

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

**Guidelines for State and
Federal Regulation**

2022

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

Guidelines for State and Federal Regulation

ERISA Working Group of the
Regulatory Framework (B) Task Force of the
Health Insurance and Managed Care (B) Committee

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INTRODUCTION

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

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

The precise boundary of state jurisdiction has been the subject of numerous disputes involving complex preemption analysis. In contrast to the detailed and substantive standards that are imposed on employee pension benefit plans, there is no comparable federal regulatory program for employee welfare benefit plans.⁴ The minimal federal standards for employee welfare benefit plans

¹ Public Law 93-406, codified at 29 U.S.C. §§ 1001 *et seq.* (2018). Note that federal laws have their own internal numbering system and the numbering of many titles of the United States Code remains “unofficial.” For example, ERISA’s preemption clause is P.L. 93-406, § 514, as amended. It is codified at 29 U.S.C. § 1144, but is often cited as “Section 514.” The Affordable Care Act and the Public Health Service Act, discussed later in this Handbook, follow similar dual citation systems.

² The terms “employee welfare benefit plan” and “welfare plan” include any “program ... established or maintained by an employer or employee organization ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise” with any of a broad range of benefits, including “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.” 29 U.S.C. § 1002(1) (2018).

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

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

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

and the imprecision and complexity of the ERISA preemption analysis result in numerous disputes over the limits of state jurisdiction in areas related to employee welfare benefit plans.

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

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

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

The principal purpose of this handbook is to provide state insurance regulators with a resource guide to help them through the labyrinth of ERISA preemption analysis. While ERISA preemption applies to a broader range of contexts, this handbook focuses exclusively on health-related employee welfare benefit plans. The first section discusses the scope of ERISA preemption. Specifically, it provides historical background information on ERISA preemption of state law and an overview of the statutory elements of the ERISA preemption analysis. The section ends with a summary of cases in which the Supreme Court has interpreted these statutory elements.

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

incorporated by reference into ERISA by the Patient Protection and Affordable Care Act (ACA), P.L. 111-148.

⁵ 29 U.S.C. § 1144(a) (2018). It should be noted that ERISA does not apply to employee benefit plans maintained by governmental or church employers or to plans maintained only to comply with applicable state workers’ compensation, unemployment or disability laws. There are additional exemptions from ERISA for unfunded excess benefit plans and plans maintained outside the U.S. primarily for nonresident aliens. ERISA does provide an opt-in provision for church employers. 29 U.S.C. § 1003(b) (2018).

⁶ 29 U.S.C. § 1144(b)(2)(A) (2018). State laws regulating banking and securities, generally applicable criminal laws, and most provisions of the Hawaii Prepaid Health Care Act are also saved from preemption. *Id.* § 1144(b)(2)–(5).

⁷ 29 U.S.C. § 1144(b)(2)(B) (2018).

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

Finally, the fourth section of this handbook contains appendices that include various regulatory alerts.

ERISA PREEMPTION OF STATE REGULATION

The Scope Of Preemption

The scope of ERISA preemption is sweeping. With the exception of state regulations applied to MEWAs, any state law that attempts to regulate ERISA-covered employee benefit plans is preempted due to federal occupation of the field.⁸ However, ERISA exempts from federal preemption state laws that regulate the business of insurance. A “saving clause” in the Act empowers states to enforce all state laws that regulate insurance. The broad language of the saving clause is limited by a “deemer clause” in the statute, which has been judicially interpreted to mean that an employee benefit plan covered by ERISA cannot be deemed to be an insurance company or engaged in the business of insurance for the purposes of the application of state laws which regulate insurance.⁹ Because little legislative history exists with respect to these clauses, the interpretation of their meaning has been developed through the judicial decision making process.

The “saving clause” is also limited by case law holding that some provisions of state insurance codes regulating insurers go beyond regulating “the business of insurance” and therefore are preempted to the extent that they apply to insurance issued to employee benefit plans.¹⁰ The Supreme Court’s “interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts; if the plan is uninsured, the State may not regulate it.”¹¹

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

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

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

The Preemption Clause

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

⁸ 29 U.S.C. § 1144(a) (2018).

⁹ *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

¹⁰ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50-51 (1987).

¹¹ *FMC*, 498 U.S. at 64.

benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.”¹²

Preemption applies only to a plan that was established or is maintained by an employer and/or an employee organization to provide any of the specified benefits to the employees of the employer or members of the employee organization.¹³ Congress defined an employer as “... any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.”¹⁴ An employee organization is defined as “any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning any employee benefit plan, or other matters incidental to employment relationships; or an employees’ beneficiary association organized for the purpose in whole or in part, of establishing such a plan.”¹⁵

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

Congress reviewed the effect of preemption under ERISA in the Activity Report of the Committee on Education and Labor of the United States House of Representatives on January 3, 1977.¹⁶ Although the Committee thought that the broad preemption provision of ERISA should be retained, it emphasized that entrepreneurial ventures masquerading as ERISA plans were “no more ERISA plans than is any other insurance policy sold to an employee benefit plan.”¹⁷ Also, “[w]here a ‘plan’ is, in effect, an entrepreneurial venture, it is outside the policy of section 514 (the preemption clause of ERISA) ... In short, to be properly characterized as an ERISA benefit plan, a plan must satisfy the definition requirement ... in both form and substance.”¹⁸ The committee concluded: “We most earnestly encourage private persons, in particular the membership of the National Association of State [*sic*] Insurance Commissioners, and urge the Department of Labor, to take appropriate action to prevent the continued wrongful avoidance of proper state regulation by the entities.”¹⁹ Finally, in 1983, Congress enacted language to facilitate the efforts of the states

¹² 29 U.S.C. § 1144(a) (2018). ERISA defines state law to include “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State,” and also any “law of the United States applicable only to the District of Columbia.” 29 U.S.C. § 1144(c)(1) (2018).

¹³ 29 U.S.C. § 1002(1) (2018).

¹⁴ *Id.* § 1002(5).

¹⁵ *Id.* § 1002(4).

¹⁶ ERISA OVERSIGHT REPORT OF THE PENSION TASK FORCE OF THE SUBCOMMITTEE ON LABOR STANDARDS, HOUSE COMMITTEE ON EDUCATION AND LABOR, H.R. Doc. No. 342-9, 94th CONG., 2d Sess. (Jan. 3, 1977) [“COMMITTEE REPORT”].

¹⁷ *Id.* at 10.

¹⁸ *Id.* at 11.

¹⁹ *Id.*

and the DOL to establish a clear and effective regulatory framework for multiple employer plans. These provisions are discussed in more detail in the section on multiple employer welfare arrangements (MEWAs).

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

The Saving Clause

Notwithstanding the preemption clause, ERISA does not substitute for or eliminate state insurance regulation. To preserve state laws regulating insurance and state authority to continue to do so, Congress included a "saving clause" in the Act. This provision reads: "Except as provided in subparagraph (B), [referring to the "deemer clause"], nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."²⁰ In other words, ERISA generally does not prohibit states from applying state insurance laws to entities engaged in the business of insurance.

The "saving clause" is consistent with the McCarran-Ferguson Act,²¹ which Congress passed in 1945 to reserve for the states the authority to regulate the business of insurance. Furthermore, ERISA explicitly states that "Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States ... or any rule or regulation issued

²⁰ 29 U.S.C. § 1144(b)(2)(A) (2018).

²¹ 15 U.S.C. §§ 1011 *et seq.* (2018). The McCarran-Ferguson Act states in part:

§ 1011. Declaration of policy

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

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

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

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

under any such law.”²² Known as an “equal dignity” clause, this provision protects the McCarran-Ferguson Act from being superseded or modified by ERISA.

The Deemer Clause

While the “saving clause” seeks to protect state authority to regulate the business of insurance, state insurance laws cannot be applied to employee benefit plans. The “deemer clause” states, “Neither an employee benefit plan described in 29 U.S.C. §1003(a) of this title, which is not exempt under §1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer ... or to be engaged in the business of insurance ... for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts”²³

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

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

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

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

The Supreme Court further complicated the issue in the April 2003 decision, *Kentucky Association of Health Plans v. Miller*,²⁴ when it announced a “clean break” from the tests the Supreme Court relied upon previously in interpreting the saving clause. Some uncertainty remains about the impact of the *Miller* case on future cases and on the precedential value of the Court’s previous ERISA preemption cases. See the summaries of a number of the key Supreme Court cases provided below.

²² 29 U.S.C. § 1144(d) (2018).

²³ *Id.* § 1144(b)(2)(B).

²⁴ 538 U.S. 329 (2003).

SHAW v. DELTA AIR LINES,
463 U.S. 85 (1983)

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

New York’s Human Rights Law contained a number of employment discrimination provisions, including one prohibiting employers from discriminating against their employees on the basis of sex, and defining sex discrimination to include discrimination on the basis of pregnancy. New York’s Disability Benefits Law required employers to provide employees the same benefits for pregnancy as were provided for other disabilities.²⁵

In its analysis, the Court held that both of these state laws “related to” employee benefit plans. The Court’s interpretation of “relate to” was according to “the normal sense of the phrase, if it has a connection with or reference to such a plan.”²⁶ The Human Rights statute prevented employers from structuring their employee benefit plans in a discriminatory fashion on the basis of pregnancy. The Disability Benefits statute required employers to include certain benefits in their employee welfare benefit plan.²⁷

The Court noted that ERISA does not merely preempt state laws that deal with requirements covered by ERISA, such as reporting, disclosure, and fiduciary responsibility. Nor does the Act merely preempt state laws specifically directed to employee benefit plans.²⁸ State laws that indirectly “relate to” employee benefit plans may also be preempted by ERISA. The Court did note that some state laws “may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.”²⁹

Following its conclusion that both state laws “related to” employee benefit plans, the Court proceeded to inquire whether either of the laws was nevertheless exempt from ERISA preemption. The state argued that the Human Rights Law was exempt from ERISA preemption because ERISA’s “equal dignity” clause prohibited interpretations that impaired other federal laws and state fair employment laws were integral to the federal enforcement scheme under Title VII. The Court rejected this claim, noting that ERISA preemption of the Human Rights Law as it related to employee benefit plans did not impair Title VII because Title VII did not prohibit the practices under consideration in this case.³⁰

With respect to the Disability Benefits Law, the Court noted that ERISA specifically exempts from coverage those plans which are “maintained solely for the purpose of complying with applicable

²⁵ *Shaw v. Delta Air Lines*, 463 U.S. 85, 88–89 (1983).

²⁶ *Id.* at 96–97.

²⁷ *Id.* at 97.

²⁸ *Id.* at 98.

²⁹ *Id.* at 100 n.21.

³⁰ *Id.* at 103–04.

... disability insurance laws.”³¹ Consequently, the Court held that states cannot apply their laws to multi-benefit ERISA plans which may include disability benefits, but can require the employer to administer a separate disability plan which does comply with state law.³²

METROPOLITAN LIFE INS. CO. v. MASSACHUSETTS,
471 U.S. 724 (1985)

In *Metropolitan Life v. Massachusetts*, the Court reviewed whether a state statute mandating coverage of mental health care was preempted by ERISA as applied to insurance policies purchased by employee welfare benefit plans. All insurance policies within the scope of the statute, including policies purchased by ERISA health plans, were required to include the mandated mental health benefit. Because the statute had the effect of requiring insured employee benefit plans to provide a particular benefit, the Commonwealth of Massachusetts did not dispute that the statute “related to” ERISA plans.³³ The Commonwealth did claim, however, that the law regulated the business of insurance, and thus, was saved from ERISA preemption.³⁴

In its analysis, the Court highlighted that ERISA does not distinguish between “traditional and innovative insurance laws.”³⁵ Further, the Court noted that “[t]he presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope.”³⁶ The Court also noted that Congress did not intend to preempt areas of traditional state regulation.³⁷

The opinion adopted a “common-sense view” of the saving clause, observing that it would seem to “state the obvious” that a law which “regulates the terms of certain insurance contracts” is “a law ‘which regulates insurance’” within the meaning of the saving clause.³⁸ The Court explained further that the case law interpreting the phrase “the business of insurance” under the McCarran-Ferguson Act “also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws ‘which regulate insurance.’”³⁹ Under the McCarran-Ferguson Act, “Statutes aimed at protecting or regulating [the insurer-policyholder] relationship, directly or indirectly, are laws regulating the ‘business of insurance.’”⁴⁰ The Court reviewed the McCarran-Ferguson “reverse preemption” cases as an aid to determine if a practice is the “business of insurance.” Those cases applied an analysis that considered three key factors:⁴¹

³¹ *Id.* at 106; *see* 29 U.S.C. § 1003(b)(3) (2018).

³² *Id.* at 107–08.

³³ *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

³⁴ *Id.* at 733.

³⁵ *Id.* at 741.

³⁶ *Id.*

³⁷ *Id.* at 740.

³⁸ *Id.*

³⁹ *Id.* at 742–43.

⁴⁰ *Id.* at 744, quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

⁴¹ *Id.* at 742, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). Although some courts, including on occasion the Supreme Court itself, have cited *Metropolitan Life* and/or *Pireno* as supporting the proposition that courts should evaluate whether the law itself “has the effect of spreading a policyholder’s risk,” that is not how the

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

The Supreme Court opinion that established this three-pronged test, *Union Labor Life v. Pireno*.⁴² specifically stated that not all of these prongs are necessary and noted, in particular, that the third prong of the test was not dispositive to a determination whether or not an entity was engaged in the business of insurance.⁴³

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

- (1) The law regulated the spreading of risk since the state legislature’s intent was that the risk associated with mental health services should be shared;
- (2) The law directly regulated an integral part of the relationship between the insurer and the policyholder;
- (3) The law met the third prong because it only imposed requirements on insurers.⁴⁴

The Court acknowledged, “we are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction created by Congress in the “deemer clause,” a distinction of which Congress is aware and one it has chosen not to alter.”⁴⁵

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

PILOT LIFE INS. CO. v. DEDEAUX,
481 U.S. 41 (1987)

Pilot Life Ins. Co. v. Dedeaux involved state common-law tort and contract claims as applied to the processing of claim benefits under an employee welfare benefit plan. In *Pilot Life*, a unanimous Court held that the plaintiff’s common-law causes of action for the insurer’s alleged bad faith handling of the plaintiff’s disability claim “related to” an employee benefit plan and were preempted by ERISA because they involved the processing of claims under an employee benefit plan.⁴⁶

standard was originally formulated by the Court.

⁴² *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

⁴³ *Id.* at 133.

⁴⁴ *Metropolitan Life*, 471 U.S. at 743.

⁴⁵ *Id.* at 747.

⁴⁶ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987).

The Court found that the state law bad-faith common-law tort claims were not protected by the “saving clause.” The Court stated that “in order to regulate insurance, a law must not just have an impact on the insurance industry, but be *specifically directed* toward that industry.”⁴⁷ Applying the criteria used to determine whether a practice constitutes the business of insurance for purposes of the McCarran-Ferguson Act, the Court determined that: (1) the common-law tort of bad faith did not effect a spreading of the risk; (2) the tort was not integral to the insurer-insured relationship; and (3) because common-law tort claims were not limited to entities within the insurance industry, the McCarran-Ferguson “business of insurance” test did not save the state law claims.⁴⁸ Further, the Court stated that “the deliberate care with which ERISA’s civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive.”⁴⁹

The Court went beyond considering the exclusive remedy as an additional factor in support of its conclusion that the bad faith tort does not “regulate insurance” within the meaning of the saving clause – the Court concluded that even if Mississippi’s law did regulate insurance, it would still be preempted. The Court distinguished *Metropolitan Life* on the ground that it “did not involve a state law that conflicted with a substantive provision of ERISA.”⁵⁰ The Court concluded that all state laws that “supplemented or supplanted” the causes of action and remedies available under ERISA were preempted,⁵¹ whether or not they “regulated insurance” within the meaning of the saving clause.

ERISA preemption also controls the forum in which the complaint is to be heard. The Federal Rules of Civil Procedure provide that “any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.”⁵² In a companion case to *Pilot Life, Metropolitan Life Ins. Co. v. Taylor*,⁵³ the Supreme Court held that state court cases can be removed to federal court if the common-law cause of action is preempted by ERISA, even though no federal law issues appear in the complaint. The Court held that this doctrine, originally developed in the context of labor law preemption,⁵⁴ was equally applicable to ERISA preemption.⁵⁵

⁴⁷ *Id.* at 50 (emphasis supplied).

⁴⁸ *Id.* at 57.

⁴⁹ *Id.* at 54.

⁵⁰ *Id.* at 56–57.

⁵¹ *Id.* at 56. The Court based its analysis on legislative history, submitted by the Solicitor General as *amicus curiae*, indicating that the preemption provisions in ERISA were based on the broad exclusive remedy provisions in the Taft-Hartley Act (LMRA), 29 U.S.C. § 185. The Taft-Hartley Act does not contain an insurance saving clause, a difference from ERISA that was not addressed by the *Pilot Life* Court. See *UNUM Life Ins. Co. v. Ward*, 526 U.S. at 376 n.7.

⁵² 28 U.S.C. § 1441(a) (2018).

⁵³ *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

⁵⁴ See *Avco Corp. v. Machinists*, 390 U.S. 557 (1968). In *Avco*, the Court permitted the removal of cases purporting to be based only on state law causes of action in labor cases preempted by Section 301 of the Labor Management Relations Act.

⁵⁵ *Taylor*, 481 U.S. at 66–67. However, as noted by the U.S. Supreme Court in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), for non-diversity-of-citizenship cases, a defendant may not remove a case to federal court unless the plaintiff’s complaint establishes that the case arises under federal law. Federal law as

The deference that the Court afforded to the civil enforcement scheme of ERISA stressed the need for exclusivity and uniformity of ERISA plan remedies.⁵⁶ As a result, it is important to distinguish state insurance regulation and enforcement relating to claims handling, utilization review, grievance handling and coverage or claim appeals from civil remedies. The Pilot Life “conflict” exception to the saving clause should not be invoked by a court reviewing an insurance regulatory provision relating to these topics because they are not a “civil remedy” for the participant, even if they have the effect of providing restitution to consumers.

FIRESTONE TIRE & RUBBER CO. v. BRUCH,
489 U.S. 101 (1989)

While *Firestone Tire & Rubber Co. v. Bruch* is often cited for the proposition that ERISA plan administrators (including insurers when the plan provides insurance benefits) are entitled to broad discretion, that is not actually what the Court held. To the contrary, the Court rejected the standard that had previously been widely applied in the lower federal courts, under which plan administrators were understood to have inherent discretionary authority, so that courts could only overturn the administrator’s decisions if it was arbitrary and capricious.⁵⁷ Instead, the Court held that such decisions are subject to *de novo* review by the courts unless the terms of the plan grant discretionary authority to the administrator.

Firestone was neither an insurance case nor a health benefit case. It involved a dispute over the employer’s severance payment plan that arose after the employer sold five of its plants to another employer. The trial court had granted summary judgment to Firestone on the basis that its denial of severance pay was not arbitrary and capricious, but the Third Circuit reversed on the ground “that where an employer is itself the fiduciary and administrator of an unfunded benefit plan, its decision to deny benefits should be subject to *de novo* judicial review. It reasoned that in such situations deference is unwarranted given the lack of assurance of impartiality on the part of the employer.”⁵⁸

The Supreme Court affirmed this standard of review. Although “ERISA abounds with the language and terminology of trust law,”⁵⁹ the “arbitrary and capricious” standard of review lower courts had often applied in ERISA cases was not based on general principles of trust law, but on precedent under the Taft-Hartley Act. Under the Taft-Hartley Act, a suit against a trustee is an extraordinary remedy; by contrast, Congress expressly provided for judicial review of decisions by ERISA fiduciaries.⁶⁰ Under general principles of trust law, a dispute over interpreting the terms of a trust is resolved by the court, not by the trustee. Accordingly, the Court held that the default standard

a defense is generally not sufficient to remove an action to federal court. The cause of action must come within the scope of ERISA’s civil enforcement provisions (29 U.S.C. §502).

