Id.* The court stated in part:

The clear wording of section 514 and the relevant legislative history show that Congress unmistakably intended ERISA to preempt a state law such as Knox-Keene that directly regulates employee benefit plans. Although [the savings clause] exempts from preemption state regulation of insurance, [the deemer clause] provides that employee benefit plans may not be considered to be in the business of insurance for purposes of the exception to preemption. *Id.* at 504 (citations omitted). In 1979 one commentator characterized *Hewlett-Packard* as "probably the strongest single judicial statement to date in favor of full preemption." Manno, *supra* note 12, at 66.

59. 423 F. Supp. 921 (D. Minn. 1976).

district court to prevent implementation of Minnesota's Comprehensive Health Insurance Act of 1976,⁶⁰ claiming that it was preempted by ERISA.⁶¹ The district court refused to enjoin enforcement of the Comprehensive Health Insurance Act, construing the preemption clause narrowly⁶² and stating that laws which relate to the substance of an employee benefit plan, as opposed to the plan's disclosure and reporting provisions required under ERISA, were not preempted.⁶³ The court also reiterated that ERISA's savings clause expressly does not relieve any person from any state law which regulates insurance, saying that the state statute must be in direct conflict with ERISA in order for the preemption clause to take effect.⁶⁴

The *Heaton* court incorrectly stated that the general rule was savings of insurance regulation, with preemption being the exception.⁶⁵ In construing ERISA's preemption clause as becoming effective only if a state law came into direct conflict with one of ERISA's substantive provisions, the court overlooked the broad language of the provision.⁶⁶ This construction, as later cases explained, clearly was inconsistent with ERISA's statutory structure, wording, and drafters' intent.

2. *Alessi and Shaw*

The United States Supreme Court attempted to clarify this issue in *Alessi v. Raybestos-Manhattan Inc.*⁶⁷ *Alessi* involved a New Jersey statute that prohibited reducing pension benefits by an amount equal to workers' compensation awards for which a retiree was eligible.⁶⁸ The

60. MINN. STAT. § 62E (1986); see also Brummond, *supra* note 6, at 91-92 (discussing the Minnesota act and its impact on employee benefit plans). The Act required that insurers offer to Minnesota residents certain "qualified" policies, which provided statutorily mandated benefits. Similarly, it required that employers who offer health care plans to employees make available a certain type of qualified plan. The Act also established a state association whose function was to offer policies to persons unable to obtain them otherwise, and to reinsure qualified policies issued by individual insurers. *Heaton*, 423 F. Supp. at 923.

61. *Heaton*, 423 F. Supp. at 926.

62. *Id.*

63. *Id.*; see Manno, *supra* note 12, at 67.

64. *Heaton*, 423 F. Supp. at 926.

65. See *supra* notes 7-11 and accompanying text.

66. The court stated:

[ERISA's preemption provision] provides that with a very narrow exception, ERISA should not be construed to relieve any person from any state law regulating insurance, banking, or securities. Thus the conflict between the challenged state insurance law and ERISA has to be very clear in order to trigger the preemption provision. The only substantive parts of ERISA which relate to health and accident insurance are the reporting and disclosure provisions. These requirements have nothing to do with the substance of the insurance plans which employers must offer their employees.

Heaton, 423 F. Supp. at 926.

67. 451 U.S. 504 (1981).

68. N.J. STAT. ANN. § 34:15-29 (West 1988).

Court held that ERISA preempted the New Jersey statute because it eliminated a method for calculating pension benefits (integration) that was permitted by federal law.⁶⁹ Although the Court did not address the limits of ERISA's preemptive language, it stated that "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern."⁷⁰ Thus, although this particular statute was preempted because of a direct conflict with federal law, the Court intimated that the state statute in question need not come into direct conflict with a substantive provision of ERISA in order to relate to an employee benefit plan.⁷¹

Since the United States Supreme Court's decision in *Shaw v. Delta Air Lines*,⁷² courts have given the preemption clause its definitive broad reading. *Shaw* involved a New York statute that prohibited discrimination in employee benefit plans on the basis of pregnancy,⁷³ and another statute that required employers to pay sick-leave benefits to employees unable to work because of pregnancy.⁷⁴ The Court found "no difficulty" concluding that the state laws related to employee benefit plans and stating that the breadth of the preemption clause is "apparent" from the wording of the section.⁷⁵ The Court cited *Black's Law Dictionary* when it stated that a "[state] law 'relates to' an employee benefit plan,

69. *Alessi*, 451 U.S. at 524.

70. *Id.* at 525. The Court stated:

It is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called "pension regulation." ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern. . . . ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision.

Id. (citation omitted).

71. *Id.* This decision effectively overruled the approach taken by the district court in *Heaton*, 423 F. Supp. 921. See Kilberg & Inman, *supra* note 49, at 1323-25; see also *supra* notes 59-66 and accompanying text.

72. 463 U.S. 85 (1983).

73. N.Y. EXEC. LAW §§ 290-301(a) (McKinney 1982). The law was a comprehensive antidiscrimination statute that prohibited discrimination on the basis of sex. The statute provided in part:

1. It shall be an unlawful discriminatory practice:

(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.

Id. § 296.1(a). The statute had been interpreted by the highest court in New York to include as a discriminatory act treating pregnancy differently from other nonoccupational illnesses. *Shaw*, 463 U.S. at 88 (citing *Brooklyn Union Gas Co. v. New York State Human Rights Appeal Bd.*, 41 N.Y.2d 84, 359 N.E.2d 393, 390 N.Y.S.2d 884 (1976)).

74. N.Y. WORK. COMP. LAW §§ 200-242 (McKinney 1982). The New York law required employers to pay sick leave benefits to employees unable to work because of nonoccupational injuries or illnesses, including pregnancy.

75. *Shaw*, 463 U.S. at 96.

in the normal sense of the phrase, if it has a connection with or reference to such a plan."⁷⁶ The *Shaw* Court stated that it was clearly Congress's intent to give the phrase "relates to" a broad, "common sense" meaning; therefore, no preemption analysis was necessary.⁷⁷ The Supreme Court's decision in *Shaw* seems to have quieted, at least for now, the question of what state statutes relate to an employee benefit plan and are subject to possible preemption under ERISA.

B. Savings Clause

1. History and Purpose

The insurance savings clause,⁷⁸ drafted in order that ERISA be consistent with the McCarran-Ferguson Act,⁷⁹ reasserted that state governments, and not the federal government, would be primarily responsible for the regulation of insurance and insurance companies.⁸⁰ Thus, Congress intended to carve out an area of exclusive federal regulation for employee benefit plans while leaving the general regulation of the "business of insurance" to the states. The problem with this approach is that the business of insurance and the creation and administration of employee benefit plans overlap. This is most apparent in the case of an employer who establishes an employee benefit plan by purchasing a

76. *Id.* at 96-97 & n.16; see also *supra* note 42.

77. *Shaw*, 463 U.S. at 96-97.

78. ERISA, *supra* note 1, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982).

79. Pub. L. No. 78-238, 59 Stat. 33 (1945) (codified at 15 U.S.C. §§ 1011-1015 (1982)).

80. 15 U.S.C. § 1012(b) (1982). The statute states 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, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance." *Id.* The McCarran-Ferguson Act was enacted following heavy lobbying by State insurance commissioners in response to the United States Supreme Court's decision in *United States v. Southeastern Underwriters Association*, 322 U.S. 533 (1944), which held that Congress, through its commerce clause power, could regulate the business of insurance. Commentators and courts have agreed that the question of how much regulatory power the states should have is a difficult one, and illustrates that the Act is not easy to apply in practice. See, e.g., *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *SEC v. National Sec., Inc.*, 393 U.S. 453 (1969); *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959); *Hahn v. Oregon Physicians Serv.*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983); *Lowe v. Aarco-Am., Inc.*, 536 F.2d 1160 (7th Cir. 1976); *United States v. Title Ins. Rating Bureau of Ariz., Inc.*, 517 F. Supp. 1053 (D. Ariz. 1981), *aff'd*, 700 F.2d 1247 (9th Cir. 1983), *cert. denied*, 467 U.S. 1240 (1984); *Lawyer's Realty Corp. v. Peninsular Title Ins. Co.*, 428 F. Supp. 1288 (E.D. La. 1977), *aff'd*, 550 F.2d 1035 (5th Cir. 1977); Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 WM. & MARY L. REV. 81 (1983); Kimball & Heaney, *Emasculation of the McCarran-Ferguson Act: A Study In Judicial Activism*, 1985 UTAH L. REV. 1; Manno, *supra* note 12; Comment, *Group Life & Health Insurance Co. v. Royal Drug Co.: The McCarran-Ferguson Act and Health Service Plans*, 5 AM. J.L. & MED. 393 (1980); Comment, *The Scope of the "Business of Insurance" Provision of the McCarran-Ferguson Act: Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 65 MINN. L. REV. 1187 (1981).

group policy from an insurance company.⁸¹ The insurance company, and consequently the plan, may be subject to a panoply of varying state regulations, while the self-funded employee benefit plan is governed exclusively by ERISA.⁸² This inherent tension has manifested itself in much of the litigation surrounding section 514.⁸³

2. *Wadsworth v. Whaland*

Because of the apparent overlap of state and federal regulation, it appeared that states could reach employee benefit plans, contrary to the expressed intent of Congress, through the regulation of both the activities of insurers who underwrite group policies purchased for those plans and the content of the group policy itself. This "indirect" regulation of employee benefit plans by the states was at issue in *Wadsworth v. Whaland*.⁸⁴ In *Wadsworth* administrators of various health and welfare funds, which provided coverage through the purchase of group insurance policies, challenged a New Hampshire statute, which regulated the contents of such policies as being preempted by ERISA.⁸⁵ The plaintiffs argued that ERISA preempted both direct and indirect regulation of employee benefit plans.⁸⁶ The First Circuit Court of Appeals found that the New Hampshire statute did relate to, albeit indirectly, an employee benefit plan and, therefore, was subject to preemption.⁸⁷ The court, however, found that the statute was not preempted because it was a statute directed at insurers, which was saved from preemp-

81. The drafters of ERISA clearly anticipated that some employee benefit plans would be insured through the purchase of group policies from insurance companies. ERISA defines employee welfare benefit plans as being established "through the purchase of insurance or otherwise." ERISA, *supra* note 1, § 3(1), 29 U.S.C. § 1002(1) (1982); *see supra* note 48.

82. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (stating that this distinction must be maintained in order to give life to the statute as worded by Congress and that although such an interpretation clearly is contrary to the congressional goal of uniformity in the regulation of employee benefit plans, only congressional action can change the statute).

83. *Id.*; *see also Northern Group Serv., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied sub nom. Northern Group Serv. v. State Farm Mut. Ins. Co.*, 108 S. Ct. 1754 (1988); *Blue Cross & Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986).

84. 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

85. N.H. REV. STAT. ANN. §§ 415:18-a, 419:5-a, 420:5-a (1983). The statute required issuers of group health insurance policies to provide coverage for the treatment of mental illnesses and emotional disorders, something not required by ERISA. *See also infra* notes 102-12 and accompanying text.

86. *Wadsworth*, 562 F.2d at 75-76.

87. *Id.* at 77. The court rejected a narrow reading of the preemption clause that would have called for preemption only of state laws directly covered by ERISA. *Id.* The court noted that the Conference Committee had replaced a narrower preemption provision with the present "sweeping" language in order "to avoid 'the possibility of endless litigation over the validity of State action that might impinge on Federal regulation . . . and potentially conflicting State laws hastily contrived to deal with some particular aspect of [employee benefit plans] not clearly connected to the Federal regulatory scheme.'" *Id.* (quoting 120 CONG. REC. 29,942 (1974) (remarks of Sen. Javits)).

tion.⁸⁸ Thus, *Wadsworth* opened the door for indirect regulation of employee benefit plans that utilize group insurance by regulating the terms of the policies purchased by such plans. *Wadsworth*, however, did not address directly whether the state statute in question was one which regulated insurance; to the court, it was obviously one that did. Later courts taking a closer look would not have the luxury of such an easy determination.

3. Current Arguments

The wording of ERISA itself provides a strong argument that plans which purchase a group policy from an insurance company should be governed only by ERISA and not by state statutes that would otherwise regulate the contents of the policy. Section 3 of ERISA states that an employee benefit plan may be insured "through the purchase of insurance or otherwise."⁸⁹ Clearly, the drafters of ERISA anticipated that some plans would provide for the purchase of a group policy, rather than self-insurance plans. Some courts, in concluding that a state statute involved is preempted, have held that when an insurance company exclusively makes final claims decisions, ERISA, not state law, governs the relationship between the insurance company and the insured.⁹⁰ Unfortunately, section 514⁹¹ does not define what type of law it considers as "regulat[ing] insurance." Various commentators⁹² and courts⁹³ have proffered their own definitions; however, no consensus on a definitive meaning has been reached. Prior to the decisions in *Metropolitan Life Insurance Co. v. Massachusetts*⁹⁴ and *Pilot Life Insurance Co. v. Dedeaux*,⁹⁵ courts focused on determining whether the plan in question was an employee benefit plan and, thus, was freed of state insurance regulation under the preemption clause and the deemer clause, rather

88. *Id.* at 78. The court stated that to find the New Hampshire statute preempted totally would read out the savings clause, something contrary to its duty "to construe [an act of Congress] in such a manner as to give effect to all its parts and to avoid a construction which would render a provision surplusage." *Id.*

89. ERISA, *supra* note 1, § 3(1), 29 U.S.C. § 1002(1) (1982); *see supra* note 48.

90. *See, e.g.,* *McLaughlin v. Connecticut Gen. Life Ins. Co.*, 565 F. Supp. 434 (N.D. Cal. 1983) (calling this conclusion "indisputable").