⁵⁶ William A. Chittenden, III, *ERISA Preemption: The Demise of Bad Faith Actions in Group Insurance Cases*, 12 S. Ill. U. L.J. 517 (1988).

⁵⁷ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109–110 (1989).

⁵⁸ *Id.* at 107–108.

⁵⁹ *Id.* at 110.

⁶⁰ *Id.* at 109–110. Another crucial difference between ERISA and the Taft-Hartley Act is that Congress did not make Taft-Hartley’s exclusive remedy provision subject to a saving clause for insurance laws, a distinction that the *Pilot Life* Court did not take into account in its analysis. *See supra* note 51.

under ERISA should be *de novo* review, and noted that this standard is consistent with the standard applied under contract law to employee benefit plans before ERISA was enacted.⁶¹

However, the Court also provided guidance for mitigating the impact of the *de novo* standard. Despite acknowledging that one of the purposes of ERISA was “to protect contractually defined benefits,”⁶² the Court interpreted ERISA as replacing contract law with trust law as the governing principle for resolving employee benefit disputes, and stated that when the trustee is exercising a discretionary power that has been expressly granted by the terms of the trust instrument, trust principles then “make a deferential standard of review appropriate.”⁶³ In this case, though, there was no discretionary clause, so the *de novo* standard was fully applicable. Finally, the Court cautioned: “Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest,” as when an insurer or employer adjudicates a claim for benefits that would be paid out of its own assets, “that conflict must be weighed as a factor in determining whether there is an abuse of discretion.”⁶⁴

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

At issue in *FMC Corp. v. Holliday* was a Pennsylvania state statute that prevented employee welfare benefit plans from subrogating a plan beneficiary’s tort recovery involving motor vehicle-related incidents. The plan at issue was a self-funded employee welfare benefit plan.⁶⁵

The Court concluded that the statute “related to” the employee benefit plan because it referenced such plans and was connected to such plans by subjecting multi-state self-funded plans to conflicting state regulations.⁶⁶ The Court also concluded that the statute fell within the “saving” clause as an insurance regulation.⁶⁷

Nevertheless, after concluding that the statute “related to” the employee benefit plan and regulated insurance, the Court ultimately held that the statute was not “saved” to the extent that it regulated ERISA-covered self-funded employee welfare benefit plans. Since the “deemer” clause exempts ERISA plans from state laws that regulate insurance, the state could not apply laws directed at the business of insurance to self-funded employee welfare benefit plans or to the terms of the plans.⁶⁸ The Court reaffirmed that the “saving” clause “retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee welfare benefit plans.”⁶⁹ Specifically, the Court stated that “if a plan is insured, a State may regulate it indirectly through

⁶¹ *Id.* at 112.

⁶² *Id.* at 113.

⁶³ *Id.* at 111. However, the Court has acknowledged that “trust law does not tell the entire story” and might be “only a starting point.” *Conkright v. Frommert*, 559 U.S. 506, 516 (2010), quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

⁶⁴ *Id.* at 115. See discussion below of *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

⁶⁵ *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990).

⁶⁶ *Id.* at 58–60.

⁶⁷ *Id.* at 60–61.

⁶⁸ *Id.* at 65.

⁶⁹ *Id.* at 64.

regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it."⁷⁰

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

In *District of Columbia v. Greater Washington Board of Trade*, the Supreme Court held that ERISA preempted a statute that required an employer to provide employees who were eligible for workers' compensation benefits with the same coverage the employer provided through its health insurance program if one was offered.⁷¹

The Court noted that the statute clearly "related to" employee welfare benefit plans because it specifically mentioned them.⁷² The Court rejected the District of Columbia's reliance on *Delta Air Lines* because *Delta* had specifically held that a state cannot apply a statute directly to an employee welfare benefit plan. Although *Delta* does allow a state to require an employer to set up a separate plan to comply with laws directed at benefits not covered by ERISA, such as disability, unemployment, and workers' compensation benefits, the District of Columbia law did not do so.⁷³ The benefit it mandated was tied directly to the terms of the employer's ERISA plan.⁷⁴

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

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

The District Court held that the surcharges "related to" ERISA plans and were thus preempted because they had the effect of increasing the costs to commercial insurers and HMOs and therefore, indirectly increasing the costs to employee welfare benefit plans. Consequently, the District Court enjoined the enforcement of the surcharges. The Court of Appeals affirmed the District Court's decision, reasoning that the "purpose[ful] interfer[ence] with the choices that the ERISA plans make for health care coverage ... is sufficient to constitute [a] "connection with" ERISA plans."⁷⁵

In a unanimous decision, the Supreme Court reversed the holding of the Court of Appeals. The Court noted that the statute did not make "reference to" an employee welfare benefit plan because

⁷⁰ *Id.*

⁷¹ *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 126–27 (1992).

⁷² *Id.* at 130.

⁷³ *Id.* at 132.

⁷⁴ *Id.*

⁷⁵ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995).

the surcharge was imposed irrespective of whether the insurance was purchased by an ERISA plan, private individual, or other purchaser.⁷⁶

After reviewing the purposes and objectives of Congress in enacting the ERISA statute, the Court also concluded that the statute did not have a “connection with” employee welfare benefit plans. The Court held that an indirect economic influence is not a sufficient connection to trigger preemption if it does not bind plan administrators to any particular choice or preclude uniform administrative practices. While a surcharge may increase plan costs and affect its shopping decisions, it does not preclude the plan from seeking the best deal that it can obtain. The Court noted that the state laws which have an indirect economic effect on the relative costs of health insurance packages leaves “plan administrators where they would be in any case, with the responsibility to choose the best overall coverage for the money.”⁷⁷

The *Travelers* Court clarified that state statutes that “produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers ... might indeed be preempted.”⁷⁸ Because the hospital surcharge statute only indirectly affects the cost of insurance policies, it does not fall into this category of indirect regulation preempted by ERISA.

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

At issue in *California Division of Labor Standards Enforcement v. Dillingham* was whether ERISA preempted California’s minimum wage law to the extent that it allowed payment of a lesser wage to workers that participate in a state-approved apprenticeship program. The Supreme Court considered whether the state law “related to” an ERISA plan and was therefore preempted under ERISA § 502(a). The Court utilized a two-part inquiry to determine whether California’s minimum wage law “related to” an ERISA plan. The Court considered whether the state law had either a “reference to” or a “connection with” an ERISA plan.⁷⁹

The Court noted common characteristics among the cases where it had held that certain state laws made “reference to” an ERISA plan. The Supreme Court highlighted cases “[w]here a State’s law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law’s operation, as in *Greater Washington Board of Trade and Ingersoll-Rand*, that “reference” will result in preemption.”⁸⁰ The Court determined that California’s minimum wage law, as it applied to apprentice wages, applied to more than just ERISA plans and, as a result, did not make “reference to” ERISA plans.

⁷⁶ *Id.* at 1677.

⁷⁷ *Id.* at 1680.

⁷⁸ *Id.* at 1683.

⁷⁹ *California Division of Labor Standards Enforcement v. Dillingham*, 519 U.S. 316, 324 (1997), quoting the test used in *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 (1992) (quoting *Shaw v. Delta Airlines, Inc.* 463 U.S. 85, 96–97 (1983).

⁸⁰ *Id.* at 325.

In order to determine whether a state law has a “connection with” an ERISA plan, the Court acknowledged that “an ‘uncritical literalism’ in applying the ‘connection with’ standard offers scant utility in determining Congress’ intent to the extent of the reach of the preemption clause.”⁸¹ In applying the “connection with” standard, the Court looked to the “objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive [ERISA preemption] as well as to the nature of the effect of state law on ERISA plans”⁸²

With respect to the issue of Congressional intent, the Supreme Court’s analysis starts with a presumption against preemption—Congress did not intend to preempt areas of traditional state regulation absent evidence that it was the clear and manifest purpose of Congress.⁸³ In *Travelers*, the Court stated that “the preemption of areas of traditional state regulation where ERISA has nothing to say would be ‘unsettling.’”⁸⁴ California’s minimum wage laws, like the hospital surcharge law at issue in the *Travelers* case, involved issues traditionally regulated by the states. In addition, the Court observed that the areas covered by the state laws at issue in both cases were “quite remote from the areas with which ERISA is expressly concerned—reporting, disclosure, fiduciary responsibility, and the like.”⁸⁵ Therefore, the Supreme Court was not persuaded that it was the intent of Congress to have ERISA preempt state laws addressing apprentice wages and wages to be paid on public works contracts.

In past ERISA preemption cases decided by the Supreme Court, a “connection with” an ERISA plan was observed when the state law at issue had either “mandated employee benefit structures or their administration.”⁸⁶ The Court compared the effect of the New York law on ERISA plans in the *Travelers* case to the effect of the California law on ERISA plans in the instant case. The indirect economic influence that resulted from the state law at issue in *Travelers* did not force ERISA plans to make a particular choice, nor did it regulate the ERISA plan itself. Similarly, California’s prevailing wage statute did not bind ERISA plans to any particular decision.⁸⁷ The Court stated that “[t]he [California] law only alters the incentives, but does not dictate the choices facing ERISA plans.”⁸⁸ The Court reasoned that the California minimum wage law was no different “from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.”⁸⁹

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

⁸¹ *Id.*, citing *Travelers*, 514 U.S. at 656.

⁸² *Id.*, citing *Travelers*, 514 U.S. at 658–659.

⁸³ *Id.*, citing *Travelers*, 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)) (citation omitted).

⁸⁴ *Id.* at 330, citing *Travelers*, 514 U.S. at 665 n. 7.

⁸⁵ *Id.* at 330, citing *Travelers*, 514 U.S. at 661 (quoting *Delta Air Lines*, 463 U.S. at 98).

⁸⁶ *Id.* at 328 (citations omitted).

⁸⁷ *Id.* at 332.

⁸⁸ *Id.* at 334.

⁸⁹ *Id.* at 334, citing *Travelers*, 514 U.S. at 668.

De BUONO v. NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND,
520 U.S. 806 (1997)

At issue in *De Buono v. NYSA-ILA Medical and Clinical Services Fund* was the application of a New York hospital tax to medical centers operated by an ERISA plan. The Court of Appeals for the Second Circuit held that the New York tax was preempted because it “related to” an ERISA plan within the meaning of ERISA §514(a). The case was appealed to the United States Supreme Court. The Supreme Court remanded the case for reconsideration in light of its opinion in *Travelers*, discussed above.⁹⁰

The Second Circuit reconsidered its opinion and, distinguishing the tax at issue in *Travelers* from the tax at issue in this case, again held the law preempted as it applied to hospitals owned by ERISA plans. The Second Circuit reasoned that in *Travelers*, the surcharge only impacted ERISA plans indirectly by influencing a plan administrator’s decision. However, in this case, the impact of the tax on ERISA plans was direct, by depleting the fund’s assets.⁹¹

On petition before the Supreme Court for the second time, the Court reversed the Second Circuit and held that the New York tax did not “relate to” an ERISA plan, and therefore, was not preempted as it applied to hospitals owned by ERISA plans. The Court explained that the holding in *Travelers* required re-evaluation of its previous interpretations of the “relates to” phrase. Prior to its decision in *Travelers*, cases requiring the Court to interpret the “relates to” language in ERISA had obvious connections to or made obvious references to ERISA plans.⁹² The Court’s decision in *Travelers* rejected a strict and literal interpretation of “relates to.”⁹³

The Court explained that the “relates to” language in §514(a) does not modify the starting presumption that Congress does not intend to preempt state law.⁹⁴ In order to overcome this presumption against preemption, one “must go beyond the unhelpful text ... and instead look to the objectives of the ERISA Statute as a guide to the scope of the law that Congress understood would survive.”⁹⁵

The Court reiterated that the scope of ERISA’s preemptive reach was not intended to extend to the historic police powers of the states, which includes matters of health and safety.⁹⁶ The Court observed that the tax at issue in this case, while a revenue raising measure and not a hospital regulation *per se*, clearly occupied a realm that was historically a state concern.⁹⁷ Consequently,

⁹⁰ *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 812 (1997).

⁹¹ *Id.* at 812, citing the decision below, *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 74 F.3d 28, 30 (1996).

⁹² *Id.* at 813, citing *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85.

⁹³ *Id.* at 812.

⁹⁴ *Id.* at 813, citing *Travelers*, 514 U.S. at 655, citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230.

⁹⁵ *Id.* at 813, 814, citing *Travelers*, 514 U.S. at 656.

⁹⁶ *Id.* at 814.

⁹⁷ *Id.*

the Fund had the “considerable burden” of overcoming the presumption against preemption of state law.⁹⁸

The Court explained that the New York hospital tax was a law of general applicability. All hospitals were required to pay the tax regardless of their relationship to an ERISA plan. Laws of general applicability may impose burdens on the administration of ERISA plans and still not “relate to” an ERISA plan.⁹⁹ The Court observed that “any state tax or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute.”¹⁰⁰ In a footnote the Court reiterated a statement from *Travelers* conceding that there may be a situation where the economic impact of the state law is so great that an ERISA plan would be forced to buy certain coverage or not use certain insurers, in which case there may be preemption.¹⁰¹ However, the tax at issue in this case was not such a law. The tax was held not to “relate to” an ERISA plan and was not preempted by ERISA.¹⁰²

UNUM LIFE INS. CO. v. WARD,
526 U.S. 358 (1999)

UNUM Life Ins. Co. v. Ward involved John Ward’s claim for disability benefits pursuant to a policy provided by his employer. Mr. Ward filed his claim with UNUM Life Insurance Company after the expiration of the deadline provided for in his insurance policy. Consequently, UNUM denied his claim. Mr. Ward filed suit under ERISA §502(a) for benefits due under the terms of the plan, claiming that under California law, *Elfstrom v. New York Life Ins. Co.*, 432 P.2d 731(1967), UNUM had received timely notice of Ward’s disability. Under *Elfstrom*, an employer that administers a group health plan is the agent of the insurer. Therefore, the notice that Ward provided to his employer, which was within the timeframe set forth in the insurance policy, served as notice to UNUM. The district court, however, disagreed and granted summary judgment in favor of UNUM. The district court reasoned that the *Elfstrom* rule did not apply to Mr. Ward’s situation because the rule “related to” an ERISA plan and was therefore preempted.

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

⁹⁸ *Id.*

⁹⁹ *Id.* at 815, citing *Travelers*, 514 U.S. at 668.

¹⁰⁰ *Id.* at 816.

¹⁰¹ *Id.* at n.16, citing *Travelers*, 514 U.S. at 668.

¹⁰² *Id.* at 816–17.

The decision of the Ninth Circuit was affirmed in part and reversed in part by the Supreme Court. The Supreme Court conducted a two-part analysis into whether the notice-prejudice rule was a law that “regulates insurance” within the meaning of ERISA’s saving clause. First, the Court considered whether the law regulates insurance from a “common-sense” perspective. Second, the Court considered three factors used to determine whether a state law is the “business of insurance” within the meaning of the McCarran-Ferguson Act.¹⁰³ Under the first factor, the Court considers whether the law “has the effect of transferring or spreading a policyholder’s risk.” Under the second factor, the Court considers “whether the law is an integral part of the policy relationship between the insurer and the insured.” Under the third factor, the Court considers “whether the law is limited to entities within the insurance industry.” The three factors assist the Court in “verify[ing] the common sense view” of whether a law regulates insurance. The Court clarified that the three McCarran-Ferguson factors are not mandatory requirements.¹⁰⁴ Each factor does not need to be met individually, but instead, they collectively serve as “guideposts”¹⁰⁵ or “considerations to be weighed”¹⁰⁶ when determining whether a law “regulates insurance” within the meaning of ERISA’s saving clause.

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

The Court considered the second part of the “regulates insurance” analysis—the three factors used to determine whether a state law regulates the business of insurance within the meaning of the McCarran-Ferguson Act. The Court declined to decide the first factor, the risk spreading factor, because the remaining two factors were clearly satisfied. However, with respect to the “risk spreading” factor, the Court acknowledged, but did not adopt, the argument forwarded by the United States as *amicus curiae*.¹⁰⁷ In its brief, the United States noted that the notice-prejudice rule “shifts risk” to the extent that the risk of late notice and stale evidence is shifted from the insured to the insurer and may result in higher premiums and spreading risk among policyholders.¹⁰⁸ The second factor is satisfied because the notice-prejudice rule dictates the terms of the insurance contract by requiring that the insurer prove prejudice before enforcing a timeliness of claim provision in the contract.¹⁰⁹ The third factor is also satisfied because the notice-prejudice rule has more than a passing impact on the insurance industry—it is aimed at it.¹¹⁰

The Court specifically rejected UNUM’s arguments that the notice-prejudice rule conflicted with ERISA. UNUM asserted that the notice-prejudice rule conflicted with ERISA’s requirement in § 504(a)(1)(D) that requires fiduciaries to act in accordance with plan documents. The Court

¹⁰³ *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 367 (1999).

¹⁰⁴ *Id.* at 372.

¹⁰⁵ *Id.* at 374.

¹⁰⁶ *Id.* at 373.

¹⁰⁷ *Id.* at 374.

¹⁰⁸ *Id.*, citing Brief of United States as *Amicus Curiae* at 14.

¹⁰⁹ *Id.* at 374–75.

¹¹⁰ *Id.* at 375 (citations omitted).

pointed out that, under this argument, ERISA § 504 preempts any state law contrary to a written plan term, an outcome that “makes scant sense”¹¹¹ and would “virtually read the saving clause out of ERISA.”¹¹² The Court, citing *Metropolitan Life*¹¹³ and *FMC Corp.*,¹¹⁴ pointed out that it had repeatedly held that state laws mandating insurance contract terms are saved from preemption under §514(b)(2)(A).¹¹⁵

UNUM also attempted to convince the Court that ERISA’s civil remedies preempt any action for plan benefits brought under state rules. The Court summarily disposed of this argument by pointing out that the cause of action in this case was brought pursuant to ERISA § 502(a)(1)(B). However, the Court specifically acknowledged in a footnote the United States’ argument as *amicus curiae* that, notwithstanding *Pilot Life*, a state law that “regulates insurance” within the meaning of the saving clause is saved from preemption even if it provides a state law cause of action or remedy.¹¹⁶

However, the Court rejected the Ninth Circuit’s conclusion that the *Elfstrom* rule does not “relate to” an ERISA plan and, therefore, was not preempted. The Court pointed out that the *Elfstrom* rule, by “deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration.”¹¹⁷ Therefore, the *Elfstrom* rule “relates to” an ERISA plan and is preempted, though that did not affect the outcome of this case because UNUM was not prejudiced by the late notice..

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

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

The Court explained that there is a presumption against preemption that informs the saving clause analysis. According to the Court, the “unhelpful drafting” of ERISA’s preemption and saving clauses require that the ordinary meaning of these “antiphonal phrases” be qualified by the assumption that “the historic police powers of the states were not meant to be superseded unless it was the clear and manifest purpose of Congress.”¹¹⁸

The Court stated that the Illinois independent review law “related to” an ERISA plan because it “bears indirectly but substantially on all insured benefit plans (citation omitted) by requiring them

¹¹¹ *Id.*

¹¹² *Id.* at 376.

¹¹³ 471 U.S. at 758.

¹¹⁴ 498 U.S. at 64.

¹¹⁵ *Id.* at 375–376.

¹¹⁶ *Id.* at n.7.

¹¹⁷ *Id.* at 379.

¹¹⁸ *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 364–365 (2002) (citations omitted).

to submit to an extra layer of review for certain benefit denials”¹¹⁹ and would be preempted unless it “regulates insurance” within the meaning of the saving clause.

The Court held that an HMO is both a health care provider and an insurer.¹²⁰ By underwriting and spreading the risk of treatment costs among the HMO participants, the HMO performs a traditional insurance function. The fact that an HMO may also provide medical services or that it may transfer some of its risk to the providers does not take the HMO out of the insurance business.¹²¹ The Court also recognized that Congress intended for state insurance laws to apply to HMOs and that most state insurance departments are primarily responsible for the regulation of HMOs.¹²² The Court stated that the application of the law to HMOs acting solely as administrators did not lead to preemption of its application to HMOs acting as insurers.¹²³

The Court applied the three McCarran-Ferguson factors,¹²⁴ pointing out that all three factors are not required in order for a law to regulate insurance within the meaning of the saving clause.¹²⁵ The Court confirmed its “common sense” conclusion by observing that the statute met at least two of the three factors: (i) it regulated an integral part of the policy relationship between the insured and insurer by providing “a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMO’s medical obligations”¹²⁶ and (ii) the statute was aimed at a practice limited to entities within the insurance industry for the same reasons it satisfied the common sense test.¹²⁷

The Court then addressed the *Pilot Life* doctrine. While acknowledging the “extraordinary preemptive power”¹²⁸ of ERISA’s civil enforcement provisions, the Court also noted that the saving clause was “designed to save state law from being preempted.”¹²⁹ The Court explained that the Illinois law does not “supplement or supplant the federal scheme by allowing beneficiaries to obtain remedies under state law that Congress rejected in ERISA”¹³⁰ because the Illinois law “provides no new cause of action under state law and authorizes no new form of ultimate relief.”¹³¹

The Court made clear that even though deferential review is “highly prized by benefit plans,” ERISA does not require that a plan’s benefit determinations be discretionary or receive deferential review.¹³² The Court stated that the Illinois law effectively “prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract’s terms” and

¹¹⁹ *Id.* at 365.

¹²⁰ *Id.* at 367.

¹²¹ *Id.*

¹²² *Id.* at 367–69.

¹²³ *Id.* at 371–72.

¹²⁴ See discussion of *Metropolitan Life v. Massachusetts*, *supra*.

¹²⁵ 536 U.S. at 373, citing *UNUM*, *supra*, 458 U.S. at 129.

¹²⁶ *Id.* at 373–74.

¹²⁷ *Id.* at 374.

¹²⁸ *Id.* at 376.

¹²⁹ *Id.* at 375.

¹³⁰ *Id.* at 378 (internal quotations omitted).

¹³¹ *Id.* at 379.

¹³² *Id.* at 384–87.

in this way, “is no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption.”¹³³ The Court observed further that, in contrast to a traditional arbitration proceeding, the law “does not give the independent reviewer a free-ranging power to construe contract terms.” Instead, the law established a process that relied on a qualified professional’s determination of medical necessity that was not adjudicatory in nature and did not conflict with ERISA’s exclusive remedy.¹³⁴

The *Rush Prudential* Court ruled that the Illinois independent review law is not preempted. However, the Court left open the possibility that a state independent review scheme might conflict sufficiently with ERISA to be preempted. *Rush Prudential* involved a state review process that resolves only disputes concerning application of medical judgment. Also, the Court mentioned that a state law would be preempted if it imposed “procedures so elaborate, and burdens so onerous that they might undermine [ERISA’s civil enforcement provisions].”¹³⁵ However, this concession is made only after the Court stated its view that state independent review laws, while entailing different procedures, would not impose unacceptable administrative burdens so as to be preempted.¹³⁶ The Court explained that disuniformities are the inevitable result of the congressional decision to save state insurance laws and that HMOs have to establish procedures for conforming with local laws in any event.¹³⁷

In the years following the *Rush Prudential* decision, external review requirements have become a standard health insurance consumer protection, and in the Affordable Care Act, Congress not only mandated that insurers comply with applicable state external review laws, incorporating them by reference into federal law,¹³⁸ but also established a federal external program for self-funded ERISA plans and for insured health plans in states that did not have external review laws consistent with the NAIC Uniform External Review Model Act.¹³⁹

KENTUCKY ASSOCIATION OF HEALTH PLANS v. MILLER,
538 U.S. 329 (2003)

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

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

¹³³ *Id.* at 386.

¹³⁴ *Id.* at 383.

¹³⁵ *Id.* at 381 n.11.

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ PHS § 2719(b)(1).

¹³⁹ *Id.* § 2719(b)(2).

offering chiropractic benefits include in their networks all chiropractors willing to accept the terms of the contract.

In determining that Kentucky’s AWP laws regulated insurance, the Court announced a new two-part test for determining whether a state law regulates insurance.¹⁴⁰ The first part of the new test requires that the state law be “specifically directed towards entities engaged in insurance.”¹⁴¹ To explain this test, the Court referred to its previous opinions in *Pilot Life, Rush Prudential and FMC Corp.*¹⁴² In order for a state law to be “specifically directed toward” the insurance industry, the state law must be more than a law of general application with some bearing on insurers.¹⁴³ But even a law specifically directed at the insurance industry must regulate an insurer with respect to the insurer’s insurance practices.¹⁴⁴

Further, the Court made clear that a state law’s impact on non-insurers is not inconsistent with the requirement that a law be “specifically directed toward” the insurance industry and does not take the law the outside the scope of ERISA’s saving clause.¹⁴⁵ The Kentucky Association of Health Plans argued that Kentucky’s AWP laws were not specifically directed at the insurance industry because of: (1) their impact on providers;¹⁴⁶ and (2) their application to “self-insurer or multiple employer arrangements not exempt from state regulation by ERISA”¹⁴⁷ and HMOs that provide administrative services only to self-insured plans.¹⁴⁸ The Court rejected these arguments.

The Court observed that all laws that regulate insurers will have some impact on entities that have relationships with those insurers, including laws the Court held regulated insurance in *FMC Corp.* and *Rush Prudential*.¹⁴⁹ With respect to the scope of the Kentucky AWP laws, the court pointed out that ERISA’s saving clause requires that a state law “regulate insurance,” not “insurance companies” or the “business of insurance.”¹⁵⁰ Therefore, the fact that Kentucky’s AWP laws apply to self-insurers and multiple employer welfare arrangements, which are entities engaged in the same kind of risk-spreading activities as are insurance companies, does not forfeit the laws’ status as laws regulating insurance within the meaning of the saving clause.¹⁵¹ ERISA’s deemer clause¹⁵² prevents states from regulating self-funded ERISA plans that they could otherwise regulate.¹⁵³

¹⁴⁰ *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329, 341–342 (2003).

¹⁴¹ *Id.* at 342.

¹⁴² *Id.* at 334–335.

¹⁴³ *Id.*, citing *Pilot Life v. Dedeaux*, 481 U.S. 41, 50; *Rush Prudential v. Moran*, 536 U.S. 355, 366; *FMC Corp v. Holliday*, 498 U.S. 52, 61.

¹⁴⁴ 538 U.S. at 334 citing *Rush Prudential v. Moran*, 536 U.S. 366.

¹⁴⁵ *Id.* at 334–335.

¹⁴⁶ *Id.* at 335–336.

¹⁴⁷ *Id.* at 336 n.1.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 335.

¹⁵⁰ *Id.* at 336 n.1.

¹⁵¹ *Id.*

¹⁵² ERISA § 514(b)(2)(B).

¹⁵³ 538 U.S. at 336 n.1.

The Court employed this same analysis to explain that Kentucky’s AWP laws are “specifically directed towards” the insurance industry, even though they apply to HMOs administering self-insured plans. The Court concluded that the activity of administering a self-insured plan, which the Court already explained engages in risk-spreading functions identical to insurers, is sufficient to bring the HMO within the activity of insurance for the purposes of ERISA’s saving clause, even though the deemer clause would prevent a state from applying the law to a self-funded plan.¹⁵⁴ Further, the Court in *Rush Prudential* had previously explained that Congress did not intend for overbreadth in the application of a state law to remove a state law entirely from the category of state regulation saved from preemption.¹⁵⁵

The second part of the new saving clause analysis requires that the state law “substantially affect the risk pooling arrangement between the insurer and the insured.” This new test is a “clean break from the McCarran-Ferguson factors”¹⁵⁶ and does not require that the state law actually “spread risk,”¹⁵⁷ or “alter or control the actual terms of insurance policies” in order to regulate insurance within the meaning of the saving clause.¹⁵⁸ The Court explained that Kentucky’s AWP laws meet the second part of the new test by “alter[ing] the scope of permissible bargains between insurers and insureds in a manner similar to the mandated benefit laws we upheld in *Metropolitan Life*, the notice-prejudice rule we sustained in *UNUM*, and the independent review provisions we approved in *Rush Prudential*.”¹⁵⁹

The practical effect of the Court’s new two-part test on state laws remains to be seen. Perhaps the fact that the McCarran-Ferguson factors are no longer a part of the preemption analysis will result in more laws being considered laws that regulate insurance within the meaning of the saving clause. On the other hand, the McCarran-Ferguson factors were only guideposts used to reinforce the common-sense understanding of whether a law regulated insurance, and a rigid interpretation of the risk-spreading factor, in particular, had already been set aside by the Court in *UNUM* and *Rush Prudential*. More than a decade later, the full impact of this change to the preemption test remains uncertain, and continues to be disputed in the lower courts.

AETNA HEALTH INC. v. DAVILA,
542 U.S. 200 (2004)

In *Aetna Health Inc. v. Davila*, the Supreme Court revisited the question first raised in *Pilot Life*, and reaffirmed that ERISA’s exclusive remedy preempts conflicting state laws even if the law is a statute expressly directed toward the insurance industry. Although the Court has still never squarely held that any state law actually falls within the *Pilot Life* exception to the Saving Clause, it made clear that if any law providing an alternative remedy for ERISA plan participants were found someday to regulate the business of insurance, it would nevertheless be preempted.¹⁶⁰

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* at 341.

¹⁵⁷ *Id.* at 339 n.3.

¹⁵⁸ *Id.* at 338.

¹⁵⁹ *Id.* at 338–339.

¹⁶⁰ *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), decided together with *CIGNA HealthCare of Texas, Inc. v.*

In 1997, the Texas Legislature enacted a provision in its Civil Practice and Remedies Code establishing that a health insurance carrier, HMO, or other managed care entity has a duty to exercise ordinary care when making health care treatment decisions, and creating a private cause of action for insureds and enrollees who claim to be harmed by a carrier's negligence.¹⁶¹ Juan Davila filed suit against Aetna, his employer's insurer, alleging that he suffered a severe reaction to a pain medication he had taken because Aetna required "step therapy" and refused to cover a safer medication that his doctor had prescribed. Aetna removed the case to federal court, but the Fifth Circuit remanded it to state court,¹⁶² ruling that the claim denial was not an ERISA fiduciary decision and that the tort remedy under Texas law had no counterpart in ERISA and therefore did not conflict with ERISA's exclusive remedy.

The Supreme Court reversed, holding that by its nature, an ERISA benefit determination is generally a fiduciary act, and the "fact that a benefits determination is infused with medical judgments does not alter this result"¹⁶³ Rejecting the plaintiffs' argument that "ordinary care" was a separate statutory duty under state law that was independent of the benefit determination,¹⁶⁴ the Court concluded that the Texas law "related to" an ERISA plan and was preempted because it conflicted with "Congress' intent to make the ERISA civil enforcement mechanism exclusive."¹⁶⁵ The Court did not decide whether the law "regulated insurance" within the meaning of the saving clause. Instead, after noting that the plaintiffs had not made that argument in the lower courts, the Court held that even if the Texas law could "arguably be characterized as 'regulating insurance,'" the exclusive remedy clause would still control over the saving clause.¹⁶⁶ The Court cited *Rush Prudential* for the proposition that "a comprehensive remedial scheme can demonstrate an 'overpowering federal policy' that determines the interpretation of a statutory provision designed to save state law from being pre-empted. ERISA's civil enforcement provision is one such example."¹⁶⁷ Although the Court was unanimous, Justice Ginsburg issued a concurring opinion, joined by Justice Breyer, urging Congressional action to correct "an unjust and increasingly tangled ERISA regime" leaving "a regulatory vacuum" in which "virtually all state law remedies are preempted but very few federal substitutes are provided."¹⁶⁸

Calad, involving an action brought under the same Texas statute by a CIGNA enrollee.

¹⁶¹ Tex. Civ. Prac. & Rem. Code § 88.002 (2018). In response to *Davila*, Tex. Civ. Prac. & Rem. Code § 88.0015 was added in 2005, making Chapter 88 inapplicable to ERISA plans. Although the Texas law is part of its civil practice code, some states include similar provisions within their insurance codes. See, e.g., Maine Health Plan Improvement Act at 24-A Me. Rev. Stat. Ann. § 4313 (2018).

¹⁶² *Roark v. Humana, Inc.*, 307 F.3d 298 (2002). The *Roark* companion case did not reach the Supreme Court with *Davila* and *Calad* because the Fifth Circuit upheld removal on the ground that the complaint also included a count for breach of contract, which was completely preempted by ERISA, giving rise to federal jurisdiction over the entire case (a warning for practitioners). A fourth companion case involved a governmental plan, so ERISA did not apply.

¹⁶³ 542 U.S. at 219.

¹⁶⁴ *Id.* at 215.

¹⁶⁵ *Id.* at 216.

¹⁶⁶ *Id.* at 217–218.

¹⁶⁷ *Id.* at 217 (citations omitted). See discussion of *Rush Prudential v. Moran*, *supra*.

¹⁶⁸ *Id.* at 222 (Ginsburg, J., concurring) (citations and internal punctuation omitted).

METROPOLITAN LIFE INS. CO. v. GLENN,
554 U.S. 105 (2008)

In *Metropolitan Life Ins. Co. v. Glenn*, the Supreme Court held that the principles set forth in *Firestone* still apply when the benefit plan is fully insured. If the insurer has been granted valid discretionary authority,¹⁶⁹ it is entitled to deference when its decisions are reviewed in ERISA litigation, notwithstanding the inherent conflict of interest that arises from its status as “a plan administrator [that] both evaluates claims for benefits and pays benefits claims.”¹⁷⁰ However, that deference is more limited than the deference that would be given to an independent decisionmaker, and the court must apply a “combination-of-factors method of review” that gives due consideration to the conflict.¹⁷¹

Wanda Glenn filed a claim under her employer’s group long-term disability policy, issued by Metropolitan Life. The insurer found her to be unable to perform her job duties and awarded benefits for two years, but once the policy’s two-year “own-occupation” period had expired, she was required to prove that she was unable to perform “the material duties of any gainful occupation for which [she was] reasonably qualified” in order to continue receiving benefits.¹⁷² At the insurer’s request, Glenn had applied for Social Security disability benefits,¹⁷³ which are also based on an “any occupation” standard, and the Administrative Law Judge found her eligible, ruling that she was disabled “from performing any jobs [for which she could qualify,] existing in significant numbers in the national economy.”¹⁷⁴ Nevertheless, the insurer conducted an independent review, decided that Glenn was insufficiently disabled, and denied benefits. After Glenn’s internal appeals were denied, she filed suit under ERISA.¹⁷⁵

Pursuant to a discretionary clause, the insurer was designated as Claim Fiduciary and was granted “discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan.”¹⁷⁶ The insurer argued that its self-interest in the outcome of claim disputes should not diminish the deference that administrators with discretionary authority are granted under *Firestone*, because the employer had

¹⁶⁹ At this writing, the Supreme Court has not yet addressed whether states retain the power under the saving clause to enact laws preventing insurers from being granted discretionary authority. However, all the Circuit Courts of Appeals that have considered the issue have upheld state prohibitions against discretionary clauses in insurance policies. See p.100 below.

¹⁷⁰ *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 112 (2008). Similarly, in *Conkright v. Frommert*, 559 U.S. 506, 513, the Court held that after an administrator’s decision is set aside as an unreasonable interpretation of the plan documents, its new decision is still entitled to deference and is not tainted by the prior adverse findings.

¹⁷¹ *Id.* at 118.

¹⁷² *Id.* at 109.

¹⁷³ Disability policies contain offset clauses, so that when the beneficiary is eligible for Social Security disability benefits, what the insurance provides is income enhancement from the level provided by Social Security to the level guaranteed by the policy. The policies require beneficiaries to apply for Social Security when it is available.

¹⁷⁴ 554 U.S. at 109.

¹⁷⁵ *Id.*

¹⁷⁶ Brief of Petitioner at 3. The NAIC Prohibition on the Use of Discretionary Clauses Model Act (Model No. 42) was amended in 2004 to include disability policies within its scope, but some states either permit discretionary clauses or prohibit them only for medical insurance policies. Challenges to the validity of laws prohibiting discretionary clauses are discussed below in the FAQ, at Page 100.

approved the terms under which the Plan would be administered by the same company that was paying the benefits.¹⁷⁷ It argued further that when claim decisions are made by a professional insurance company, paying claims is its business and the market provides strong incentives to make accurate claim decisions.¹⁷⁸

The Court agreed that the insurer was entitled to deference under *Firestone*, and that its self-interest in the outcome did not require *de novo* review of its claim denials.¹⁷⁹ It did not consider the possibility that a *Firestone* “discretionary trust” analysis might not be the best way to decide whether an insurer has complied with its contractual obligations under an insurance policy,¹⁸⁰ when the insurer is not merely the administrator of the contract but one of the parties. However, the Court held that there is an inherent conflict of interest when “a plan administrator both evaluates claims for benefits and pays benefits claims,” and that conflict “must be weighed as a factor in determining whether there is an abuse of discretion.”¹⁸¹

Thus, a nuanced, case-specific, multi-factor analysis is required. The Court held that the Sixth Circuit had properly applied this standard, enumerating the various factors that were weighed, including in particular “the fact that MetLife had encouraged Glenn to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in doing so (the remainder going to the lawyers it recommended), and then ignored the agency’s finding.”¹⁸² Therefore, the Court affirmed the ruling that Glenn was entitled to reinstatement of her benefits.

GOBEILLE v. LIBERTY MUTUAL INS. CO.,
577 U.S. ---, 136 S.Ct. 936 (2016)

In *Gobeille v. Liberty Mutual Ins. Co.*, the Court held that states cannot require self-insured ERISA plans or their third-party administrators to participate in all-payer claims databases, which provide a comprehensive resource intended to track substantially all health care expenditures in the state.

Vermont’s law was challenged by two insurance companies, but neither of them was acting in its capacity as an insurer.¹⁸³ The plaintiff, Liberty Mutual, provided a self-funded employee health plan for its 80,000 U.S. employees. Fewer than 200 were located in Vermont, so Liberty Mutual was below the mandatory reporting threshold. However, the plan was administered by Blue Cross Blue Shield of Massachusetts (BCBSMA), which had enough TPA activity in Vermont that it was

¹⁷⁷ 554 U.S. at 112.

¹⁷⁸ *Id.* at 114.

¹⁷⁹ *Id.* at 116. The Court noted that the stronger the safeguards that have been established to ensure impartial and accurate decisionmaking, the less significant the conflict of interest becomes, “perhaps to the vanishing point.” *Id.* at 117.

¹⁸⁰ See Brief of *Amicus Curiae* NAIC at 20–21. The only time the Justices used any form of the word “contract” was in a string citation in a dissenting opinion, describing one of the cited cases as involving a “pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics.” 554 U.S. at 123 (Roberts, C.J., dissenting in part and concurring in the judgment).

¹⁸¹ 554 U.S. at 111–12 (internal punctuation and citations omitted).

¹⁸² *Id.* at 118.

¹⁸³ Therefore, the Court did not consider the question of whether the saving clause protects such laws as applied to insured plans.

required to report claims to the database on behalf of all of its Vermont clients.¹⁸⁴ Liberty Mutual instructed BCBSMA not to report any information from the Liberty Mutual plan, and sought a declaratory judgment that the statute was preempted by ERISA.