91. ERISA, *supra* note 1, § 514(a), 29 U.S.C. § 1144(a) (1982).

92. *See, e.g.,* *Brummond*, *supra* note 6, at 122-24; *Okin, Preemption of State Insurance Regulation by ERISA*, 13 *FORUM* 652, 672-78 (1978); *Comment, ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws*, 78 *COLUM. L. REV.* 1536 (1978).

93. *See, e.g.,* *Wayne Chem., Inc. v. Columbus Agency Serv. Corp.*, 567 F.2d 692 (7th Cir. 1977); *Providence v. Valley Clerks Trust Fund*, 509 F. Supp. 388 (E.D. Cal. 1981); *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980).

94. 471 U.S. 724 (1985).

95. 481 U.S. 41 (1987).

than determining whether the statute involved was one that regulated insurance and, therefore, was saved from preemption.⁹⁶

The most compelling argument in favor of a broad reading of the savings clause is the plain wording of the statute. If the drafters of ERISA had intended the statute to displace all state regulation of employee benefit plans, direct and indirect, they would not have inserted a clear intention that state regulation of insurance is to be saved from preemption. Without the savings clause, the only state insurance statutes that would survive ERISA would be those that did not relate to an employee benefit plan and, therefore, were not preempted. If this was Congress's goal, it could have been achieved more easily by one sweeping preemption clause, rather than a preemption clause qualified by both a savings clause and a deemer clause.

An approach courts could use to delineate the scope of the preemption and savings clauses is to divide state regulation of group insurance into distinct categories. The National Association of Insurance Commissioners (NAIC) has offered some guidance in this area,⁹⁷ categorizing state regulation as: (1) laws that relate to the corporate and financial structure of companies issuing insurance, (2) laws that relate to the selling of insurance contracts, such as statutes governing the licensing of agents and the setting of rates, and (3) laws that relate to the contract of insurance itself, such as mandated-benefits statutes.⁹⁸ State laws falling into the first two categories would not be preempted by ERISA, because they neither regulate the "terms and conditions" of the plan,⁹⁹ nor arguably relate to an employee benefit plan.¹⁰⁰ State regulation falling into the third category, however, involves the "inexorable intersection of insurance benefits and employee benefit plans."¹⁰¹ Employee benefit plans that are insured through the purchase of group policies

96. Following *Metropolitan Life and Pilot Life*, a three-step analysis, which tracks the language of § 514, became the accepted manner by which to approach an ERISA preemption question. See *infra* notes 102-60 and accompanying text.

97. See Manno, *supra* note 12, at 57-58 (citing NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, STATEMENT ON FEDERAL PREEMPTION OF STATE INSURANCE REGULATION OF ERISA 17-19 (1976)); see also Brummond, *supra* note 6, at 81-84 (discussing the NAIC categories of insurance regulation and how these types of insurance regulation affect employee benefit plans).

98. See Manno, *supra* note 12, at 57-58.

99. See *id.* at 53, 58; ERISA, *supra* note 1, § 514(a), 29 U.S.C. § 1144(a) (1982); see also SEC v. National Sec., Inc., 393 U.S. 453, 459-60 (1969) (stating that the business of insurance for the purposes of the McCarran-Ferguson Act does not include all the activities of insurance companies, such as mergers and acquisitions, stock sales, and general corporate business activities, but is limited to "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement").

100. ERISA, *supra* note 1, § 514(a), 29 U.S.C. § 1144(a) (1982). Arguably, however, in light of the expansive reading given to the preemption clause following *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), it is difficult to conceive of a state law that does not relate to an employee benefit plan.

101. Manno, *supra* note 12, at 58.

rather than self-insuring inevitably will be subject to state laws governing the content of those policies. It is this broad category of state regulation that has given courts the most trouble.

4. *Metropolitan Life and Pilot Life*

The Supreme Court finally defined the scope of the savings clause when it addressed the question of whether state mandated-benefit laws were preempted by ERISA. In *Metropolitan Life Insurance Co. v. Massachusetts*,¹⁰² a Massachusetts statute required the provision of certain minimum mental health care benefits to in-state residents who were insured under general insurance policies, accident or sickness insurance policies, or employee health-care plans that covered hospital and surgical expenses.¹⁰³ Metropolitan issued group health policies for employee benefit plans and to employers and unions which employed and represented employees living in Massachusetts; but Metropolitan failed to provide the benefits mandated by the statute. Metropolitan claimed that the statute was inapplicable to any group policy issued for an ERISA plan within Massachusetts because it was preempted by ERISA's preemption clause.¹⁰⁴ Massachusetts argued that ERISA's savings clause saved the statute from preemption because it was a law that regulates insurance.¹⁰⁵

The Court found that the savings clause saved the statute from

102. 471 U.S. 724 (1985).

103. MASS. GEN. LAWS ANN. ch. 175, § 47B (West Supp. 1985). The Massachusetts statute provided:

Any blanket or general policy of insurance . . . or any policy of accident and sickness insurance . . . or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is promulgated or renewed to any person or group of persons in this commonwealth . . . shall, provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:

(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 outpatient 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

Id.

104. *Metropolitan Life*, 471 U.S. at 734-35.

105. *Id.* at 735.

preemption.¹⁰⁶ The Court first cited *Shaw v. Delta Air Lines*¹⁰⁷ for the broad proposition that a state law relates to an employee benefit plan “if it has a connection with or reference to such a plan.”¹⁰⁸ The Court then reasoned that although the statute “clearly” met this test and could be subject to preemption,¹⁰⁹ it was one that regulated insurance by regulating the terms of insurance contracts¹¹⁰ and, therefore, was saved from preemption.¹¹¹

The impact of *Metropolitan Life* was significant. It meant that the states could regulate indirectly employee benefit plans by regulating the terms of group policies purchased for the plans from insurance companies.¹¹² It also meant that employees asserting claims against insurance companies for wrongful denial of benefits could pursue causes of action under state law, as well as those spelled out in ERISA’s civil enforcement provisions.¹¹³ This is especially significant because ERISA does not provide for the recovery of punitive damages,¹¹⁴ while a suit, for example, based on a state common-law theory for tortious breach of contract, or based on a state statute authorizing recovery of punitive damages, would expose insurance companies to tremendous liability and, in some instances, provide employees with huge windfalls.

106. *Id.* at 744.

107. 463 U.S. 85 (1983).

108. *Metropolitan Life*, 471 U.S. at 739. The Court added that “[t]he 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.* (citing *Shaw*, 463 U.S. at 98-99).

109. *Id.* at 739.

110. *Id.* at 740. This was common sense to the Court, and it drew ample support from the plain language of ERISA, especially the deemer clause. In particular, the Court noted that “[b]y exempting from the saving clause laws regulating insurance 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.” *Id.* at 741. The Court also applied the factors set forth in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982), which were used to determine whether a particular practice constitutes the business of insurance for the purposes of the McCarran-Ferguson Act. *Metropolitan Life*, 471 U.S. at 742-44; see *infra* notes 146-60 and accompanying text.

111. *Metropolitan Life*, 471 U.S. at 744.

112. Because only large companies could afford to self-insure, and many of these companies found it easier to let an expert in the field (the insurance company) administer the employee benefit plan, state insurance regulators could reach any employee benefit plan that was not self-insured.

113. See ERISA, *supra* note 1, §§ 501-514, 29 U.S.C. §§ 1131-1145 (1982).

114. See *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (holding that the remedies provided under ERISA’s civil enforcement provisions, which do not include punitive damages, were intended to be exclusive); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456 (5th Cir. 1986) (holding that punitive damages are not available under ERISA §§ 409(a), 502(a)(3)), *cert. denied*, 479 U.S. 1034 (1987). *But see* *Schoenholtz v. Doniger*, 657 F. Supp. 899, 913-14 (S.D.N.Y. 1987) (holding that ERISA’s provision for “such other equitable or remedial relief as the Court may deem appropriate” will permit the awarding of punitive damages in certain instances (emphasis in original)).

Metropolitan Life thus undermined one of Congress's main objectives in enacting ERISA: to bring uniformity to the area of employee benefit plans.¹¹⁵ Uniformity simply cannot be achieved if states are permitted to regulate indirectly the terms of employee benefit plans which provide for the purchase of group policies that may be subject to mandated-benefit statutes. This is a result clearly contrary to the express intent of the drafters of ERISA.¹¹⁶ *Metropolitan Life* further undermines the objective of uniformity because, by allowing employees to sue insurers under state law theories for denial of employee benefits, cases would vary widely from state to state, depending on whether a state statute or common law authorized punitive damages. This situation also would be difficult for interstate employers because they would be faced with a wide range of state laws with which they would have to comply.

The question then remained open, in the wake of *Metropolitan Life*, as to what other state laws, in addition to mandated-benefit statutes, would relate to employee benefit plans, but also would regulate insurance and thus would be saved from preemption. The Supreme Court again considered this question in the recent case of *Pilot Life Insurance Co. v. Dedeaux*.¹¹⁷ In *Pilot Life* respondent Dedeaux instituted suit in the United States District Court for the Southern District of Mississippi asserting the tort of bad faith and breach of contract claims against petitioner Pilot Life for Pilot Life's failure to pay benefits under a group insurance policy.¹¹⁸ The district court granted summary judgment for Pilot Life, finding that Dedeaux's common-law causes of action were preempted by ERISA.¹¹⁹ On appeal to the Fifth Circuit, the Court of Appeals reversed.¹²⁰ The Fifth Circuit relied heavily on *Metropolitan Life* in finding that Dedeaux's claims were based on state common law that regulated insurance and, therefore, were saved from preemption.¹²¹

In a unanimous opinion, the Supreme Court reversed.¹²² The Court found that Dedeaux's common-law causes of action for the tort of bad faith and breach of contract were based on state laws that related to an

115. See *supra* notes 1-37 and accompanying text.

116. See ERISA, *supra* note 1, § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1982). The deemer clause states that an employee benefit plan shall not be deemed to be an insurance company for the purposes of subjecting it to state insurance regulation.

117. 481 U.S. 41 (1987).

118. *Id.* at 43. Dedeaux was employed by Entex, Inc., which had established a long-term disability employee benefit plan by purchasing a group insurance policy from Pilot Life. Pilot Life had the fiduciary duty of determining who would receive benefits under the policy.

119. *Id.* at 44.

120. *Id.*

121. *Id.*; see *Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311 (5th Cir. 1985).

122. *Pilot Life*, 481 U.S. at 57.

employee benefit plan and thus fell within the preemptive reach of section 514(a).¹²³ The Court, however, disagreed with the Fifth Circuit and held that the Mississippi common laws of bad faith and contracts did not regulate insurance so as to be saved from preemption under section 514(b)(2)(A).¹²⁴

In its opinion the Court propounded a set of guidelines that courts could utilize to determine whether state statutes purporting to regulate insurance are saved from preemption.¹²⁵ The Court predictably employed the expansive definition of "relates to" in section 514(a), defining a state law which relates to an employee benefit plan as one that has "connection with or reference to such a plan."¹²⁶ According to the *Pilot Life* Court, the Mississippi common law of bad faith and contracts "undoubtedly" met this definition.¹²⁷

In turning to the question of whether the state common law regulated insurance and was therefore saved from preemption under ERISA's savings clause, the Court set forth a series of factors to be considered.¹²⁸ The Court referred to *Metropolitan Life*, in which it had ruled that mandated-benefit laws regulated insurance, and reiterated the criteria it had employed in that case. First, the *Pilot Life* Court took a common sense view of the language of the savings clause.¹²⁹ The Court concluded that in order for a state law to be one that regulates

123. *Id.* at 47. The Court stated:

There is no dispute that the common law causes of action asserted in Dedeaux's complaint "relate to" an employee benefit plan and therefore fall under ERISA's express pre-emption clause, § 514(a). In both *Metropolitan Life* and *Shaw v. Delta Air Lines* we noted the expansive sweep of the pre-emption clause. In both cases "[t]he 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.'" In particular we have emphasized that the pre-emption clause is not limited to "state laws specifically designed to affect employee benefit plans."

Id. (citations omitted) (citing *Metropolitan Life*, 471 U.S. at 739, quoting *Shaw*, 463 U.S. at 97).

124. *Id.* at 50.

125. *Id.* at 48-49.

126. *Id.* at 47 (citing *Metropolitan Life*, 471 U.S. at 739, quoting *Shaw*, 463 U.S. at 97); see *supra* notes 72-77 and accompanying text.

127. *Pilot Life*, 481 U.S. at 48.

128. *Id.* at 48-49; see *infra* notes 129-36 and accompanying text.

129. *Pilot Life*, 481 U.S. at 50. The Court stated:

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 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.