Vermont asserted that the statute was a public health law rather than an employee benefit law, and that it did not impose any material costs on employers, so that its incidental impact on employee benefit plans did not “relate to” ERISA plans as the Court had interpreted that term in *Travelers*.¹⁸⁵ The Court, however, described reporting as a core obligation under ERISA, particularly so because ERISA’s regulatory scheme relies on recordkeeping and disclosure rather than on imposing substantive requirements on benefit plans.¹⁸⁶ Therefore, the Court held that preemption “is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans,”¹⁸⁷ and because federal authority occupies the field, preemption does not require any inquiry into whether a particular state requirement is in fact novel, inconsistent or burdensome.¹⁸⁸ Although ERISA reporting concentrates on financial matters, that does not mean reporting of health data is reserved for the states to regulate; the Court held that it is sufficient that USDOL has the authority to require reporting of health data and has chosen not to do so.¹⁸⁹

Justice Breyer wrote a separate concurrence to note that USDOL’s authority to prescribe reporting requirements included the ability to collect this data for the states or to mandate compliance with state reporting requirements.¹⁹⁰

Justice Ginsburg dissented, joined by Justice Sotomayor. She interpreted *Travelers*, *Dillingham* and *De Buono* as having “reined in” the “relate to” clause “so that it would no longer operate as a ‘super-preemption’ provision.”¹⁹¹ She observed that seventeen states already had similar laws, which “serve compelling interests, including identification of reforms effective to drive down health care costs, evaluation of relative utility of different treatment options, and detection of instances of discrimination in the provision of care.”¹⁹² She criticized the focus on “the sheer number of data entries that must be reported to Vermont.... Entirely overlooked in that enumeration is the technological capacity for efficient computer-based data storage, formatting, and submission” of this information, which any insurer or plan administrator generates in the ordinary course of business.¹⁹³ She concluded that the law should not be preempted because it is a law that “applies to all health care payers and does not home in on ERISA plans,”¹⁹⁴ and does not

¹⁸⁴ *Gobeille v. Liberty Mutual Ins. Co.*, 136 S.Ct. 936, 942 (2016).

¹⁸⁵ *Id.* at 946. *See supra* pp. 20-21.

¹⁸⁶ *Id.* at 943–945. While this is an accurate description of the traditional ERISA approach, the Affordable Care Act has now included self-insured ERISA plans within the scope of many of its substantive protections, *See ERISA* § 715, *enacted by PPACA* § 1563(e).

¹⁸⁷ *Id.* at 945.

¹⁸⁸ *Id.*.

¹⁸⁹ *Id.* at 945–946.

¹⁹⁰ *Id.* at 949. Justice Thomas also concurred separately, agreeing with the majority’s interpretation of ERISA but questioning whether ERISA was constitutional. *Id.* at 947.

¹⁹¹ *Id.* at 958. *See supra* pp. 20-24 .

¹⁹² *Id.* at 951.

¹⁹³ *Id.* at 956.

¹⁹⁴ *Id.* at 953.

relate to or interfere with ERISA’s exclusive regulation of the management and solvency of ERISA plans or address relationships between entities that are subject to ERISA.¹⁹⁵

RUTLEDGE v. PHARMACEUTICAL CARE MANAGEMENT ASS’N,
141 S.Ct. 474 (2020)

In *Rutledge v. PCMA*, the Court upheld an Arkansas law, Act 900, which required pharmacy benefits managers (“PBMs”)¹⁹⁶ to reimburse pharmacies at a price equal to or higher than what the pharmacy paid to buy the drug. Act 900 required PBMs to provide administrative appeal procedures for pharmacies to challenge reimbursement prices that are below the pharmacies’ acquisition costs, and it also authorized pharmacies to decline to dispense drugs when a PBM would provide a below-cost reimbursement. Act 900 applied to all transactions between PBMs and pharmacies, including transactions where the PBM was acting on behalf of a self-insured ERISA plan. Thus, the saving clause was not at issue in this case.

In a suit brought by Pharmaceutical Care Management Association (“PCMA”), a national trade association representing 11 PBMs, the Eastern District of Arkansas had ruled that Act 900 was preempted by ERISA, and the Eighth Circuit affirmed.¹⁹⁷ Both courts relied on a recent Eighth Circuit decision striking down a similar Iowa law because it “made ‘implicit reference’ to ERISA by regulating PBMs that administer benefits for ERISA plans”¹⁹⁸ and “was impermissibly ‘connected with’ an ERISA plan because, by requiring an appeal process for pharmacies to challenge PBM reimbursement rates and restricting the sources from which PBMs could determine pricing, the law limited the plan administrator’s ability to control the calculation of drug benefits.”¹⁹⁹

The Supreme Court, however, held that because Act 900 “regulates PBMs whether or not the plans they service fall within ERISA’s coverage,” it is analogous to the law upheld by the Court in *Travelers*, “which did not refer to ERISA plans because it imposed surcharges ‘regardless of whether the commercial coverage [was] ultimately secured by an ERISA plan, private purchase, or otherwise.’”²⁰⁰ The Court held that under *Travelers*, “State rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage are not preempted by ERISA.”²⁰¹

The Court rejected PCMA’s contention “that Act 900 has an impermissible connection with an ERISA plan because its enforcement mechanisms both directly affect central matters of plan administration and interfere with nationally uniform plan administration.”²⁰² The Court acknowledged that Act 900 required ERISA plan administrators to “comply with a particular

¹⁹⁵ *Id.* at 954–55.

¹⁹⁶ As the term is spelled in Act 900. Supreme Court style refers to “pharmacy benefit managers.”

¹⁹⁷ *PCMA v. Rutledge*, 891 F.3d 1109 (8th Cir. 2018).

¹⁹⁸ 141 S.Ct. at 479, quoting *PCMA v. Gerhart*, 852 F.3d 722, 729 (8th Cir. 2017).

¹⁹⁹ *Id.* at 479, quoting *Gerhart*, 852 F.3d at 726, 731.

²⁰⁰ *Id.* at 481, quoting *Travelers*, 514 U.S. at 656.

²⁰¹ *Id.* at 480, citing *Travelers*, 514 U.S. at 668.

²⁰² *Id.* at 481–482.

process” and standards,²⁰³ but explained that those enforcement mechanisms “do not require plan administrators to structure their benefit plans in any particular manner, nor do they lead to anything more than potential operational inefficiencies” for PBMs.²⁰⁴ The Court emphasized that State law governs disputes between plans and providers.²⁰⁵ The Court held further that ERISA did not preempt Act 900’s decline-to-dispense provision, even though it “effectively denies plan beneficiaries their benefits” because any denial of benefits would be the consequence of the lawful state regulation of reimbursement rates and the PBM’s refusal to comply.²⁰⁶

Finally, the Court rejected PCMA’s claim that the law had an impermissible “reference to” ERISA. As the Court explained, Act 900 “applies to PBMs whether or not they manage an ERISA plan,” and Act 900 did not treat ERISA plans differently than non-ERISA plans.²⁰⁷

However, *Rutledge* does not represent an open-ended approval of state pharmacy benefit regulation in general. The Court only considered the provisions of the Arkansas PBM law as they stood at the time PCMA filed its preemption challenge. While *Rutledge* was making its way through the appellate courts, Arkansas amended its PBM law to add new requirements and prohibitions, so it is important that *Rutledge* not be read as a finding that the Court analyzed Arkansas’ PBM law as it existed in 2020. Additionally, the Court did not address issues that have been raised by other State PBM-pharmacy laws, including laws regulating networks, prohibitions and limitations on corporate practice of medicine, and laws regulating what pharmacies may discuss with their patients. The *Rutledge* decision has opened the door to additional ERISA challenges, which, at the time of this writing are making their way through the courts.

Conclusion

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

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

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

²⁰³ *Id.* at 482, quoting PCMA brief at 24.

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ *Id.*

²⁰⁷ *Id.* at 481.

- Subject to the saving clause, state laws that “relate to” employee welfare benefit plans are preempted by ERISA.
- “Relate to” means having a reference or a connection to an employee welfare benefit plan.
- A state law of general applicability that has an indirect economic influence on ERISA plans, does not “relate to” an ERISA plan and therefore is not preempted by ERISA. State laws that impose such high indirect costs on ERISA plans that the laws force ERISA plans to adopt a certain scheme of substantive coverage or effectively restrict a plan’s administration may be preempted by ERISA.
- The status of a law otherwise “saved” as a law that regulates insurance is not changed even if the law has the effect of indirectly regulating the substance of ERISA plans that purchase insurance.
- While states can regulate the business of insurance and the terms of insurance contracts purchased by employee welfare benefit plans, they cannot apply those laws directly to employee welfare benefit plans.
- A state law is “saved” to the extent that it regulates insurance even if the law’s application to noninsurers is preempted.

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

ERISA PLAN CHARACTERISTICS AND RELATIONSHIP TO STATE REGULATION

The relevance of the preemption analysis discussed in the preceding section presupposes the existence of an ERISA-covered plan. However, not all entities meet the criteria defining an ERISA-covered plan.²⁰⁸ In addition, some arrangements that meet the criteria to be a plan are exempted from ERISA coverage generally or specifically from the ERISA preemption provisions. Such entities are generally subject to state law. Problems occur when certain operators seek to take advantage of the complexities in ERISA and illegitimately claim exemption from state laws under ERISA. It is crucial that state regulators understand what constitutes an ERISA-covered plan.

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

- Single-employer plans (including certain groups of closely affiliated employers);
- Multiemployer plans (plans established pursuant to bona fide collective bargaining agreements); and
- Multiple employer welfare arrangements (MEWAs).²⁰⁹

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

Non-Covered Benefit Arrangements

Certain types of benefit arrangements are not covered by ERISA, even though they meet the basic defining criteria for employee welfare benefit plans because of the nature of the plan or the nature of the employer. For example, ERISA exempts plans maintained solely for the purpose of

²⁰⁸ State insurance regulators may seek assistance from the DOL's Employee Benefits Security Administration Office of Regulations and Interpretations by requesting a formal or informal opinion on the scope of ERISA preemption as it applies to a particular arrangement. However, this should not delay the state regulator's investigation and enforcement action. A DOL Advisory opinion is helpful, but it is only advisory, based on assumed facts, and is not required as the basis to issue an enforcement action.

²⁰⁹ It should be noted that many MEWAs are not actually employee welfare benefit plans, a fact which is recognized by the statutory definition. ERISA requirements for employee benefit plans do not apply directly to a MEWA which is not a plan, although the DOL has taken the position that each employer participating in a non-plan MEWA sponsors its own plan. *See MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*, FR Doc. 2013-04863, www.dol.gov/ebsa/pdf/mwgguide.pdf (MEWA Guide). State insurance regulators should not assume that an arrangement that has made filings with the DOL or taken other measures purporting to comply with the requirements for ERISA-covered plans is actually covered by ERISA, even if the arrangement's managers sincerely believed their arrangement was an ERISA plan.

compliance with state workers' compensation, unemployment, and disability laws.²¹⁰ ERISA also excludes governmental plans and church plans.

Regulators will find that some arrangements obviously fall under the governmental and church plan exceptions to ERISA coverage, such as state employees' retirement and health plans, plans covering police and firefighters, and plans covering employees of a specific church. However, many more plans fall outside the coverage of ERISA than may be immediately obvious. For example, many hospitals are publicly funded, and their plans may be governmental plans under ERISA. The same is true of public educational institutions. Similarly, many hospitals, schools, and nursing homes are owned by religious organizations. The plans that these organizations offer may be church plans.²¹¹

Plans excluded from ERISA coverage normally fall within the jurisdiction of the state unless they are specifically excluded under state statutes. Knowledge of the exclusion of certain types of plans from ERISA may be useful when a state wishes to assess the potential impact of legislation on entities within the insurance department's jurisdiction, or seeks to assist a consumer who may appear at first glance to be covered by an ERISA plan.²¹²

General Characteristics of an ERISA Plan

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

- established or maintained;
- by an employer or by an employee organization, or by both;
- for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits;
- to participants or their beneficiaries.²¹³

Arrangements that do not meet the definition of an ERISA plan and whose activities fall under the state's definition of the business of insurance must acquire a state certificate of authority as an insurer or cease operations. Such arrangements that do not comply with state law are subject to the unauthorized insurer statutes of the various states.²¹⁴

As with much of the language in ERISA, the definition of employee welfare benefit plan raises more questions than it answers. The administrative and judicial branches have been left with the

²¹⁰ 29 U.S.C. § 1003(b) (2018).

²¹¹ See *Advocate Health Care Network v. Stapleton*, 581 U.S. ----, 137 S.Ct. 1652 (2017) (holding that plans established and maintained by church-affiliated hospital systems were church plans).

²¹² The implications of the "governmental plan" exclusion, for example, are not always taken into consideration in drafting or implementing state legislation, resulting in a lack of clarity as to the nature and scope of regulatory oversight of self-funded state and local governmental plans.

²¹³ 29 U.S.C. § 1002(1) (2018).

²¹⁴ *Bell v. Employee Security Benefit Ass'n*, 437 F.Supp. 382 (D. Kan. 1977).

task of providing guidance to state insurance regulators and legislators, insurance industry representatives, and employers on what makes an arrangement an employee welfare benefit plan within the meaning of ERISA.

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

Plan, Fund, or Program Established or Maintained Requirement

The first element of the definition of an employee welfare benefit plan is whether an arrangement is a “plan, fund, or program” that has been “established or maintained.” The Eleventh Circuit specifically discussed this requirement in the much-cited *Donovan v. Dillingham*.²¹⁵ In its analysis, the court stated that the minimum criteria to use to determine whether there was a plan, fund, or program was whether there were:

- intended benefits,
- intended beneficiaries,
- a source of financing, and
- a procedure to apply for and collect benefits.²¹⁶

The *Donovan* court noted that a plan, fund, or program has been “established or maintained” if “a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.”²¹⁷

The Court noted that an employer does not “establish” a plan merely by deciding to offer benefits. To prove the existence of an employee benefit plan, the employer must provide evidence that its decision has actually been implemented. Furthermore, although the purchase of health insurance is substantial evidence that a plan has been established, the Court stated that it is not by itself conclusive proof.²¹⁸

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

²¹⁵ *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982). At issue in *Donovan* was whether the District Court had subject matter jurisdiction to decide if a particular multiple employer trust was subject to the fiduciary requirements of ERISA. The Eleventh Circuit held that the District Court did have subject matter jurisdiction. The Court stated that a consensus existed among the courts, congressional committees, and the Secretary of the U.S. Department of Labor that multiple employer trusts are generally not employee welfare benefit plans. *Id.* at 1372. However, they may be subject to ERISA’s fiduciary responsibilities if they are fiduciaries to employee benefit plans established by others, such as in this case. *Id.* at 1372 n.10.

²¹⁶ *Id.* at 1372.

²¹⁷ *Id.* at 1373.

²¹⁸ *Id.*

- No contributions are made by an employer or employee organization;
- Participation [in] the program is completely voluntary for employees or members;
- The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
- The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.²¹⁹

In *Johnson v. Watts*,²²⁰ the First Circuit discussed the “established and maintained” requirement in the context of this regulation. It specifically focused on the meaning of the third criterion of employer neutrality. The court stated that the employer “would be said to have endorsed a program ... if, in light of all the surrounding facts and circumstances, an objectively reasonable employee would conclude on the basis of the employer’s actions that the employer had not merely facilitated the program’s availability but had exercised control over it or made it appear to be part and parcel of the company’s own benefit package.”²²¹

In this case, the court held that the employer had not endorsed the program although it had collected premiums through payroll deductions, remitted insurance premiums to CIGNA, issued certificates, kept track of employee eligibility, distributed sales brochures and other materials necessary for enrollment, and recommended enrollment through a letter to employees in which the letter specifically stated that the decision was exclusively the employees’. The court also noted that the employees paid the entire cost of their own insurance, and that the employer did not participate in designing the plan, working out its structural components, determining eligibility for coverage, interpreting policy language, investigating, allowing, and disallowing claims, handling litigation, or negotiating settlements.²²² The court contrasted the facts in this case with the facts of *Hansen v. Continental Ins. Co.*²²³ In *Hansen*, the employer performed many of the same functions as the employer in *Johnson*. Nevertheless, the court held that the employer had endorsed the plan because the employer had distributed material about the insurance program in a booklet embossed with the corporate logo. In addition, the booklet referred to the plan as the company’s plan.²²⁴

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

- the employer intended to provide benefits on a regular and long-term basis;
- the employer financially contributed to the plan; and

²¹⁹ 29 C.F.R. § 2510.3-(j) (2018).

²²⁰ *Johnson v. Watts*, 63 F.3d 1129 (1st Cir. 1995).

²²¹ *Id.* at 1135.

²²² *Id.* at 1135–36.

²²³ *Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991).

²²⁴ *Johnson*, 63 F.3d at 1137.

- the employer had sufficient involvement with the administration of the plan.²²⁵

Employer or Employee Organization Requirement

The second element is whether an arrangement is sponsored by an “employer or employee organization.” An arrangement is not an ERISA plan unless the entity that establishes or maintains it is an employer or employee organization of the individuals covered by the plan.

Direct and Indirect “Employers”: Although the statute refers to a plan established or maintained by “an employer,” the term “employer” is defined in ERISA as “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.”²²⁶ Thus, the sponsor of an ERISA plan could be an “indirect employer,” such as an employer association. Historically, DOL and the courts construed this term narrowly, requiring that to be a bona fide employer association “acting ... indirectly in the interest of an employer,” the employers that constitute the association must have direct or indirect control over the benefit plan. DOL has identified a variety of factors that are relevant to determining whether a bona fide employer association exists. These factors include:

- how members are solicited;
- who is entitled to participate and who actually participates in the association;
- the process by which the association was formed;
- the purposes for which it was formed;
- what, if any, were the preexisting relationships of its members;
- the powers, rights, and privileges of employer members that exist by reason of their status as employers; and
- who actually controls and direct the activities and operations of the benefit program.²²⁷

Associations of otherwise unrelated employers established for the purpose of sponsoring a profit-making plan which is made generally available and which is not controlled by employer members do not meet the definition of bona fide employers, and their plans are not ERISA plans.²²⁸

In October of 2017, President Trump issued an Executive Order directing the Secretary of Labor to “consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs [Association Health Plans]” and to “consider ways to promote AHP formation on the basis of common geography or industry.”²²⁹ In June of 2018, DOL adopted a new Final Rule entitled “Definition of ‘Employer’ Under Section

²²⁵ See, e.g., *Wickman v. Northwestern National Ins. Co.*, 908 F.2d 1077 (1st Cir. 1990); *Grimo v. Blue Cross/Blue Shield, of Vt.*, 34 F.3d 148 (2nd Cir. 1994), 899 F. Supp. 196 (D. Vt. 1995).

²²⁶ 29 U.S.C. § 1002(5) (2018).

²²⁷ Department of Labor Opinion 94-07A re: *United Service Association for Health Care* (Mar. 14, 1994); see generally MEWA Guide, *supra* note 209.

²²⁸ *Id.*

²²⁹ Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, EO 13813, October 12, 2017.

3(5) of ERISA—Association Health Plans,”²³⁰ which makes “bona fide group or association of employers” a formal legal term, and establishes the following criteria for “bona fide” status:

- It “must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits”; however, offering and providing health coverage as its primary purpose is no longer inconsistent with “bona fide” status;²³¹
- Each participating employer must be the direct employer of at least one participating employee; however, working owners (partners, shareholders, and sole proprietors) are considered employees for this purpose if they work at least 20 hours per week or 80 hours per month, or earn enough from the business to pay for the coverage;²³²
- It must have “formal organizational structure with a governing body and has by-laws or other similar indications of formality”;²³³
- Employer control of both the association and the health plan “must be present both in form and in substance”;²³⁴
- Member employers must either be in the same trade, industry, line of business, or profession, or be located in the same region within a single state or metropolitan area;²³⁵
- Coverage must be limited to current or certain former employees and their beneficiaries;²³⁶
- It may not engage in underwriting or rating discrimination on the basis of health status, nor use a facially neutral criterion such as geography as a pretext for prohibited discrimination. This prohibits experience rating at the employer level, but does not prohibit occupation or industry rating based on aggregate claims experience;²³⁷ and
- It may not be a health insurance issuer, nor be owned or controlled by an issuer; this does not prohibit an issuer or its affiliate from being a member employer.²³⁸

The Rule is effective September 1, 2018, for fully insured plans, on January 1, 2019, for existing non-fully-insured plans, and on April 1, 2019 for all other plans. The accompanying DOL Fact Sheet describes the Rule as providing “a new pathway” for establishing AHPs, while it also “retains the existing AHP pathway.”²³⁹ In other words, the criteria set forth in the Rule are a safe harbor that will entitle the AHP’s sponsor to recognition as a “bona fide” group or association, but arrangements qualifying as employee benefit plans under prior DOL guidance will continue to be recognized as employee benefit plans. The Rule’s Preamble explains that it “provides an additional

²³⁰ 83 F.R. 27812, June 21, 2018.