Id.

insurance, it must not only impact on that industry, but also must be "specifically directed toward that industry."¹³⁰ Because the Mississippi laws of bad faith and contracts were grounded in general principles of Mississippi tort and contract law, and were not principles specifically applicable to the insurance industry, they did not regulate insurance from a common sense point of view.¹³¹

The second and more probing inquiry employed by the Court was an application of the factors defining business of insurance for the purposes of the McCarran-Ferguson Act to the Mississippi law in question.¹³² First, the Mississippi common law of bad faith did not affect the spreading of policyholder risk.¹³³ Second, although the Mississippi common law of bad faith could be said to affect the policy relationship between the insurer and the insured, the Court characterized this connection as "attenuated at best."¹³⁴ Finally, because the Mississippi common law of bad faith was derived from general principles of that state's common law, it was not specifically directed towards entities within the insurance industry.¹³⁵ Therefore, the Mississippi common law of bad faith, at best, met one of the three McCarran-Ferguson criteria and could not be said to regulate insurance.¹³⁶

Pilot Life thus further defined the contours of ERISA's preemption provisions. The preemption clause itself generally will be given an expansive reading, in accordance with *Shaw v. Delta Air Lines*,¹³⁷ meaning that a wide variety of state laws conceivably could be found to relate to an employee benefit plan.¹³⁸ The scope of the savings clause was narrowed by the seemingly broad holding in *Metropolitan Life* to preserve only state mandated-benefit laws and, presumably, any state statute specifically regulating the terms of an insurance contract.¹³⁹ The savings clause, however, does not save state laws of general applicability that may affect incidentally the insurer-insured relationship, such as common-law principles of contract and tort.¹⁴⁰ In distinguishing *Metro-*

130. *Id.*

131. *Id.*

132. *Id.* at 50-51.

133. *Id.* at 50.

134. *Id.* at 51.

135. *Id.*

136. *Id.*

137. 463 U.S. 85 (1983).

138. Such laws could include mandated provider laws and freedom-of-choice laws, as well as more extreme examples such as building permit requirements and zoning ordinances, because they could affect the value of the plan funds or restrict in some way their use.

139. In light of this holding, mandated provider laws and freedom-of-choice laws could be saved from preemption, while building permit requirements and zoning ordinances clearly would not.

140. See *supra* note 139; *infra* notes 152-60 and accompanying text.

politan Life, Pilot Life implicitly reaffirmed the notion that states may continue to regulate indirectly employee benefit plans by regulating the terms of group insurance policies either purchased for the plans, or adopted by employers as the terms of their plans.

5. Present Inquiry: Business of Insurance

In the wake of *Pilot Life*, courts have begun to break down the preemption inquiry into a three-step process, guided by *Metropolitan Life, Pilot Life*, and the wording of section 514.¹⁴¹ First, a court asks whether the state law involved is one which relates to an employee benefit plan. If the state law does not relate to an employee benefit plan, it is not preempted as stated in section 514(a).¹⁴² If the state law clears this hurdle, it must be tested under the savings clause. As a second step a court asks whether the state law is one which regulates insurance. If the statute is not found to regulate insurance, it is preempted under section 514(a).¹⁴³ If it is found to regulate insurance, however, a court takes the last step and tests the state law under the deemer clause, which states that an employee benefit plan shall not be deemed to be an insurance company or other insurer for the purpose of the clause. Thus, even if the state statute involved purportedly regulates insurance, but is operating on the employee benefit plan as if that plan were an insurance company or insurer, it still will be preempted.¹⁴⁴ This approach is a sound one, amply supported by the wording of section 514 and Congress's expressed intent to preserve from preemption only those statutes directed at insurance companies acting uniquely as insurance companies, but not as underwriters of employee benefit plans.

The test set forth in *Union Labor Life Insurance Co. v. Pireno*¹⁴⁵ to determine whether a practice constitutes the business of insurance for the purpose of the McCarran-Ferguson Act appears to be the standard courts will adopt in order to determine whether a state statute is saved from ERISA preemption. The Supreme Court used this test in both *Metropolitan Life* and *Pilot Life*, finding in *Metropolitan Life* that the state statute involved did regulate insurance and thus was saved,¹⁴⁶ while concluding in *Pilot Life* that the state law did not regu-

141. ERISA, *supra* note 1, § 514, 29 U.S.C. § 1144 (1982); *see also supra* notes 102-40 and accompanying text.

142. ERISA, *supra* note 1, § 514(a), 29 U.S.C. § 1144(a) (1982). ERISA only preempts state laws which relate to an employee benefit plan. Thus, state law which does not relate to an employee benefit plan cannot be preempted *a priori* by ERISA.

143. *Id.* § 514(a), 29 U.S.C. § 1144(a) (1982).

144. *Id.* § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1982).

145. 458 U.S. 119 (1982).

146. *Metropolitan Life*, 471 U.S. at 744.

late insurance and, therefore, was preempted.¹⁴⁷

The test answers the question of whether the state law is one which regulates insurance by ascertaining how the state law comes to bear on the business of insurance. The three criteria used are: First, whether the practice has the effect of spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and finally, whether the practice is limited to entities within the insurance industry.¹⁴⁸ If a state law meets all three criteria, it is likely a law that regulates insurance, while if none of the three criteria are met, it likely is not.¹⁴⁹ Somewhere in between lies a "gray area" in which a court, depending on how strongly one or more of the criteria are met, could come down on either side. Although the Court has stated that no one factor is determinative and that the factors should be considered together,¹⁵⁰ the test should provide a useful framework through which an analysis can be made, and predictability and certainty achieved, in insurance preemption cases under ERISA.

California's Unfair Claims Practices Act¹⁵¹ has been a recent source of controversy surrounding the respective scopes of ERISA's preemption and savings clauses. The Unfair Claims Practices Act sets forth a list of unfair and deceptive insurance practices for which a private claimant, until recently, could recover both compensatory and punitive damages.¹⁵² Once again, the question courts currently are attempting to

147. *Pilot Life*, 481 U.S. at 49.

148. *Pireno*, 458 U.S. at 129; *Pilot Life*, 481 U.S. at 48-49.

149. See *supra* notes 139-40 and accompanying text.

150. *Pireno*, 458 U.S. at 129.

151. CAL. INS. CODE § 790.03 (West 1972 & Supp. 1988). The California act is based on an NAIC Model Act, the Unfair Claims Settlement Practices Act, which, as of 1981, had been adopted in 32 states. The analysis herein, therefore, is relevant not only for California but also for other states in which the issue will be whether the statute regulates insurance and therefore is saved from preemption. For an analysis of the Model Act and whether it allows a private right of action, see Comment, *The Unfair Claims Settlement Practices Act: A Private Cause of Action for Third Party Claimants Seeking Punitive Damages*, 6 U. DAYTON L. REV. 73 (1981).

152. CAL. INS. CODE § 790.03 (West 1972 & Supp. 1988). The portion of the act most often involved in the litigation is subsection (h). The statute reads, in part:

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance[:]

. . . .