²³¹ 29 CFR § 2510.3-5(b)(1).

²³² *Id.* §§ 2510.3-5(b)(2) & (e)(2)(iii). Except for purposes of participation in AHPs, working owners and their spouses are not considered “employees” for purposes of ERISA. *Id.* § 2510.3-3(c). HIPAA permits partners to be covered by group health plans as employees, but sole proprietors may only be covered as non-employee participants; therefore, a sole proprietor is ineligible to buy small group health insurance without at least one other employee who is not his or her spouse. 42 U.S.C. § 300gg-21(d).

²³³ *Id.* § 2510.3-5(b)(3).

²³⁴ *Id.* § 2510.3-5(b)(4).

²³⁵ *Id.* §§ 2510.3-5(b)(5) & (c).

²³⁶ *Id.* § 2510.3-5(b)(6).

²³⁷ *Id.* § 2510.3-5(b)(4).

²³⁸ *Id.* § 2510.3-5(b)(4).

²³⁹ <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/association-health-plans.pdf>

mechanism for groups or associations to meet the definition of an ‘employer’ and sponsor a single ERISA-covered group health plan; it is not the sole mechanism.”²⁴⁰ Thus, the Rule and accompanying guidance create two different types of AHPs: “Traditional Pathway” AHPs formed under the pre-2018 guidance (sometimes called “Pathway One”) and “New Pathway” AHPs formed under the Rule (sometimes called “Pathway Two”).

The Traditional Pathway does not simply grandfather existing AHPs. DOL “emphasizes” that this alternative continues to be available for newly formed employer associations that seek to establish AHPs,²⁴¹ which is important because the two Pathways are subject to different requirements. That is a consequence of DOL’s position that the nondiscrimination provisions in the AHP Rule are not necessary for associations that comply with the pre-2018 DOL guidance, because the “pre-rule sub-regulatory guidance had a stronger employer nexus requirement.”²⁴² In particular, DOL permits experience rating at the member employer level for “Traditional Pathway” AHPs that follow the pre-2018 guidance – regardless of when the AHP was formed – as long as experience rating is not used as a pretext for discriminating against a particular employer or plan participant.

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

any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees’ beneficiary association organized for the purpose, in whole or in part, of establishing such a plan.²⁴³

The meaning of the term “employee organization” was discussed in *Bell v. Employee Security Benefit Ass’n*.²⁴⁴ At issue in *Bell* was an association that claimed that it offered an employee welfare benefit plan. The Kansas Commissioner of Insurance filed suit to enjoin the association from conducting business in Kansas on the ground that the association was offering insurance, not an employee benefit plan. The court found for the Commissioner of Insurance.

In analyzing whether the association was an employee organization, the court looked at (1) the participation of the employees, (2) the purpose of the organization, and (3) the relationship among the employees. The court found that the employees had no meaningful participation in the activities of the association and the organization did not exist, in whole or in part, for the purpose of dealing with employers since there was no employer interaction at all with the plan. Additionally, in inquiring whether the organization was an employees’ beneficiary association, the court noted that commonality of interest was a dominant factor in the analysis. The court found that there was no commonality of interest among the employees since the association did not limit the benefits to

²⁴⁰ Preamble to AHP Final Rule, 83 F.R.28916 (emphasis in original).

²⁴¹ *Id.*

²⁴² *Id.* at 28928 n.40.

²⁴³ 29 U.S.C. § 1002(4) (2018).

²⁴⁴ *Bell v. Employee Security Benefit Ass’n*, 437 F.Supp. 382, 396 (D. Kan. 1977).

any particular employer, union, or industry, but made the benefits available to any individual who was employed.²⁴⁵ Consequently, the entity did not meet the definition of an employee organization.

Purpose Requirement

The next element is the “purpose” requirement. The ERISA statute delineates the specific welfare benefits that are covered under ERISA. The plan must be established or maintained for the purpose of providing “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or any benefit described in section 186 (c) [referring to Taft-Hartley trusts] of this subchapter (other than pensions on retirement or death, and insurance to provide such pensions).”²⁴⁶

As mentioned previously, however, ERISA specifically exempts plans maintained solely to provide disability, workers’ compensation, and unemployment compensation.²⁴⁷

Participants Requirement

The last element is the “participants” requirement. This last requirement relates to whether the benefits are provided to plan participants or their beneficiaries. The statute defines a participant as “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.”²⁴⁸

There is no threshold requirement in the text of ERISA for the number of participants that an employee benefit plan must have. There are DOL opinions and case law that suggest that a plan can have as few as one employee participant and still be governed by ERISA.²⁴⁹ ERISA defines “employee” to mean a person who works for salary or wages under the control and direction of an employer.²⁵⁰ Generally, this is determined on the basis of the common-law employment tests the courts have developed.²⁵¹ However, DOL has issued regulations establishing that a business is not an “employer” for ERISA purposes unless it has at least one common-law employee who is not a working owner or working owner’s spouse.²⁵² Confusingly, although it is possible for a

²⁴⁵ *Id.*

²⁴⁶ 29 U.S.C. § 1002 (1) (2018).

²⁴⁷ 29 U.S.C. § 1003(b) (2018). For more information on state regulation of these benefits see discussion in *Questions & Answers About Insurance Department Jurisdiction*.

²⁴⁸ 29 U.S.C. § 1002(7) (2018).

²⁴⁹ See, e.g., *Williams v. Wright*, 927 F.2d 1540, 1545 (11th Cir. 1991).

²⁵⁰ 29 U.S.C. § 1002(6) (2018).

²⁵¹ See *infra* p. 69.

²⁵² 29 CFR § 2510.3-3. The PHS act allows partners (but not sole proprietors or sole shareholders) to be treated as employees for purposes of access to the small group health insurance market, and the DOL rule was amended in 2018 to allow working owners that meet the AHP Rule’s time or income threshold to be deemed their own employees for the limited purpose of allowing them to buy coverage as AHP member employers. 29 CFR § 2510.3-3(c), *referencing Id.* § 2510.3-5(e).

spouse to meet the common-law employment standard, the term “common-law employee” is often used to mean an employee meeting the more restrictive ERISA standard.

Conclusion

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

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

Single-Employer Plans

Characteristics of a Single-Employer Plan

A single-employer plan is one that is sponsored by one employer for its employees.²⁵³ However, a plan operated by two or more employers under common ownership or control may also be considered a single-employer plan for purposes of ERISA. The statute refers to “businesses within the same control group” and defines control group to mean a “group of trades or businesses under common control.”²⁵⁴

The term “common control” must be defined by DOL in a manner consistent with section 414(c) of the Internal Revenue Code.²⁵⁵ Factors that DOL considers in determining whether two or more employers are under common control include whether the employers are affiliated service groups or “share ownership interests in such a way as to be within the same control group.”²⁵⁶ Those trades or businesses with less than 25 percent ownership interest do not meet the standards for common control.²⁵⁷

²⁵³ Technically, the term “single-employer plan” is defined in ERISA to mean any plan that is not a multiemployer plan. Paradoxically, this definition would include MEWAs, if they are employee benefit plans. 29 U.S.C. § 3(41) (2018) However, this Handbook will follow ordinary usage and use “single-employer plan” to mean an employee benefit plan that covers only one employer and its affiliates.

²⁵⁴ See 26 U.S.C. § 414(c) (2018); 26 C.F.R. § 1.414 (2018).

²⁵⁵ 29 U.S.C. § 1301(b)(1) (2018).

²⁵⁶ USDOL Advisory Opinion 95-29A re: *Employee Staffing of America, Inc.* (Dec. 7, 1995).

²⁵⁷ See MEWA Guide, *supra* note 209.

Single-Employer Plans and State Regulation

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

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

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

Persons, including licensed insurance agents, who promote unauthorized insurance under the guise of “ERISA covered plans” have come to recognize that if they are to sound plausible at all, they must at least use the term “single-employer plan.” Unfortunately, many times the only real relation to a single-employer plan is that terminology. Health arrangements that do not meet the requirements for being a single-employer ERISA plan are subject to the unauthorized insurer statutes of the various states.²⁵⁸

As noted in the discussion of MEWAs below, some employee leasing companies and professional employer organizations claim to offer “single-employer plans” under ERISA to their clients, but such an arrangement will almost certainly be a MEWA for ERISA purposes.²⁵⁹ Other types of operations have claimed to “employ” each enrollee, usually to promote the plan or ostensibly some product or service. In those situations, it is usually quite apparent that the “employment” is pro forma.

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

²⁵⁸ *Bell v. Employee Security Benefit Ass’n*, 437 F.Supp. 382 (D. Kan. 1977).

²⁵⁹ Some states have chosen to treat such plans as single-employer plans, but that is a matter of state law and is not mandated by ERISA. Those states usually require a license or registration.

“saving” provision in the statute), but may not regulate the ERISA plan directly (in accordance with the “deemer” provision in the statute).

Conclusion

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

Collectively Bargained Multiemployer Plans

Characteristics of a Multiemployer Plan

As used in ERISA, the term “multiemployer plan” does not simply mean a plan maintained by more than one employer. ERISA draws a fundamental distinction between multiemployer plans, discussed in this section, and multiple employer welfare arrangements (MEWAs) discussed in the next section. The terminology is confusingly similar, but the difference is important because “multiemployer plans” are exempt from state regulation, while MEWAs are not. To qualify for ERISA’s multiemployer plan exemption, an employee benefit plan must be maintained pursuant to a collective bargaining agreement between one or more employee organizations and must have more than one contributing employer.²⁶⁰

As a practical matter, multiemployer plans are plans jointly established by employers and labor organizations. These are commonly referred to as “union plans.” In order for a plan to be exempt from regulation as a MEWA, regulations adopted by the U.S. Department of Labor require at least 85% of the plan participants to have an employment nexus through a bona fide collective bargaining agreement. In addition to active employees who are represented by the union, this employment nexus may include several ancillary categories of permitted plan participants such as retirees, management employees, and employees of the union.²⁶¹ Whether the agreement is a bona fide collective bargaining agreement is a fact-specific inquiry based on such factors as the terms of the agreement, the status of the parties, and the nature of the bargaining process.²⁶² As discussed above, plans operated by businesses under common control are considered single-employer plans, not multiemployer plans, even if contributions are made pursuant to a collective bargaining agreement. Multiemployer plans receive contributions from unrelated employers who make the contributions for participants. Those plans are usually administered by a board that consists of employer and union trustees.

²⁶⁰ 29 U.S.C. § 1002(37)(A) (2018); 29 CFR § 2510.3-37.

²⁶¹ See “Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA,” 29 CFR § 2510.3-40(b)(2)(i) through (x). The history and purpose of this regulation is discussed more fully in the next section of the Handbook, on Multiple Employer Welfare Arrangements.

²⁶² See discussion of plans maintained pursuant to collective bargaining agreements, MEWA Guide, *supra* note 209.

Multiemployer Plans and State Regulation

As with single-employer plans, the ability of states to regulate multiemployer plans is very limited. Generally, states do not have the authority to regulate a multiemployer plan directly,²⁶³ although they retain the authority to regulate organizations that contract with multiemployer plans to provide benefits, including the authority to regulate the underlying insurance contracts if a multiemployer plan is fully insured or protected by stop-loss insurance. As will be discussed below in the section on multiple employer welfare arrangements,²⁶⁴ not all arrangements that ostensibly involve collective bargaining agreements are covered by ERISA or are exempted from the application of state law. They may, in fact, be multiple employer welfare arrangements and consequently, subject to state insurance law.

Conclusion

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

Multiple Employer Welfare Arrangements²⁶⁵

Characteristics of MEWAs

The previous sections explained that benefit plans operated by a group of affiliated employers under common ownership are deemed to be single-employer plans, and that certain collectively bargained plans qualify as “multiemployer plans.” With two extremely narrow exceptions, all other benefit plans involving more than one employer fall into a third category. They are classified by ERISA as “multiple employer welfare arrangements” (MEWAs). ERISA defines a MEWA as: “[A]n employee welfare benefit plan, or any other arrangement...which is established or maintained for the purpose of offering or providing any benefit described in paragraph 1²⁶⁶ to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries,” unless a specific statutory exception applies.²⁶⁷

²⁶³ The exception is a plan that qualifies as a “multiemployer plan” under 29 U.S.C. § 1002(37) and 29 CFR § 2910.3-37, but is nevertheless subject to state regulation as a MEWA because it fails to meet the more stringent standards required to qualify as a plan established or maintained “under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements” under 29 U.S.C. § 1002(40)(A)(i) and 29 CFR § 2910.3-40.

²⁶⁴ See discussion below of the DOL Final Rules Regarding Section 3(40) of ERISA.

²⁶⁵ Regulators are encouraged to read the DOL MEWA Guide, *supra* note 209, for a more detailed discussion of MEWAs and state regulation.

²⁶⁶ The benefits may include, *inter alia*, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.

²⁶⁷ 29 U.S.C. § 1002(40)(A) (2018). The only exceptions, other than the exceptions discussed earlier for collectively bargained plans and for plans that are deemed to be single-employer plans based on common ownership and control, are plans established or maintained by a rural electric cooperative or by a rural telephone cooperative association. *Id.* §§ 1002(40)(A)(ii) & (iii).

MEWAs have had a troubled history since the enactment of ERISA. Originally, with the exception of the collectively bargained “multiemployer” plans discussed earlier, ERISA did not draw any distinctions between single-employer and multiple employer benefit plans. While Congress had intended that multiple employer plans be set up at the grassroots level by small business owners and local unions, Congress had not anticipated the involvement of third party promoters using multiple employer plans as profit making vehicles. The 1977 Activity Report of the House Committee on Education and Labor indicates that abuses started almost as soon as ERISA became law in 1974.²⁶⁸ The lack of adequate consumer protection standards at the federal level and misunderstanding the scope of ERISA preemption of state laws facilitated abusive and fraudulent practices by MEWAs that resulted in significant sums of unpaid claims and the loss of health insurance for participants.

Congress enacted the Erlenborn-Burton Amendment in 1983 because of a concern regarding the financial insolvency of multiple employer welfare arrangements and a desire to remove impediments to action by state regulators to prevent those abuses. The amendment saved state regulation of MEWAs from ERISA’s preemption and deemer provisions,²⁶⁹ permitting state insurance regulators to regulate risk-bearing MEWAs as insurance companies. The extent to which state law applies to a MEWA depends on whether the MEWA is an ERISA covered plan and on whether it is “fully insured” or not.

The definition of MEWA is broad. It includes both ERISA plans and “any other arrangement.” An “arrangement” might involve a specific legal entity that has undertaken to provide coverage, which might be issued a “MEWA” license by a state. In other cases, the essence of “the MEWA” might be a contractual agreement between two legal entities - an insurance company and an association – each of which has its own independent existence and many other activities outside the MEWA. But there is also an infinite variety of other ways that an “arrangement” can be created without such a clearly defined formal structure.

This broad definition of MEWA encompasses both fully insured MEWAs (such as association group insurance and multiple employer trust group insurance) and non-fully insured MEWAs. It should be noted that MEWAs that are not fully insured are typically funded by their participating employers. If the premiums collected from employers are insufficient, the entity responsible for payment varies according to the structure of the MEWA. It might be a third party such as a PEO, but often, the employers themselves are jointly and severally responsible for any shortfall. And in the worst-case scenario, participating employers and employees, and their health care providers, discover only after a MEWA collapses that nobody has assumed responsibility for the unpaid claims, or that the responsible entity named in the contract has had its assets stripped, is out of reach of U.S. creditors, or never actually existed.

One common source of confusion is ERISA’s inconsistent use of the term “employer.” There is a statutory definition, but it is circular: an “employer” is an entity that acts directly as an “employer” or indirectly in the interest of an “employer.” This definition, which clarifies that a “group or association of employers” may sponsor a benefit plan, recognizes both “direct” and “indirect”

²⁶⁸ COMMITTEE REPORT, *supra* note 16.

²⁶⁹ 29 U.S.C. § 1144(b)(6) (2018).

employers, and it subjects indirect employers to the same regulatory requirements as direct employers when they sponsor benefit plans. However, ERISA occasionally uses the term “employer” more narrowly, as it is used in ordinary English, to mean a direct employer. This is most obvious in the definition itself, which would not make sense if the phrase “common-law employer or bona fide employer group or association” were substituted for “employer” throughout. DOL has issued two separate rules construing the definition of “employer”: one, issued in 1975, provides criteria for qualifying as a direct employer, while the other, issued in 2018, provides criteria for qualifying as an indirect employer.²⁷⁰

The distinction between direct and indirect employers is most important as it applies to the concept of a “multiple employer” welfare arrangement. The fundamental purpose of ERISA’s MEWA clause was to create a distinction between plans with a single direct employer (including a single group under common ownership and control) and plans covering multiple direct employers. Congress would not have gone to the trouble of creating a specific regulatory framework for MEWAs that are employee benefit plans if recognition of the sponsoring association as an “indirect employer,” qualifying the arrangement for “Plan” status, would mean the arrangement was not a MEWA. In the preamble to its 2018 AHP Rule, DOL has reaffirmed at length that all AHPs are MEWAs, even though a “bona fide” association is deemed to be “an employer” for purposes of employee benefit plan sponsorship, and as such, are subject to state regulation, as discussed more fully below.²⁷¹

In practice, MEWAs are commonly formed by several types of entities. Associations of employers in a common trade, industry or profession (*e.g.*, bankers, retail grocers) often make health plans available to employer members and their employees, as do associations that have no employment related commonality. Professional employer organizations describe their business as co-employing a client workforce. Employee leasing firms describe their business as leasing employees to a variety of unrelated business.²⁷² PEOs or employee leasing firms may also sponsor health plans for these employees. An employee leasing or PEO arrangement can relieve smaller employers from the administrative costs of personnel and payroll record keeping, and the PEO’s or leasing organization’s benefit plans can make pricing economies of scale available to an employer that would otherwise be only a very small group purchaser.²⁷³ In the few specific PEO or employee leasing arrangements that the DOL has reviewed, the focus of the review was whether the PEO was acting as a plan sponsor. The DOL has consistently determined those plans to be MEWAs, regardless of whether they are also ERISA plans. The 2018 AHP Rule is unlikely to have a material impact on PEO health plans, because a PEO cannot qualify under the Rule as a “bona fide” AHP unless it is controlled “both in form and in substance” by its client employers.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a filing requirement for MEWAs, and the Affordable Care Act (ACA) added a requirement that MEWAs

²⁷⁰ 29 CFR §§ 2510.3-3 & 2510.3-5.

²⁷¹ *See, e.g.*, Preamble to AHP Final Rule, 83 F.R. 28917, 28919 & n.18, 28936–37, 28942, 28959.

²⁷² However, some state laws use the single term “PEO” or “employee leasing” to encompass both business models. These laws may deem the client to be a co-employer or to be the sole employer notwithstanding any language to the contrary in the contract between the client and the PEO or employee leasing company.

²⁷³ *See* discussion below regarding self-funded PEO plans’ status as MEWAs notwithstanding the claim made by some PEOs to be sponsoring single-employer plans.

which are not group health plans in their own right must register before they may do business.²⁷⁴ The Form M-1 filing requirement is designed to keep the DOL informed about MEWAs' compliance with the requirements of Part 7 of ERISA (including the provisions of HIPAA, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act). The one-page Form M-1 is filed with DOL once a year online, usually on March 1. The MEWA M-1 forms that have been filed with DOL are accessible online at <http://www.askebsa.dol.gov/mewa>. The ACA also strengthened federal enforcement authority over MEWAs by giving DOL the power to issue cease and desist orders, summary seizure orders, and orders restoring state regulatory authority that would otherwise be preempted by ERISA or by the Risk Retention Act.²⁷⁵

MEWAs and State Regulation

MEWAs that are not Employee Benefit Plans: Whether a MEWA is itself an ERISA covered plan or not, the states have authority to regulate MEWAs. If the MEWA is not an ERISA covered plan, ERISA places no limits on state regulatory authority over the MEWA. A MEWA does not qualify as an ERISA-covered plan unless it is “established or maintained by an employer or employee organization.” For this purpose, the term “employer” includes “any person acting ... indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.” As discussed above, DOL has issued a safe harbor rule establishing criteria that qualify the sponsor of a MEWA to be recognized as “an employer,” and has also issued guidance for determining whether or not it qualifies if it does not meet the safe harbor requirements. A MEWA that is a single employee benefit plan at the association level is often called a “Plan MEWA” for short. The term “Association Health Plan” (AHP) is often used as a synonym for Plan MEWA, but is sometimes used more generically to refer to all MEWAs operated by or on behalf of associations.

Fully Insured MEWAs that are Employee Benefit Plans: The extent of state regulatory authority over a Plan MEWA depends on whether it is “fully insured.” A MEWA is “fully insured” when all of the benefits of the arrangement are guaranteed under an insurance contract.²⁷⁶ If a MEWA is a “fully insured” ERISA covered plan, state regulatory authority is primarily directed at the insurance policy; however, states may also enforce such requirements on the “fully insured” MEWA as minimum reserving and contribution standards.²⁷⁷ Operators of MEWAs have claimed that they and the coverage they sell are exempt from state insurance law because they are “fully insured” through arrangements such as surety bonds or reinsurance contracts. These do not meet the statutory definition because the insurer is not making any contractual promise to the beneficiaries. Furthermore, even if the arrangement is genuinely fully insured (which also means

²⁷⁴ 29 U.S.C. § 1021(g) (2018), as amended by PPACA § 6606. The significance of this requirement is that it provides federal jurisdiction (concurrent with the states where the MEWA does business) even if the MEWA is not a group health plan,

²⁷⁵ ERISA §§ 520–521, added by PPACA §§ 6604–6605.

²⁷⁶ 29 U.S.C. § 1144(b)(6)(D) (2018) states that “a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.”

²⁷⁷ 29 U.S.C. § 1144(b)(6)(A)(i) (2018).

the coverage must be issued by an authorized insurer, not a surplus lines company, risk retention group, or offshore insurer), the state has full authority to regulate the terms of the insurance contract, the rates the insurer charges, and the sales practices and personnel used by the insurer. See the discussion on this specific type of scam in the section titled “Typical Illegal Operations Claiming ERISA Status.”

Non-Fully-Insured MEWAs that are Employee Benefit Plans: If a MEWA is not fully insured, even if it is an ERISA covered plan, states may generally enforce all insurance regulations, including requiring the MEWA to qualify for and obtain a certificate of authority as an insurer. Purchasing reinsurance or stop-loss coverage does not make a MEWA “fully insured.” The deemer clause does not protect Plan MEWAs from state regulation. The reason Congress has preserved state regulation of non-fully-insured MEWAs is that to the extent that the MEWA is not buying insurance, the MEWA itself is providing the insurance. Although non-fully-insured MEWAs are commonly referred to as “self-insured,” they do not truly self-insure – they insure their member employers, collecting premiums in return for a promise to pay claims.²⁷⁸

ERISA places only four limits on states’ authority to regulate Plan MEWAs that are not fully insured:

- A group of businesses under common ownership and control is treated as a single employer, so a plan maintained by a single control group is not a MEWA.²⁷⁹
- The definition of MEWAs expressly excludes three categories of plans maintained by multiple employers: rural electric cooperative plans, rural telephone cooperative plans, and plans established or maintained under bona fide collective bargaining agreements.²⁸⁰ The regulations governing the collective bargaining exception are discussed more fully below.
- The law may not be inconsistent with the subchapter of ERISA regulating employee welfare benefit plans. The scope of this prohibition is narrow: states may not prohibit a Plan MEWA from doing what ERISA requires, nor require a Plan MEWA to do what ERISA prohibits. The fact that a state law is more restrictive than ERISA is not enough to make the law “inconsistent.” Congress has, after all, expressly phrased this as an exception to the broad authority it has granted to apply “any law of any State which regulates insurance” to Plan MEWAs that are not fully insured.²⁸¹
- Finally, as discussed more fully below, DOL has been granted the authority to issue regulations designating certain Plan MEWAs, individually or by class, as exempt from most state regulation.²⁸² As of the writing, DOL has never exercised this authority, although the AHP rulemaking proposal requested comment on whether such exemptions would be appropriate, and the preamble to the final AHP Rule indicated that DOL views

²⁷⁸ Legitimate MEWAs are typically nonprofit arrangements with no assets of their own, and as such, they do not really have any “self” to insure. The participating employers do, however, take on a form of self-insurance risk. If the premiums collected are insufficient to pay all claims when due, member employers are generally responsible for the shortfall – even if the shortfall was the result of some other participating employer’s adverse claims experience.

²⁷⁹ 29 U.S.C. §§ 1002(3)(40)(B)(i) through (iii) (2018).

²⁸⁰ 29 U.S.C. § 1002(3)(40)(A) (2018).

²⁸¹ 29 U.S.C. § 1144(b)(6)(A)(ii) (2018).

²⁸² 29 U.S.C. § 1144(b)(6)(B) (2018).

this exemption authority as “a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by this final rule.”²⁸³

No state is required to take specific legislative action in order to regulate MEWAs. States may regulate MEWAs under their general insurance statutes. However, some states have chosen to adopt MEWA-specific laws, making alternative licensing or registration frameworks available to MEWAs meeting certain statutory qualifications. Unless the state has adopted such a law, a non-fully-insured MEWA is simply a type of insurer. In either case, it is illegal for the non-fully-insured MEWA to do business without meeting the qualifications set forth in the applicable state laws and obtaining the necessary authorization in each state where the MEWA has participating employers, unless DOL issues regulations exempting certain MEWAs from state licensing requirements.

Federal Authority to Exempt Plan MEWAs from Certain State Insurance Laws: Although non-fully-insured MEWAs are currently subject to state insurance regulation even if they are employee benefit plans, Congress did grant DOL the power to issue regulations that would limit state jurisdiction in this area. Such an exemption may be granted either individually – *i.e.*, qualifying MEWAs would be able to obtain a federal license, or its equivalent, rather than being required to obtain state licenses – or through a “class exemption” for all MEWAs meeting the criteria set forth in the regulation.²⁸⁴ As explained earlier, DOL announced in 2018 that it might consider exercising this authority for the first time, but at this writing has not yet issued or proposed any regulations. Even if DOL does decide to exercise this preemptive power in the future, states should be aware that ERISA places two significant limitations on this power:

- First, DOL’s rulemaking authority applies only to those MEWAs that meet all the qualifications for recognition as “employee benefit plans,” including but not limited to a sponsoring organization that qualifies as an “indirect employer.” States’ authority over Non-Plan MEWAs would not be restricted.
- Second, DOL may only exempt MEWAs “from subparagraph (A)(ii)” of 29 U.S.C. § 1144(b)(6), and state solvency laws are described in Subparagraph(A)(i). The consequence, as described by DOL, is that ERISA “does not allow the Department to exempt self-insured AHPs from state insurance laws that can be applied to fully-insured AHPs, *i.e.*, laws related to reserve and contribution requirements that must be met in order for the fully-insured MEWA plan to be considered able to pay benefits in full when due, and provisions to enforce such standards.”²⁸⁵ Thus, such regulations might exempt certain MEWAs from state licensing requirements, but not from state solvency regulation.

In summary, ERISA is clear that a MEWA is subject to state insurance regulation. States may apply certain standards to “fully-insured” MEWAs, may regulate the insurer of a “fully-insured” MEWA, and continues, at this writing, to have full regulatory discretion with regard to all MEWAs that are not fully insured. Some states have enacted specific MEWA licensing statutes, but ERISA does not require the states to have done so in order to exercise their authority. The NAIC Reporting

²⁸³ Preamble to AHP Final Rule, 83 F.R. 28937.

²⁸⁴ 29 U.S.C. § 1144(b)(6)(B) (2018).

²⁸⁵ Preamble to AHP Final Rule, 83 F.R. 28937.

Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs Model Regulation²⁸⁶ is designed to assist states in becoming aware of the operation of MEWAs within their jurisdiction before an insolvency occurs. In addition, several states have enacted specific statutory structures that govern PEOs.²⁸⁷

Exception to the MEWA Definition for Collectively Bargained Plans: As discussed above, the definition of MEWA excludes multiemployer plans that are “established or maintained under or pursuant to one or more agreements which the Secretary of Labor finds to be collective bargaining agreements.”²⁸⁸ Unscrupulous operators have claimed to meet this exception to the definition of MEWA to avoid complying with state laws. States should be aware that plans purportedly established through collective bargaining may in fact be MEWAs subject to state insurance laws. DOL has adopted two rules that establish criteria for determining whether a plan qualifies for the collective bargaining exceptions and establish procedures for resolving questions or disputes regarding the status of a plan.²⁸⁹

History of the Collective Bargaining Exception: Unscrupulous MEWA operators have tried to avoid state regulation by establishing sham unions as a vehicle for marketing health coverage, and claiming to be protected by ERISA’s exclusion of collectively bargained plans from the definition of “MEWA.” In other cases, they have made arrangements with legitimate unions to sell coverage under multiemployer plans to other employers and individuals who have no collective bargaining relationship with the union. During the years before the current rules were promulgated, because the statutory exemption applies only if “the Secretary find” the agreement in question to be a collective bargaining agreement, both regulators and representatives would make requests to the DOL when the status of a plan was in dispute.²⁹⁰

The DOL determined that it would not make individualized findings with respect to whether specific plans met the exception for collectively bargained plans.²⁹¹ In 1995, the Fourth Circuit held that the DOL did not have any statutory obligation to make individualized findings about whether a particular entity met the exception to the definition of a MEWA for collectively bargained plans.²⁹² The DOL’s refusal to make an individualized finding in the *Virginia Beach* case had the same effect as a refusal to grant the exception. The lower court found that “only if the Secretary chooses to make a finding, would a MEWA receive exemption from state regulation.”²⁹³

²⁸⁶ In 1982, the NAIC adopted the Jurisdiction to Determine Jurisdiction of Providers of Health Care Benefits Model Act (Model #95), to assist states in becoming aware of the operation of MEWAs within their jurisdiction before an insolvency occurs. However, this Model was determined to be obsolete and has been withdrawn. In 1992, the NAIC adopted the Reporting Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs Model Regulation (Model # 220).

²⁸⁷ See, e.g., 24-A Me. Rev. Stat. § 6603-A (2018).

²⁸⁸ 29 U.S.C. § 1002(40)(A)(i) (2018) (ERISA § 3(40)(A)(i)).

²⁸⁹ 29 CFR §§ 2510.3-40 & 2570.150 through 2570.159. For an index of rules implementing ERISA, see https://www.dol.gov/dol/cfr/Title_29/Chapter_XXV.htm.

²⁹⁰ See *Virginia Beach Policemen’s Benevolent Association v. Reich*, 881 F. Supp. 1059 (E.D. Va. 1995), *affirmed*, 96 F.3d 1440 (4th Cir. 1996); 60 F.R. 39209, August 1, 1995, Note 3.

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

²⁹² See *Virginia Beach*, 881 F. Supp. 1059, 1069–70.

²⁹³ *Id.* at 1070.

On August 1, 1995, the DOL published a Notice of Proposed Rulemaking setting forth criteria that must be met in order for the Secretary of Labor to find that an agreement is a collective bargaining agreement for purposes of the exception to the MEWA definition.²⁹⁴ The proposed rule also set forth criteria for determining when an employee benefit plan is established or maintained under or pursuant to such an agreement. The DOL received many critical comments. Due to the numerous concerns raised in those comments, rather than publish a final rule, the DOL decided in 1998 to terminate the pending rulemaking and initiate a new proceeding to promulgate a rule by negotiated rulemaking. The ERISA Section 3(40) Negotiated Rulemaking Advisory Committee completed its report to the Secretary with attached draft notices of proposed rulemaking on November 16, 1999. The final rules were published in the Federal Register on April 9, 2003.²⁹⁵

Final Rules Regarding Section 3(40) of ERISA: The first rule, Employee Retirement Income Security Act of 1974; Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA,²⁹⁶ sets forth criteria for determining whether an agreement is a bona fide collective bargaining agreement within the meaning of the exception to the definition of “MEWA”, and for determining whether a plan is established or maintained under such an agreement. The second rule, Procedures for Administrative Hearings Regarding Plans Established or Maintained Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA,²⁹⁷ establishes a procedure whereby an entity may petition the DOL for an individualized finding when a state’s jurisdiction has been asserted against the entity through any state enforcement action.

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

Conclusion

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

Presently, some MEWAs fraudulently claim that they meet the exemption requirements for singleemployer plans or collective bargaining arrangements. MEWAs that operate fraudulently and that do not comply with state regulatory requirements harm both employers and employees, often in a relatively short period of time. Employers contributing to these fraudulent MEWAs have

²⁹⁴ 60 F.R. 39209.

²⁹⁵ 68 F.R. 17472–17491.

²⁹⁶ 29 CFR § 2510.3-40.

²⁹⁷ 29 CFR §§ 2570.150 through 2570.159.

lost their investment in the employee benefit they sought to offer and employees are left with unpaid claims and no health insurance.

Because employee welfare benefit plans offered through single-employer plans and collective bargaining arrangements are exempted from state regulation under ERISA, effective regulation of MEWAs requires an ongoing cooperative relationship with the DOL. The states and the DOL have worked together to make great strides to curtail this fraudulent activity and maximize the effective regulation of MEWAs. In its 2018 AHP Rule, DOL acknowledged the history of abusive practices, and reaffirmed its commitment to work cooperatively with the states as more Plan MEWAs commence operation under the rule, subject to concurrent state and federal enforcement authority.

TYPICAL ILLEGAL OPERATIONS CLAIMING ERISA STATUS

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

1. The ongoing, and not isolated, nature of the activity;
2. The potential for dishonest or criminal activity within the business of insurance – both with respect to the creators of the illicit plans, and those recruited to sell the plans, enroll consumers and service claims;
3. The adverse consequences to authorized insurers and other insurance licensees;
4. The potential for large quantities of unpaid claims due to dishonesty in the operation, actuarial unsoundness, or both;
5. The absence of any state or federal guaranty fund to cover the unpaid claims of an unauthorized insurer;
6. Potential issues arising out of participants’ lack of creditable coverage;²⁹⁸ and
7. The public perception that it is the duty of state insurance regulators to protect them from illicit insurance schemes, and to ensure that benefits are paid as contracted.

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

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

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

An employee welfare benefit plan is “any plan, fund, or program established or maintained by an employer or by an employee organization for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, etc.”²⁹⁹ “Participant” under ERISA means “any employee ... of an employer ... who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer.”³⁰⁰ Employee is defined as “any individual employed by an

²⁹⁸ For example, participants might be subject to penalties in states that require enrollment in a health plan.

²⁹⁹ 29 U.S.C. § 1002(1)(A) (2018).

³⁰⁰ *Id.* § 1002(7).

employer.”³⁰¹ The term “beneficiary” is defined as “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.”³⁰²

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

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

A few courts have construed the ERISA definition of “beneficiary” as permitting an employee welfare benefit plan to include anyone by its terms.³⁰³ However, these cases are not consistent with *Nationwide v. Darden*.³⁰⁴ In that case the U.S. Supreme Court rejected applying ERISA to an agent’s claim for benefits, holding that the agent was not an “employee.” The Court did not consider a contention that the agent was nevertheless a “beneficiary” because the Fourth Circuit had already disposed of that argument at a much earlier stage of the case:

“‘[B]eneficiary,’ for the purposes of ERISA, is a person other than one whose service resulted in the accrual of the benefits, but who is designated as the recipient of benefits accrued through the service of another. 29 U.S.C. § 1002(8).”³⁰⁵

- B. Such a plan is a “multiple employer welfare arrangement” and subject to state insurance regulation as provided by 29 U.S.C. § 1044 (6). A “multiple employer welfare arrangement” is defined as “an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, ...”³⁰⁶ Since the consumer enrollees are not employees of the entity offering the coverage (regardless of whether they are in fact “agents”) they are either employees of multiple employers, or self-employed, and the plan is a multiple employer welfare arrangement subject to state insurance jurisdiction.

³⁰¹ *Id.* § 1002(6).

³⁰² *Id.* § 1002(8).

³⁰³ See *Turnoy v. Liberty Life Assurance Co.*, 2003 U.S. Dist. LEXIS 1311; 29 Employee Benefits Case (BNA) 260.

³⁰⁴ 503 U.S. 318 (1992).

³⁰⁵ *Darden v. Nationwide Mutual Ins. Co.*, 796 F.2d 701, 705 (1986).

³⁰⁶ 29 U.S.C. § 1002(40) (2018).

- C. The “agency” relationship with the enrollee consumers is usually fictitious. The enrollees in fact enroll to obtain the offered coverage, not to act as agents for the entity. The entity is an entrepreneurial operation, and therefore not an employee welfare benefit plan.³⁰⁷

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

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

This type of MEWA differs from the others in that the entity operating the MEWA is not necessarily acting as an insurer. Indeed, in many of these arrangements, the insurance coverage is issued by a licensed insurance company, and the MEWA’s role is focused on sales and third-party administrative services. In order to conduct effective enforcement, it is essential for states to understand how these plans work, and to make sure that their laws do not have loopholes through which these plans can escape meaningful regulation.

What this type of plan has in common with other MEWAs is that insurance coverage is packaged as something else, and then marketed under false claims of ERISA immunity from state regulation. As one marketing brochure describes it:

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

The most important thing for regulators to remember is that these plans are not truly self-funded, and ERISA does not preempt meaningful state regulation of these plans. Self-insurance is not something employers can buy—self-insurance simply means the employer has not bought insurance! There is no philosopher’s stone that can take the risk out of self-insurance. If someone is paying a fixed amount for a defined package of benefits they are buying insurance and ERISA reserves the right to regulate insurance to the states, even when that insurance is connected with an employee benefit plan. Some plans of this type are out-and-out frauds.

The stop-loss coverage might be placed with an unlicensed company, or might not exist at all. The employer’s “trust contributions” might be commingled with other employers’ payments, or might

³⁰⁷ See *Bell v. Employee Security Benefit Association*, 437 F. Supp. 382 (D. Kan. 1977).

go straight into the pockets of the promoters. When this level of fraudulent behavior is involved the arrangement is not materially different from other unlicensed entity scams and should be pursued in the same manner, although it may be necessary to address some of the jurisdictional issues discussed below, depending on how the promoters respond.