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverage at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

address is whether the statute regulates insurance and, therefore, is saved from preemption.¹⁵³ The consequences are important for employ-

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds, when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

Id. As one might imagine, this laundry list of acts and omissions that imposes a "reasonableness" standard, and utilizes such terms as "prompt," "fair," and "equitable" is a proverbial magnet for litigation. *See, e.g.,* *Kanne v. Connecticut Gen. Life Ins. Co.*, 859 F.2d 96 (9th Cir. 1988), *rev'd* *Kanne v. Connecticut Gen. Life Ins. Co.*, 607 F. Supp. 899 (C.D. Cal. 1985); *Roberson v. Equitable Life Assurance Soc'y*, 661 F. Supp. 416 (C.D. Cal. 1987); *Presti v. Connecticut Gen. Life Ins. Co.*, 605 F. Supp. 163 (N.D. Cal. 1985). In *Kanne* the court considered a claim under the Unfair Claims Practices Act for wrongful denial of benefits. The district court held that the California statute was saved from preemption. *Kanne v. Connecticut Gen. Life Ins. Co.*, 607 F. Supp. 899 (C.D. Cal. 1985). On appeal, the Ninth Circuit reversed, 819 F.2d 204 (9th Cir. 1987), but withdrew its opinion for reconsideration in light of *Pilot Life*. 823 F.2d 284 (9th Cir. 1987). The court ultimately found the Unfair Claims Practices Act preempted by ERISA. *Kanne*, 859 F.2d 96, 98 (9th Cir. 1988). Under the case of *Royal Globe Ins. Co. v. Superior Court*, 23 Cal. 3d 880, 592 P.2d 329, 153 Cal. Rptr. 842 (1979), claimants could assert a private right of action under § 790.03. *Royal Globe* was overruled recently, however, by the California Supreme Court in *Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 46 Cal. 3d 287, 758 P.2d 58, 250 Cal. Rptr. 116 (1988). In light of this decision, California claimants will no longer be able to bring a cause of action for violation of § 790.03.

153. *See* cases cited *supra* note 152. Although under *Moradi-Shalal* California plaintiffs can no longer sue under § 790.03, the court stated that the *Royal Globe* rule allowing a private right of action would continue to apply to cases filed prior to the *Moradi-Shalal* decision. Furthermore, other states which have adopted the Model Unfair Claims Practices Act provision do recognize a private right of action for enforcement. *See, e.g.,* *First Sec. Bank v. Goddard*, 181 Mont. 407, 593 P.2d 1040 (1979); *see also* Comment, *supra* note 151, at 76-77.

ers, insurance companies, and claimants under employee benefit plans; if the California statute is found to be saved from preemption, punitive damages will be available to claimants. As a consequence, employers and insurers again will be forced to pay heed to a state regulation that imposes obligations other than those imposed by ERISA.

Applying the business of insurance test, the California statute would probably not clear the three *Pireno* hurdles. First, the statute does not seem to be directed at the spreading of a policyholder's risk. It imposes standards of conduct on insurers reviewing claims for benefits under policies, but does not affect the spreading of risk, which is an essential feature of the business of insurance. Second, one could argue that the statute regulates the policy relationship between the insurer and the insured. The statute does so, however, by codifying general principles of common law such as misrepresentation, unreasonable processing of claims, and lack of good faith.¹⁵⁴ Finally, the statute is directed at claims settlement, a practice undertaken by both private insurers and public pension funds. Thus, it is not targeted directly at the insurance industry. The type of actions it makes illegal, are actions for which a claimant already would have a cause of action in contract or in tort, making the statute more like a codification of the common-law principles, which were found not to regulate insurance in *Pilot Life*, than a mandated-benefits statute, which was found to regulate insurance in *Metropolitan Life*.¹⁵⁵

The Eleventh Circuit recently considered whether a Florida statute, FLA. STAT. ANN. § 624.155 (West 1984), which allowed the insured to bring a civil action against an insurer for wrongful denial of disability benefits under an employee benefit plan group policy, was preempted by ERISA. See *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988). The court relied heavily on *Pilot Life* in concluding that the Florida statute was preempted. *Id.* at 1468-69.

154. In light of *Pilot Life*, therefore, courts should take a closer look at statutes that purport to regulate insurance. If state statutes that impose reasonableness standards are treated differently from common-law principles directed at insurers, states would be able to avoid ERISA by codifying the same "law" that was found not saved from preemption in *Pilot Life*. A state should not be able to avoid ERISA's preemptive reach by claiming that because the obligation imposed on the insurer is statutorily created—rather than derived from common-law—it regulates insurance and, therefore, is saved from preemption. To the extent that such statutes merely codify a common-law obligation, under contract or tort theory, they should be preempted under *Pilot Life*. Only when such statutes impose an obligation on an insurer beyond that required under the common law should courts undertake the business of insurance inquiry under *Pireno* and *Pilot Life*. In some cases, however, this analysis may not be necessary, because such statutes probably would fail the second prong of the *Pireno* test.

155. The Massachusetts mandated-benefits statute is distinguished easily from both the common law of contract and tort at issue in *Pilot Life* and the California Unfair Claims Practices Act because it imposes a duty on insurers—to provide mental health coverage—that otherwise would probably not be imposed by the common law. The Massachusetts statute would meet the *Pireno* requirement that it be targeted directly at insurers, and presumably, because the Supreme Court found it saved from preemption in *Metropolitan Life*, would also clear one or two of the other *Pireno* hurdles. See also *General Ins. Co. v. Mammoth Vista Owners Ass'n*, 174 Cal. App. 3d

The obvious benefit of the *Pireno* approach is that it provides a doctrinal construct by which state laws can be tested. Rather than taking a common sense view¹⁵⁶ of what constitutes insurance regulation, the *Pireno* approach provides guidelines to aid courts in their determinations. Furthermore, it is consistent once again with the McCarran-Ferguson Act¹⁵⁷ because the factors used in the *Pireno* test are the same criteria used to define business of insurance for the purposes of that Act. Because ERISA was drafted with the McCarran-Ferguson Act in mind, it would be appropriate if some consistency in definition could be achieved between the two Acts.

Unfortunately, the *Pireno* approach also possesses shortcomings. There is always the strong possibility that a state law will meet one or two of the *Pireno* criteria and not emerge clearly as a law that does or does not regulate insurance. Once again the court will be forced to use the more subjective common sense approach,¹⁵⁸ creating the very uncertainty and lack of predictability sought to be eliminated. Courts also could differ in their conclusions as to the application of the *Pireno* criteria, with the worst scenario being one court finding that a state law meets all three, while another finds that the same law fails to meet any of the three.¹⁵⁹ In other words, application of the criteria themselves is a subjective inquiry, resulting once again in uncertainty.

C. Deemer Clause: Further Complications

1. Background

Prior to ERISA's enactment self-insured plans and plans that purchased group insurance were treated the same. Employers who set up employee benefit plans were subject to the same state insurance regulation as entities engaged in the insurance business.¹⁶⁰ This meant that an

810, 822, 220 Cal. Rptr. 291, 297 (1985) (stating that § 790.03(h) is "merely a codification of the tort of breach of the implied covenant of good faith and fair dealing as applied to insurance"). *But cf. Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 46 Cal. 3d 287, 758 P.2d 58, 250 Cal. Rptr. 116 (1988) (holding that there is no private right of action under § 790.03, and overruling *Royal Globe Ins. Co. v. Superior Court*, 23 Cal. 3d 880, 592 P.2d 329, 153 Cal. Rptr. 842 (1979)).

156. *See Pilot Life*, 481 U.S. at 48 (where the Court ran the Mississippi common law of contract and tort through the common sense test before embarking on the *Pireno* analysis); *supra* note 129.

157. 15 U.S.C. §§ 1011-1015 (1982 & Supp. 1986); *see also supra* notes 78-83 and accompanying text.

158. *See supra* notes 30 & 156.

159. This is less likely considering the recent Supreme Court pronouncements in *Pilot Life* and *Metropolitan Life*, which if followed would provide state and lower federal courts with a great deal of guidance. An example that comes immediately to mind, however, is a state statute that governs how an insurance company may invest its capital. It is not far-fetched to suggest that such a statute could clear none or as many as three of the *Pireno* criteria.

160. States could reach self-insured employee benefit plans under the premise that because

employer who had employees in more than one state would have to comply with the regulations of every state in which his employees resided, or in which he conducted business. The costs of compliance with conflicting state requirements were a great deterrent to the implementation of employee benefit plans.¹⁶¹ In fact, one of ERISA's primary purposes was to bring uniformity to the area of employee benefit plans by subjecting them to one body of federal law.¹⁶²

Following ERISA's enactment employee benefit plans no longer could be treated as insurers for the purpose of state insurance regulations. Congress made clear its intent in the deemer clause,¹⁶³ which explicitly forbids a state from "deeming" an employee benefit plan to be an insurer or insurance company for the purpose of any state law purporting to regulate insurance. Thus, according to a literal reading of the deemer clause, insurance companies that sell and often administer group policies are subject to a full range of state regulation, while employers who fund and administer their own plans are free of state regulation, even though the spreading and underwriting of risk present in an insurance contract¹⁶⁴ are also present in the plan.¹⁶⁵

2. Recent Cases

The Fifth Circuit directly addressed the seemingly anomalous distinction between employee benefit plans underwritten by an insurer and self-insured plans in *Light v. Blue Cross & Blue Shield of Alabama*.¹⁶⁶ In *Light* a former employee of South Central Bell sued Blue Cross and Blue Shield under state law seeking actual and punitive damages for benefits allegedly due under the South Central Bell plan.¹⁶⁷ The plan was self-insured, not underwritten by Blue Cross and Blue

the plans were underwriting the spreading of employee risk, the plans were engaging in the business of insurance and, therefore, were subject to all state insurance regulation. For a discussion of the pros and cons of self-insuring, see Brummond, *supra* note 6, at 78-79.

161. See *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211 (1987), where the Court stated: ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Id. at 2217, cited in *MacLean v. Ford Motor Co.*, 831 F.2d 723, 727 (7th Cir. 1987).

162. See *supra* notes 2-3.

163. ERISA, *supra* note 1, § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1982).

164. See *Blue Cross & Blue Shield of Kansas City v. Bell*, 798 F.2d 1331, 1335 (10th Cir. 1986).

165. *Id.*; see also *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979).

166. 790 F.2d 1247 (5th Cir. 1986).

167. *Id.* at 1247-48.

Shield.¹⁶⁸ Although he conceded that the plan was self-insured, Light still argued that state law was saved from preemption under *Metropolitan Life*¹⁶⁹ and *Eversole v. Metropolitan Life Insurance Co.*¹⁷⁰ The Fifth Circuit disagreed, saying that the distinction between a self-insured plan and a plan underwritten by an insurance company or other insurer is critical in determining whether state regulations are preempted.¹⁷¹ Self-insured plans are free of state insurance regulation, while plans that purchase group insurance may be regulated indirectly by states.¹⁷²

The absurdity of this situation is illustrated further when an attempt is made to draw the line as to when an employee benefit plan is not subject to state insurance regulation, notwithstanding the plan's association with an insurance company. The best example is when an employer establishes a trust fund and adopts the terms of a group insurance policy issued by an insurance company as the terms of its plan.¹⁷³ Technically, the plan has not purchased an insurance policy from the insurance company—it does not pay premiums, and the insurer does not underwrite the spreading of risk.¹⁷⁴ Instead, the employer makes monthly contributions to the fund and claims are paid only out of the fund, not from any of the insurance company's proceeds. The insurance company does act, however, as the administrator of the plan, making claims decisions on behalf of the employer.¹⁷⁵ Thus, the insurance company is not acting as an insurer because it is not underwriting the spreading of its policyholder's risk; it is acting, however, as a fiduciary or administrator of the plan, making claims decisions based on the terms of a policy with which it is familiar, because the policy is one generally issued by that insurer.¹⁷⁶

168. *Id.* at 1247. South Central Bell and Blue Cross and Blue Shield had an agreement whereby Blue Cross and Blue Shield was responsible for adjudicating all claims and paying all benefits provided for under the plan. *Id.* This arrangement is fairly common for self-insured plans.

169. 471 U.S. at 724.

170. 500 F. Supp. 1162 (C.D. Cal. 1980).

171. *Light*, 790 F.2d at 1248-49 n.3.

172. See *Metropolitan Life*, 471 U.S. at 741-42.

173. See, e.g., *Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986); *Hutchinson v. Benton Casing Serv.*, 619 F. Supp. 831 (S.D. Miss. 1985).

174. The spreading and underwriting of the policyholder's risk is viewed as the essential feature of an insurance contract, and a company, albeit an insurance company, which is not performing such a function is not acting in the capacity of an insurer. See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979).

175. Insurers acting in such capacities also generally defend or settle legal actions on claims filed under the plan. Courts have held that these too are administrative functions and do not relate to the spreading and underwriting of a policyholder's risk. See *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986).