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

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

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

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

- “It's only reinsurance.” Recall the marketing blurb quoted at the beginning of this section: “Once the employer has created their ERISA plan then the risk of the self-funded plan is reinsured through various markets.” However, a contract is not legally considered reinsurance unless the ceding company is regulated as an insurer. The point at which an

unregulated entity first cedes risk to a regulated entity is a regulated insurance transaction.³⁰⁸

- “This is a self-insured plan.” It is a complex web of transactions (which should already be a red flag) that, if it is “done right,” includes both a self-insured component and an insurance policy. The self-insured component of the plan will likely be of interest to federal investigators, but our concern is the state-regulated insurance policy. Our lack of authority to regulate the self-insured component of these plans is no great loss, since the self-insured component typically represents 5% or less of the dollar value and essentially none of the risk.
- “ERISA preempts state regulation of stop-loss insurance.” Although nothing in the text of ERISA or the relevant Supreme Court jurisprudence would remotely suggest such a result, the Fourth Circuit has ruled that ERISA places some limitations on how states can regulate stop-loss insurance.³⁰⁹ However, even in jurisdictions where *American Medical Security* is considered binding precedent or persuasive authority, that opinion makes clear that even under ERISA the authority to “regulate stop-loss insurance policies ... is clearly reserved to the states.”³¹⁰
- “Your state has no regulatory interest in the insurance coverage.” This argument is based on the notion that neither the employer nor the employees are parties to the stop-loss contract, which is typically issued to an out-of-state benefit trust. However, even if a valid out-of-state trust exists (it often does not!), the employer is the real party in interest,³¹¹ since it is the employer’s risk that is covered by the policy.³¹²
- “Your state has no jurisdiction because the policy is issued out of state.” This is a variation on the same theme, and has no more merit than saying that the policy is governed exclusively by Delaware law if the employer establishes a Delaware corporation. These “extraterritorial” jurisdictional issues have been dealt with extensively in the traditional

³⁰⁸ In some states, state statutes expressly clarify this point. In Maine, for example, “The transaction of employee benefit excess insurance does not constitute the conduct of the business of reinsurance.” 24-A Me. Rev. Stat. § 707(1)(C-1) (2018).

³⁰⁹ *American Medical Security v. Bartlett*, 111 F.3d 358 (4th Cir. 1997). The NAIC has taken the position that this decision is at odds with the plain language of the ERISA saving clause, which gives the states free rein to regulate “insurance,” not just “health insurance,” and with the Supreme Court’s ERISA jurisprudence, which acknowledges that the saving clause creates “a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not.” *Metropolitan Life v. Massachusetts*, 471 U.S. 724, 747 (1985). The Fourth Circuit elaborated on this doctrine by drawing the line between insured and uninsured plans on the basis of the kind of insurance they purchase, an approach that has become even more questionable now that the Supreme Court has further clarified the broad scope of state regulatory authority in *Kentucky Ass’n of Health Plans v. Miller*, 123 S. Ct. 1471 (2003).

³¹⁰ *American Medical Security*, 111 F.3d at 365.

³¹¹ If state law regulates the policy as health insurance, the employees may also have a legal interest in the coverage.

³¹² If the benefit plan purports to create no liability for benefits on the part of the employer, then the trust is acting as an unlicensed, undercapitalized insurer. Perhaps because of the fiduciary liability exposure that is created, these plans tend not to be structured in this manner.

group insurance market in context of association group policies and multiemployer trust policies, and states can and should exercise the same regulatory authority here.

- “What we were selling wasn’t insurance.” The producers, licensed or unlicensed, who sell this product to the employer will try to distance themselves by claiming that they only market the ERISA plan, not the insurance. However, the employer would not buy the product if it weren’t made clear somehow that the plan is not truly self-funded. Sometimes the producer slips up and actually offers an “insurance quote” in so many words. However, even if the producer avoids that pitfall, somewhere in the marketing or application of materials there will have to be some discussion of the stop-loss coverage.
- “Any sales, solicitation, or negotiation of insurance took place out of state.” Despite the out-of-state trust documentation, the product was bought and paid for by the employer, who was almost certainly solicited at the employer’s place of business. Almost invariably, all subsequent transactions involving the employer also took place within the state.

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

Which laws apply to these plans will vary from state to state. The lack of any direct contractual relationship between the insurer and the plan participants takes it outside most states’ definitions of “health insurance,”³¹³ even though the self-insured retention is a nominal amount which from the employer’s perspective is simply part of the premium. Under the NAIC Stop-Loss Insurance Model Act, a stop-loss policy cannot be issued unless, among other requirements, its aggregate attachment point for small groups is at least 120% of expected claims and its specific attachment point (if there is specific coverage) is at least \$20,000. In states that have adopted this model act, or a similar regulation, an insurer is prohibited from issuing a stop-loss policy with the minimal retention these schemes purport applies to their arrangements.

Purported “Fully Insured” Plans

This type of MEWA is in some sense the mirror image of synthetic group health insurance. In each case, there is often a reverse-fronting arrangement in which an unlicensed entity cedes risk to a licensed entity. The difference between these plans and the plans discussed in the previous section is which layer is actually acting as an insurer. In synthetic group health insurance arrangements, the fronting “single-employer” plan holds itself out as self-funded, concealing the fact that the

³¹³ As discussed above, *American Medical Security* prohibits states in the Fourth Circuit from classifying indirect-payment coverage as health insurance.

insurance risk is actually passed on to the stop-loss insurer. Here, by contrast, an unlicensed insurer, usually structured as a multiple employer trust, holds itself out as “fully insured” by virtue of its reinsurance arrangements.

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

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

[I]n the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured ... any law of any State which regulates insurance may apply to such arrangement to the extent such law provides—

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

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

[A] multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

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

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

Most entities falsely claiming to be “fully insured MEWAs,” like most other entities making abusive preemption claims, fail the threshold test because they are not ERISA plans in the first place. While the 2018 AHP Rule significantly expands the ability of a MEWA to qualify for ERISA plan status, outright scams will still fail to meet the rule’s requirements. Nevertheless, this will not stop promoters from taking advantage of the uncertainty surrounding any significant law

change and making false claims that they qualify as “bona fide AHPs.” Regulators must never take for granted a MEWA’s claim to be an employee benefit plan. Remember that a MEWA can provide ERISA benefits without being an ERISA plan.³¹⁴ In that case, the state can regulate the MEWA as an insurer (or if it chooses, as a state-licensed MEWA) without ERISA entering the picture at all.

Often, however, it is easier to refute the claim that the MEWA is “fully insured,” because compliance with the entire framework of state and federal regulatory requirements for fully insured plans is precisely what the promoters are trying to avoid. In particular, many such plans have claimed to be fully insured by virtue of a purported “reinsurance” contract, surety bond, or other contract between a state-licensed or surplus-lines-eligible insurer and the MEWA. However, when ERISA defines “fully insured” in terms of the insurer’s contractual guarantee that benefits will be paid, the insurer must make this guarantee to the individual plan participants, not merely to the MEWA or even to the covered employers.³¹⁵ Furthermore, ERISA provides that a MEWA is “fully insured” only if “the Secretary determines” that the amount of all plan benefits “are guaranteed under a contract, or policy of insurance.” The Secretary has issued no such findings.

More important, even if the MEWA does qualify as a fully insured employee benefit plan, only state regulation of the MEWA is subject to preemption, not regulation of the insurer and the insurance policy that “fully insures” the MEWA and participating employers. ERISA is designed to dovetail with state insurance regulation, not to preempt it. States might not be able to regulate the MEWA as an insurer, but that is because they can regulate the insurer as an insurer. The prototypical fully insured MEWA, after all, is the traditional multi-employer group health policy. A state may, and many do, require that the insurer be licensed, the policy filed and approved, and the group policyholder meet the qualifications for permissible groups established by state law.

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

As noted earlier, this is no accident. MEWA promoters try to distract regulators by seizing on ERISA’s phrase “qualified to conduct business in a State,” arguing that “qualified” could mean surplus lines authority, and “a state” does not mean “every state where covered employers do business.” Let the analogy of traditional multiemployer group health policies be your guide here. As a threshold matter, the coverage must be issued in compliance with the laws of the state where the master group policy is issued. That is enough to satisfy the requirements of ERISA. Beyond that point, it is entirely up to the other states to decide whether and how their laws will apply when

³¹⁴ See USDOL Advisory Opinion 92-21A regarding MEWAs that are not “established or maintained” by an employer: MEWAs that allow participation by one-family group or other groups that are not considered employee groups under ERISA.

³¹⁵ See USDOL Advisory Opinion 94-07A, *United Service Association for Healthcare* (Mar. 14, 1994) for further discussion of this requirement from the Department of Labor’s perspective.

their employers are covered under the policy—ERISA neither requires such regulation nor does ERISA restrict it in any way.

Finally, regulators must also keep in mind that ERISA does not preempt state solvency regulation of fully insured MEWAs. As the DOL explains in its MEWA Guide,³¹⁶ “it is the view of the Department of Labor that 514(b)(6)(A)(i) clearly enables states to subject [fully insured] MEWAs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of State insurance law necessary to ensure compliance with the State insurance reserves, contributions and funding requirements.”

Non-Fully-Insured Multiple Employer Arrangements Claiming “Single-Employer” Plan Status—Issues Related to Professional Employer Organizations (PEOs) and Employee Leasing Companies

Whether a self-funded benefit arrangement sponsored by an employee leasing company (or professional employer organization (PEO)) is exempt from state regulation because of ERISA preemption depends upon whether the arrangement is an ERISA-covered single-employer plan or a MEWA. Under ERISA, the first inquiry of the state regarding an employee leasing company or PEO arrangement should be whether the arrangement is fully-insured or whether it is self-funded. It is important for regulators and insurers to understand that there are some fundamental differences between self-insured PEOs and self-insured traditional employers. Unlike a traditional employer, the PEO is being paid by its clients to provide this coverage, either as a separate line item or part of a global PEO service fee. Like an insurer, the PEO makes a profit or loss depending on whether the fees are sufficient to pay for the costs of the health plan, and the employer is dependent on the PEO’s ability to pay all claims when due.

Many PEOs across the country do not take on that risk, and provide fully insured health benefit arrangements with authorized carriers. These are less likely to raise regulatory concerns, but the PEO’s carrier must be licensed in every state where it does business. It is not sufficient to be licensed in the state where the PEO is based if licensure is required by the laws of one or more states where the PEO has clients. Marketing on behalf of the PEO might also require licensure as a producer if it includes the solicitation of insurance coverage.³¹⁷ Rating is another issue regulators need to consider. Before the ACA, rating was controlled by state law, and states took different approaches.³¹⁸ Now, community rating is required in the small group market on a uniform nationwide basis, and if federal and state definitions of “small employer” conflict, the federal definition controls for purposes of federal law.

DOL has examined a limited number of PEO or employee leasing benefit plans to date, and based on the facts and circumstances of those arrangements, has determined them to be MEWAs. If the benefit arrangement is fully-insured, the state has authority to regulate the carrier and to establish

³¹⁶ See *supra* note 209.

³¹⁷ However, the National Association of Professional Employer Organizations (NAPEO) has identified at least 14 states that have laws expressly providing that the sale of PEO services is not considered the sale of insurance.

³¹⁸ For example, New York law recognizes a PEO as a single employer for purposes of offering fully-insured health coverage on a large group basis, 31 N.Y. Labor Code § 922(5), while Maine law requires each client with 50 or fewer employees to be separately rated as a small employer. 24-A Me. Rev. Stat. § 2808-B(1)(H).

certain standards for the MEWA itself. The state has far greater authority in the situation where the MEWA is not fully-insured. Regardless of the employer status of the PEO or the employee leasing company, the DOL has indicated in these decisions that if one or more of the client companies is also deemed to be an employer under common-law standards, the arrangement is a MEWA and the self-funded plan is subject to state regulation.

States may allow PEOs to self-fund, but they may not dictate how ERISA treats such plans. This is true despite a contract purporting to designate the PEO as the sole employer, even if the PEO is designated as the sole employer. Both state and federal law look to commonlaw factors, including day to day control of the employees, in determining whether the clients' businesses are in fact acting as employers.

Some operators of PEOs occasionally cite the ERISA provision treating employers "under common control" as single employers. However, that provision does not apply even if the PEO can be said to manage its clients' businesses, because client businesses are not all under common ownership, which is the basis of the statutory test for single-employer status.³¹⁹

DOL reviews plans based on the particular facts and circumstances involved. DOL has consistently said that a PEO or employee leasing company plan cannot qualify as a single-employer plan under ERISA unless the PEO is actually the sole common-law employer of all of the individuals under the arrangement. The question of whether or not a common-law employer-employee relationship exists depends upon the specific circumstances of the case. In *Nationwide Mutual Ins. Co. v. Darden*,³²⁰ the Supreme Court held that federal common-law principles of employment govern the definition of employee contained in ERISA. Whether the PEO is a "co-employer"³²¹ is irrelevant. If the client businesses employ the participating employees, the PEO self-funded plan arrangement is a MEWA. In *Darden*, the Court held that the following factors should be considered to determine the existence of an employer-employee relationship. Each factor must be separately weighed and none is decisive. Moreover, the actual practices, rather than the contractual terms, are determinative.

1. the hiring party's right to control the manner and means by which the product is accomplished;
2. the skill required;
3. the source of the instrumentalities and tools;
4. the duration of the relationship between the parties;

³¹⁹ See 29 U.S.C. § 1002(40)(B)(2018). This assumes that the plan is sponsored by a commercial PEO, not a captive staffing entity that is genuinely under common ownership and control with all its "clients." Such an entity could serve as the vehicle for a bona fide single-employer plan for a group of affiliated employers, and is outside the scope of this discussion.

³²⁰ 503 U.S. 318 (1992).

³²¹ The DOL opinions finding PEO benefit plans to be MEWAs do not adopt the dual employment doctrine, but they do not reject it either. The key to the analysis is that the client is an employer. Depending on the circumstances of the particular PEO-client relationship, the PEO might also be entitled to claim an employer-employee relationship with its leased employees, and even if the PEO does not qualify as a common-law employer, it could still be an indirect "employer" for purposes of benefit plan sponsorship if it is acting in the interests of its clients. However, that does not alter the plan's status as a MEWA. because an employee may have more than one employer. See *Vizcaino v. US District Court*, 173 F.3d 713, 723 (9th Cir. 1999).

5. the location of the work;
6. the right of the hiring party to assign additional projects to the hired party;
7. the extent of the hired party's discretion over when and how long to work;
8. the method of payment;
9. the hired party's role in hiring and paying assistants;
10. whether the work is part of the regular business of the hiring party;
11. whether the hiring party is in business;
12. the provision of employee benefits; and
13. the tax treatment of the hired party.³²²

The few DOL opinions on this topic have generally concluded, based on the facts of the arrangements under review, that the client businesses in these arrangements were common-law employers of the employees. Therefore, these arrangements included multiple employers and as such were MEWAs.³²³ In an opinion letter to the Virginia Department of Insurance, the DOL evaluated whether the health benefit program offered by the employee leasing company, Employers Resource Management Company, Inc. (ERM), constituted a single-employer plan or a MEWA. The DOL concluded that the arrangement was a MEWA under the facts as presented. The Department noted several non-exclusive factors which it considers when making a determination of whether the participants are employees of the client business, including who has the right to control and direct the individual who performs the services, the result to be accomplished, the means by which it is accomplished, and the right to discharge the individual performing the services. The Department also stated that the payment of wages, taxes, and provision of benefits do not, in and of themselves, establish an employer-employee relationship.³²⁴ It should also be noted that the enactment of the ACA means that it is not necessarily in the PEO's interest to be treated as the "employer" for health benefit purposes, since that could make the PEO an "applicable large employer" subject to the "shared responsibility" requirement.

A PEO-operated or employee leasing company "self-funded" health benefit plan covering co-employees or "leased" employees is highly likely, under the criteria outlined above, to constitute a MEWA under ERISA. In those cases, state insurance law is not preempted and the PEO or employee leasing self-funded arrangement would be an unauthorized insurer unless it is operating solely in states that have a specific PEO regulatory scheme and it is in compliance with those regulations.³²⁵ Although DOL's 2018 AHP Rule has made substantial changes in the test for

³²² *Darden*, 503 U.S. at 323–24. The IRS, on the other hand, applies a conceptually similar but differently phrased test for common-law employee status. Its 20-factor test is published in Revenue Ruling 87-41.

³²³ Similarly, in its October 2018 Notice of Proposed Rulemaking entitled *Definition of 'Employer' Under Section 3(5) of ERISA—Association Retirement Plans and Other Multiple-Employer Plans*, DOL described a PEO plan as a type of multiple-employer plan. While acknowledging that a *bona fide* PEO "performs substantial employment functions," DOL advised in the PEO section of the preamble that generally, "whether a PEO is an 'employer' under section 3(5) depends on the 'indirectly in the interest of an employer' provision." See 83 F.R. 53534, 53538–39, 53560, October 23, 2018.

³²⁴ USDOL Advisory Opinion 93-29A re: *Employers Resource Management Company, Inc.* (October 22, 1993).

³²⁵ In Maine, for example, a plan that is not fully insured may not be offered unless it is licensed as a MEWA. 32 Me. Rev. Stat. § 14055(1)(A); 24-A Me. Rev. Stat. Ann. § 6603-A. Other states, such as New York, recognize a PEO as a single employer "for purposes of sponsoring welfare benefit plans for its worksite employees," 31 N.Y. Labor Code § 922(5). Some states, such as Oklahoma, exempt PEO welfare benefit plans from licensing requirements. 40 Okla. Stat. § 600.7.F.2. Texas requires that PEOs be licensed, and if they wish to self-insure, they must submit to an extensive

determining which entities qualify as “indirect employers” under ERISA, there have been no changes in the common-law test for the existence of a direct employment relationship. Thus, as discussed earlier, the AHP Rule is unlikely to have any material impact on the status of PEO health plans.

While the states have the authority to define employer status for the purposes of state law,³²⁶ it is strictly a matter of federal law whether a PEO is a MEWA under ERISA. Thus, contrary state laws are preempted. In *Payroll Solutions Group Ltd. v. Nevada*,³²⁷ a federal trial court struck down a Nevada law providing that an employee leasing company “[s]hall be deemed to be the employer of its leased employees for the purposes of sponsoring and maintaining any benefit plans, [i]ncluding, without limitation, for the purposes the Employee Retirement Income Security Act of 1974.”³²⁸ The court held that the Nevada law “impermissibly declares that benefit plans offered by employee leasing companies, such as defendants’, that are in all respects Multiple Employer Welfare Arrangements (‘MEWAS’) under state and federal law shall nevertheless be legally deemed single employer plans (‘SEPs’) for purposes of ERISA,”³²⁹ because “[o]nly federal law may determine what is a SEP or a MEWA under ERISA.”³³⁰

certification process. Tex. Lab. Code Ch. 91; 28 Tex. Admin. Code Ch. 13, Subch. F.

³²⁶ See, e.g., 31 N.Y. Labor Code § 922(5), *supra*, which provides that “[a] fully insured welfare benefit plan or plans offered by a registered professional employer organization to its employees and/or worksite employees shall not be considered for purposes of state law a multiple employer welfare arrangement.” (Emphasis added.)

³²⁷ 2010 U.S. Dist. LEXIS 80838 (D. Nev. Aug. 6, 2010), *granting partial summary judgment as to preemption; final judgment granted* Dec. 2, 2010, 2010 U.S. Dist. LEXIS 127487.

³²⁸ Nev. Rev. Stat. § 616B.691(2) (2010).

³²⁹ *Payroll Solutions*, 2010 U.S. Dist. LEXIS 80838, slip op. at 2–3.

³³⁰ *Id.* at 5.

PREVENTION

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

Consumer Education

One of the biggest problems regulators encounter with illegal unauthorized entities is educating the public about the problem and how they can assist in prevention. Consumer alerts, bulletins, pamphlets and public service announcements (both television and radio) are all ways to alert the public to the presence and dangers of sham health plans. Some states have undertaken entire media campaigns to educate the public, complete with billboards, and radio and television spots. For example, Florida has conducted a statewide media campaign urging Floridians to “Verify Before You Buy.” They have incorporated a cartoon figure in a gaping hospital gown with the slogan “Unlicensed Insurance –Think You’re Covered? Check to see if your company is licensed.” This cartoon is on the Florida Department of Insurance website as well as on billboards and television spots. The Nevada Department of Insurance has also implemented a media campaign designed to alert consumers to the presence of unlicensed insurers in the state. Using the image of a dark forest with red eyes peering out, the Nevada slogan cautions “Don’t fall prey to phony insurance.” There is a Nevada Insurance Alert Website that is dedicated to providing additional information about avoiding unauthorized health insurance and how to choose a licensed insurer. These media campaigns utilize simple slogans and memorable images to help alert consumers to the existence of a potential problem—a crucial first step in preventing the proliferation of unlicensed entities. Unfortunately, most consumers have never heard of unlicensed insurers until tragedy strikes.