176. See *McLaughlin v. Connecticut Gen. Life Ins. Co.*, 565 F. Supp. 434, 441 (N.D. Cal. 1983) (stating that "[i]t is indisputable that where the insurance company makes final claims deci-

The result of this distinction prescribed by the deemer clause is that the plan cannot be reached by state regulation because it technically is self-insured. ERISA's deemer clause explicitly provides that an employee benefit plan cannot be deemed to be an insurance company for the purposes of state statutes regulating insurance.¹⁷⁷ Thus, despite insuring its employees under a policy issued by an insurance company, and despite the insurance company making final claims decisions, the plan has circumvented state insurance regulation by funding the entire plan in advance through the establishment of the trust.¹⁷⁸

There is a caveat to what seems to be both a logical and legal arrangement for avoiding the reach of state insurance regulation. Plans which set up such a trust fund and thus self-insure, often purchase "stop-loss" insurance from the administrator-insurer.¹⁷⁹ The purpose of stop-loss insurance is to cover claim payments in the event that the trust fund is depleted during a particular period due, for example, to a large number of valid claims resulting from a catastrophe, such as a fire, epidemic, or accident at the place of employment. To determine the amount in the trust fund from which claims are to be paid, the employer and insurer calculate an average amount paid out each month in claims and measure how much accordingly needs to be in the fund. This could be done by taking an average based on twelve months of claims, or by any other means which tend to guarantee that the amount in the fund will be sufficient to cover claims, but not so great as to tie up necessary capital. The problem arises when, for a given month, claims exceed the amount in the fund. Stop-loss insurance provides that should this happen, the insurance company administrator will step in and pay those claims out of its own funds.¹⁸⁰ When proceeds of the fund once again exceed claims amounts, the insurance company will be

sions under a group insurance policy issued to an employee benefit plan, ERISA governs the relationship between the insurance company and the insured").

177. ERISA, *supra* note 1, § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1982).

178. In this situation the plan clearly is acting like an insurer because it is spreading and underwriting risk. It is not deemed to be an insurance company for the purpose of state regulation of insurance. It is exactly that type of situation the deemer clause was inserted to address—states which would attempt to regulate self-insured employee benefit plans by calling them insurers. If not for the deemer clause, the states totally could undermine one of the primary purposes of ERISA: the reservation of employee benefit plan regulation exclusively to the federal government.

179. See, e.g., *Insurance Bd. Under the Social Ins. Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987); *Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986) (both holding that a plan that purchases stop-loss insurance is not an insured plan for the purposes of ERISA). *Contra Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986).

180. If claims never exceed the amount in the employer's fund, the insurer never incurs its obligation to pay out the amounts in excess. An insurer in this situation, therefore, seems to be acting merely as an administrator of a self-insured plan.

reimbursed by the employer or the plan.

In this situation the insurance company is acting as more than simply an administrator of a self-insured plan. It is receiving a premium and, in exchange, is underwriting the spreading of the plan's risk—the risk of claims exceeding fund proceeds.¹⁸¹ It would appear then that even a self-funded plan being administered by an insurance company and adopting a group insurance policy as the terms of its plan could be subject to state insurance regulation if the “trigger” point—the point at which the insurance company needs to pay claims from its own funds—is reached.¹⁸²

The stop-loss caveat creates uncertainty as to whether and when such a plan will be subject to state insurance regulation. Is the savings clause resurrected by the mere existence of stop-loss insurance? Should the plan be subject to state insurance regulation on a claim-by-claim basis? Is the savings clause resurrected eternally if the trigger is reached only once? Does triggering in a given month only subject the plan to state insurance regulation for that particular month, or for the plan's entire fiscal year? Is one trigger enough to subject the plan to state insurance regulation? Does the existence of stop-loss insurance not matter at all? The fact that there are no easy answers to these questions indicates that perhaps the entire legal debate that has attempted to draw the line between those plans that are subject to state insurance regulation and those that are not should be ended and replaced by a framework that provides clarity, predictability, and ease of administration.

Courts addressing this question should adopt the view taken by the Ninth Circuit in *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*¹⁸³ and *Moore v. Provident Life & Accident Insurance Co.*¹⁸⁴ The Ninth Circuit held that the existence of stop-loss insurance does not recharacterize a self-insured plan as an insured plan, which would open the plan up to state insurance

181. The Sixth Circuit accepted this argument in *Baerwaldt*, 767 F.2d at 308. The *Baerwaldt* court found a Michigan mandated-benefit law, similar to the one at issue in *Metropolitan Life*, saved from preemption because the plans in question had purchased a stop-loss policy from an insurance company. The court stated that “[t]he ‘stop-loss’ nature of the plans does not alter our conclusion” because *Metropolitan Life* results in a distinction between insured and uninsured plans and because “the plans include an arrangement whereby the plans pay premiums to [the insurance company] to insure that [the insurance company] will pay all benefits in excess of the claims liability limit under the group policies.” *Id.* at 312-13.

182. Once the trigger point has been reached, the insurer has acted in the capacity of an insurer, as well as an administrator of the plan. This situation provides the strongest argument for the savings of state regulation directed at such insurers.

183. 801 F.2d 1157 (9th Cir. 1986).

184. 786 F.2d 922 (9th Cir. 1986).

regulation.¹⁸⁵ This approach would allow employers to self-insure their plans, while providing employers with flexibility through the purchase of stop-loss insurance in case of unusually high claims liability for a given period.

V. CONCLUSION

It is clear that courts have come a long way in the last decade in untangling ERISA's preemption provisions. They have exercised prudence in attempting to interpret the plain meaning of the statute's words, supplemented with a thorough examination of the statute's legislative history, in order to better ascertain Congress's intent. Perhaps their interpretations have been in line with Congress's intentions when drafting ERISA; some commentators would argue that congressional inaction in the wake of judicial interpretation means exactly this. Congress, however, should not hesitate to clarify the interpretation problems that remain and legislate to correct judicial pronouncements which are inconsistent with congressional intent. ERISA has had a positive impact in the area of employee benefits, but uncertainty about the meaning of some of its provisions could undermine the very goals Congress set out to achieve. Thus far, courts have interpreted intelligently ERISA's preemption provision, opening up a dialogue with Congress and constantly looking to it for guidance. Congress should be wary, however, not to be lax and allow courts to misconstrue its intentions and, as a consequence, frustrate Congress's objectives.

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185. The reasoning of the court in *Pacyga* and *Moore* is both sensible and consistent with ERISA's purpose and prior case law interpreting the statute. The *Pacyga* court stated:

[Stop-loss insurance] cannot be termed health insurance, nor can it be said that the Plan is providing an insurance contract to its participants. The stop-loss coverage provides for payment to the Plan . . . to reimburse the Plan in the event that it must pay out more than a certain amount in claims in a given year. The stop-loss insurance does not pay benefits directly to participants, nor does the insurance company take over administration of the Plan at the point when the aggregate amount is reached. Thus, no insurance is provided to the participants, and the Plan should properly be termed a non-insured plan. . . .

801 F.2d at 1161-62.