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

Agent Education

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

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

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

A bulletin is one way to inform the producer community of the problem of unauthorized insurance, the responsibilities of the agent community to assist the insurance department in combating the problem, and who to contact in the insurance department with any information. A sample agent alert is contained in Appendix 2.

Licensed Insurer Education

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

Education of Other Industries

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

Conclusion

The public, insurance producers and licensed companies all need to work together to bring suspicious entities to the attention of the departments of insurance. In order to make sure that the insurance department is made aware of any suspicious entities, insurance departments should make sure that the department website address is widely publicized. Insurance department websites can be a critical resource for consumers, producers, and licensed insurers. Department websites should include tools to verify whether an entity is licensed. Insurance departments should designate one

individual to answer all MEWA and unlicensed insurer related inquiries and have that individual's contact information prominently displayed on the website. In addition, the entire department should know to refer all related inquiries to that individual. The NAIC website contains links to the individual state insurance department websites as well as a list of 50 state MEWA contacts.

ANALYTICAL CHECKLIST FOR DETERMINING STATE JURISDICTION OVER ENTITIES OFFERING HEALTH CARE BENEFITS

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

- single-employer plan;
- multiemployer plan; or
- “fully insured” or not “fully insured” MEWA plan.

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

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

ERISA Analysis

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

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

Step 2: If the arrangement is an ERISA-covered plan, the next step of the analysis is to classify the arrangement. Determine whether the arrangement is a single-employer plan, multiemployer plan, “fully insured” MEWA plan, or not “fully insured” MEWA plan. (If the plan has come to your attention as an unlicensed entity, it is unlikely to be a single-employer plan.) After accurately classifying the plan, regulators should proceed to step 3 of the analysis.

Step 3: Once the type of plan under consideration is determined, consider the degree of state jurisdiction:

- If the arrangement is either a bona fide single-employer plan OR found by the Secretary of Labor to be established or maintained pursuant to a bona fide collective bargaining

agreement, the department may not regulate the plan. (Rural electric cooperatives and rural telephone cooperative associations are also excluded from the definition of MEWA and thus exempt from state regulation.)

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

Step 4: If the entity is in violation of the state’s Unauthorized Insurers Act (*i.e.*, it is not a bona fide single-employer plan or bona fide collectively bargained multiemployer plan), the next step is to take the enforcement action your department would take against any other kind of unauthorized insurer offering insurance in your state. You might also check the NAIC’s database to see if the organization or its principals are in the Special Activities Database (SAD).³³¹

³³¹ For further discussion on state regulation and unauthorized entities, see *NAIC’s Unauthorized Entities Manual for State Departments of Insurance*.

Table: Regulatory Jurisdiction over Employee Benefit Plans

	SUBJECT TO FEDERAL REGULATION	SUBJECT TO FEDERAL AND STATE REGULATION	SUBJECT TO STATE REGULATION ONLY
Single-Employer Plans	<ul style="list-style-type: none"> • Sponsored by Single Employer • Meets ERISA Coverage Test • Not Excepted from ERISA Coverage 		<ul style="list-style-type: none"> • State and Local Government Employee Plans
Multiemployer Plans	<ul style="list-style-type: none"> • Meets ERISA Coverage Test • Is Sponsored by More Than One Employer • Established Pursuant to a Bona Fide Collective Bargaining Agreement 		
Multiple Employer Welfare Arrangements*		<ul style="list-style-type: none"> • Meets ERISA Coverage Test • Provide Benefits to Employees of More Than One Employer 	<ul style="list-style-type: none"> • Does Not Meet ERISA Coverage Test • Provides Benefits to Employees of More Than One Employer And Does Not Meet Exceptions to MEWA Definition • Fully Insured: State Regulates the Insurance • Not Fully Insured: MEWA Itself Subject to State Insurance Laws

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

QUESTIONS AND ANSWERS ABOUT INSURANCE DEPARTMENT JURISDICTION

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

What is a Taft-Hartley Trust?

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

The Taft-Hartley Act described, among other things, the manner in which collectively bargained fringe benefits could be paid by employers to unions. The Taft-Hartley Act required the establishment of a trust administered by an equal number of management and union representatives for the purpose of paying “medical or hospital care, pensions on retirement or death of employees, compensation for injuries or illness resulting from occupational activity or insurance to provide any of the foregoing, or unemployment benefits or life insurance, disability and sickness insurance, or accident insurance” for employees and their dependents.³³²

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

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

³³² 29 U.S.C. § 186(c)(5)(A) (2018).

Characteristics of a Taft-Hartley Trust

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

- The payments contributed to the trust be used exclusively for funding benefits for employees and their dependents.³³³
- The benefits provided be for medical or hospital care, pensions on retirement or death of employees, compensation for injuries or illness resulting from occupational activity or insurance to provide any of the foregoing, or unemployment benefits or life insurance, disability and sickness insurance, or accident insurance.³³⁴
- The written agreement between the employer and the labor organization specify the detailed basis upon which payments are to be made.³³⁵
- The trust be jointly administered by an equal number of persons representing the employees and employers, as well as by any neutral persons that have been agreed upon by the employee and employer representatives.³³⁶
- The written agreement provide for an annual audit of the trust fund that is open to inspection by interested persons.³³⁷
- Pension and annuity trusts be kept separate from health and welfare trusts.³³⁸

Taft-Hartley trusts are required to file certain information with DOL that states may find useful to obtain as they research a particular entity. All of the reports are available to the public at the Office of Labor-Management Standards (OLMS) National Office in Washington, D.C., and the field office in the geographical district where a particular labor organization reports. These reports and documents may be given to state agencies without charge upon request of the governor of the state.³³⁹ Reporting requirements include the following:

Labor organizations that are engaged in an industry affecting commerce, except public employee organizations, are required to adopt a constitution and bylaws and file two copies with the OLMS and an initial report (Form LM-1) giving details about the organization's procedures, including membership qualifications, participation in benefit plans and authorization for disbursement of funds.³⁴⁰ These reports are required to be filed within 90 days after the labor organization first becomes subject to the Labor-Management Reporting and Disclosure Act of 1959 (LMRDA).³⁴¹ Any changes to the information initially reported on the LM-1 must be filed on Form LM-1-A along with the annual financial report.³⁴²

³³³ 29 U.S.C. § 186(c)(5) (2018).

³³⁴ 29 U.S.C. § 186(c)(5)(A) (2018).

³³⁵ 29 U.S.C. § 186(c)(5)(B) (2018).

³³⁶ *Id.*

³³⁷ *Id.*

³³⁸ 29 U.S.C. § 186(c)(5)(C) (2018).

³³⁹ *Id.* § 435(c) (2018).

³⁴⁰ *Id.* §§ 402(i) & 431 (2018); 29 C.F.R. § 402.2 (2018).

³⁴¹ 29 C.F.R. § 402.3(a) (2018).

³⁴² 29 U.S.C. § 431(a)(5) (2018); 29 C.F.R. § 402.4 (2018).

When the initial report is filed, the OLMS assigns a six-digit file number to the organization that is shown on the annual financial reports. These reports are due 90 days after the end of the organization's fiscal year using Form LM-2. If an organization has gross receipts of less than \$200,000, the organization may file form LM-3, and with gross receipts of less than \$10,000, the organization may file form LM-4.³⁴³

Persons who handle the funds of a labor organization or a trust in which a labor organization is interested must be bonded.³⁴⁴ Every surety company having such bonds in force must file an annual report with OLMS within 150 days after the end of the company's fiscal year.³⁴⁵

The administrator or sponsor of an employee benefit plan subject to ERISA is required to file an annual return/report with the Internal Revenue Service (IRS) by the last day of the seventh month after the plan year ends.³⁴⁶ The IRS sends a copy of this report to the DOL Employee Benefits Security Administration (EBSA). If any benefits under the plan are provided by an insurance company, insurance service, or similar organization, a Schedule A must be attached to these forms. Schedule C details service provider and trustee information. An independent auditor's report (IPA) must also be attached unless the plan is exempt from this requirement.³⁴⁷ These forms are also open to public inspection at EBSA's Public Disclosure Room in Washington, D.C.

Valid Taft-Hartley trusts should have a discernible paper trail. When attempting to determine the validity of a claimed Taft-Hartley trust, a state may want to obtain the collective bargaining agreement, the plan document, the summary plan description which must be given to employees, IRS annual report Form 5500 with the schedules attached, the LM-1, and the LM-2, LM-3, or LM-4. The reporting labor organization must keep supporting records for five years after the OLMS reports are filed,³⁴⁸ and plans must retain supporting documentation for six years after reports are filed with EBSA.³⁴⁹ A review of these records may be useful during any investigation. While a valid Taft-Hartley trust may have failed to comply with these reporting requirements, the absence of such filings is a warning that further investigation may be warranted.

Taft-Hartley Trusts and State Regulation

A Taft-Hartley trust is a type of plan that usually falls under the exception to the definition of a MEWA in Section 3(40) of ERISA as a plan established or maintained pursuant to one or more collective bargaining agreements. However, a purported Taft-Hartley trust may be a MEWA, and as such be subject to state regulation, if it fails to meet the criteria established in DOL regulations to identify bona fide collectively-bargained plans. State insurance regulators should also be aware that certain legitimate Taft-Hartley trusts may be MEWAs because they fail to meet the definition of an employee benefit plan under ERISA.

³⁴³ 29 U.S.C. § 431(b) (2018); 29 C.F.R. § 403.2-4 (2018).

³⁴⁴ 29 U.S.C. § 502 (2018).

³⁴⁵ 29 U.S.C. § 441 (2018); 29 C.F.R. § 409.2-3 (2018).

³⁴⁶ 29 U.S.C. § 1024 (2018); 29 C.F.R. § 2520.103-1 (2018).

³⁴⁷ 29 U.S.C. § 1023 (2018); 29 C.F.R. § 2520.103-1 (2018).

³⁴⁸ 29 U.S.C. § 436 (2018).

³⁴⁹ 29 U.S.C. § 1027 (2018).

The courts have permitted Taft-Hartley trusts to cover a broad range of employee classes, including employees who are not in a collective bargaining unit or whose employer does not have a collective bargaining agreement. The courts have held that a Taft-Hartley trust may include retired employees, employees and officers of a union, employees of the trust fund, and employees who are not union members in addition to the employees governed by the collective bargaining arrangement. For example, in *Doyle v. Shortman*,³⁵⁰ the court refused to bar Taft-Hartley trust coverage of employees of employer members of employer associations which did not have collective bargaining agreements with the unions and of employees who were members of other unions or who were not represented by a union. The Taft-Hartley trust may provide benefits to persons between whom the employee/employer relationship or the bargaining relationship is sufficiently tenuous as to cause the arrangement to lose its character as an employee benefit plan within the meaning of ERISA.

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

States should be aware, however, that even if ERISA does not preempt state insurance regulation of a Taft-Hartley trust, a state may be nevertheless limited in, or prevented from, applying insurance regulation to a Taft-Hartley trust. The complex provisions of ERISA are superimposed over other laws that apply to Taft-Hartley trusts. These provisions may also prevent or impede application of state insurance regulation to Taft-Hartley trusts. Prior to the enactment of ERISA, many states included provisions in their insurance codes that explicitly exempted Taft-Hartley trusts from regulation or which have been interpreted to exempt Taft-Hartley trusts from insurance regulation. A state may have addressed this issue by administrative interpretation. While there is very little case law on this subject, state insurance departments should be aware of any statutory or administrative provisions particular to their state.

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

Conclusion

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

³⁵⁰ *Doyle v. Shortman*, 311 F. Supp. 187 (S.D.N.Y. 1970).

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

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

ERISA expressly excludes workers' compensation, unemployment compensation, and state-mandated disability insurance from its purview, leaving those areas to state regulation. The literal language of this carveout only allows state regulation of a "plan [which] is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability laws."³⁵¹ The Supreme Court recognized that those laws would be impossible to enforce if the employer could avoid the state mandate by using an ERISA plan that provides other benefits. In *Shaw v. Delta Air Lines*,³⁵² a case involving a disability plan, the Court made clear that states' authority to regulate separate state-mandated benefit plans entails the authority to require employers to maintain such plans. The Supreme Court held that while the state cannot compel the employer to alter its ERISA plan, the state may require that an employer choose between setting up a disability plan that complies with state law and is separate from the ERISA plan or providing the state-mandated benefits through the ERISA plan. If the ERISA plan does not comply with the state's requirements, the state may compel the employer to maintain a separate plan.³⁵³ The ability of states to prevent employers from evading compliance with state workers' compensation laws was reiterated by the Ninth Circuit when it stated: "The premise of the complaint in this case is that ERISA opened a loophole so that employers could avoid buying workers' compensation insurance. It does not."³⁵⁴

Most states require employers to secure coverage of their workers' compensation exposure either by purchasing a commercial workers' compensation policy, participating in a state fund, establishing a state-regulated self-insurance plan, or participating in a state-regulated self-insurance group. These laws have been upheld by a number of federal courts.³⁵⁵ These decisions have rejected claims that *Delta Air Lines* does not apply to these state laws; that it only applies to state minimum benefit requirements and not state solvency requirements; or that it has been overruled or drastically modified by subsequent Supreme Court cases, most notably *District of Columbia v. Greater Washington Board of Trade*.³⁵⁶ The circuit courts observed that cases such as *Greater Washington Board of Trade* can easily be distinguished on the ground that the laws that were held to be preempted, unlike laws requiring coverage or other state-regulated security

³⁵¹ 29 U.S.C. §1003(b)(3) (2018) (emphasis added).

³⁵² *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).

³⁵³ *Id.* at 108.

³⁵⁴ *Employee Staffing Services v. Aubry*, ("Stafcor"), 20 F.3d 1038, 1039 (9th Cir. 1994).

³⁵⁵ See *Stafcor*; *Combined Management v. Superintendent of Insurance of Maine*, 22 F.3d 1 (1st Cir. 1994), *cert. denied*, 513 U.S. 943 (1994); *Contract Services Employee Trust v. Davis*, 55 F.3d 533 (10th Cir. 1995).

³⁵⁶ *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) (invalidating a law that required employers — even those with self-funded plans — to keep workers on the plan while they were out on workers' compensation.)

mechanisms for state law benefits, directly infringe on such core ERISA concerns as self-funded health and pension plans.

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

In states where participation in the workers' compensation system is voluntary, employers that opt out can provide similar coverage through employee benefit plans, which (to the extent that they are bona fide employer-maintained plans) are governed by ERISA rather than state law, because they are not set up to comply with a state workers' compensation law. Texas has developed a long line of unique cases dealing with various ramifications of this situation. South Carolina and New Jersey also have a unique approach to this issue. Cases from states such as New Jersey, South Carolina, and Texas, which have distinct approaches to this issue, must be read very carefully before assuming that their holdings have relevance to any other state's laws.

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

Association Coverage: Is it Individual, Small Group or Large Group Coverage?

Most people have health coverage either through their employer (ERISA-covered group health plans), or by purchasing a plan directly from an insurer (individual plans). An alternative is to obtain coverage through a membership-based organization, like an association. This coverage is often issued through a group policy, with the organization or a trustee as the master policyholder, and may be subject to state laws regulating group health insurance. This can be a source of confusion, because the phrase "group health insurance coverage" has an entirely different meaning under HIPAA and the ACA. For purposes of federal law, the distinction between "individual" and "group" coverage is not based on whether the contract is a group policy, but rather whether the

coverage is issued in connection with a group health plan.³⁵⁷ “Group health plan,” in turn, means an employee benefit plan, as defined in ERISA, to the extent that the plan provides medical care.³⁵⁸

Group coverage, in turn, is divided into small group coverage and large group coverage, based on the size of the employer. A “large” employer is usually defined to mean one with more than 50 employees, but states have the option to raise the threshold to 100 employees.³⁵⁹ Thus, all health insurance coverage is classified under federal law as either individual, small group, or large group coverage. There is no separate category for association coverage. Generally, coverage issued to an employer through an association is classified based on the size of the employer, not the aggregate number of employees covered through the association. However, as discussed below, there is an exception for AHP coverage when the AHP qualifies as an ERISA plan at the association level.

How Association Coverage is Classified

Federal law establishes a “look-through” methodology for regulating group policies issued to associations, or to any other group comprising more than one employer or more than one household; *i.e.*, the individual, small group and large group markets are defined by the nature of the customer that buys the coverage, not by the form of the contract. In particular, the Public Health Service (PHS) Act defines the “small group market” as “the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.”³⁶⁰ In exactly the same manner, all health insurance provided through a large employer’s group health plan, “directly or through any arrangement,” is defined to constitute the large group market.³⁶¹

And the individual market is defined to encompass everything else falling within the federal definition of “health insurance coverage,” whether it is written as an individual policy, a family policy, or as some type of non-employment-based group policy.³⁶² The PHS Act also includes some specific “rules for determining employer size,” including an aggregation rule spelling out limited circumstances in which some (but not all) “persons treated as a single employer” for tax purposes – notably, affiliated businesses under common ownership and control – are combined for purposes of determining “small” or “large” employer status.³⁶³ The look-through principle reflects concerns that granting small employers the right to choose between buying community-rated small group coverage and non-community-rated large group coverage might result in adverse selection

³⁵⁷ 42 U.S.C. §§ 300gg-91(b) (4). Some states make similar distinctions under state law. For example, in Maine, “individual health plans” include both individual policies and certificates under association, credit union, and discretionary group policies, except for coverage issued through an employer that is a member of an association or discretionary group. 24-A Me. Rev. Stat. §§ 2701(2)(C) & 2736-C(1)(C) (2018).

³⁵⁸ 42 U.S.C. § 300gg-91(a)(1) (2018).

³⁵⁹ 42 U.S.C. § 300gg-91(e)(4), as amended by PACE Act, Pub. Law 114-60. As of this writing, four states define employers with 100 or fewer employees to be “small” employers. See http://www.ncsl.org/research/health/small-business-health-insurance.aspx#small_group=50.

³⁶⁰ 42 U.S.C. § 300gg-91(e)(5). See also ACA § 1304(a)(3) (42 U.S.C. § 18024(a)(3)).

³⁶¹ 42 U.S.C. § 300gg-91(e)(3).

³⁶² *Id.* § 300gg-91(e)(1).

³⁶³ *Id.* § 300gg-91(e)(6)(A) (2018), referencing I.R.C. §§ 414((b), (c), (m) & (o)). See also ACA § 1304(b)(4). (The list of referenced Tax Code provisions also expressly excludes I.R.C. § 414(n), relating to employee leasing companies.)

against the small group market. Some actuaries believe the destabilizing impact could be significant.

This framework entitles individuals to the same consumer protections whether they buy their coverage directly or through some other “arrangement” such as an association, and does the same for small employers that maintain group health plans. It reduces the opportunity for regulatory arbitrage by providing a level playing field where carriers competing for the same customers are subject to the same rules. The only way in which HIPAA recognized any difference between association coverage and coverage sold directly to individuals or employers was through limited exceptions to guaranteed issue and guaranteed renewal for coverage that “is made available ... only through one or more bona fide associations.” These exceptions allowed the insurer to deny coverage under such plans to employers that were not association members and to terminate such coverage if association membership ceased. However, the ACA repealed the bona fide association exception to guaranteed issue. The guaranteed renewal exception remains in force, but applies only to the remaining “association-only” plans that are still in force, largely grandfathered plans.

Individual Market Coverage

If health insurance coverage offered to an individual through an association is not offered in connection with a group health plan, it is defined in PHS Act §§ 2791(b)(5) and (e)(1)(A) as individual health insurance coverage being sold in the individual market. The ACA’s “Health Insurance Market Rules; Rate Review” final rule (Market Rule final rule) provides: “Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage.”³⁶⁴ This includes “mixed” associations whose membership comprises both employers and individuals; the individual members of the association are part of the individual market risk pool in the state and the carrier providing the association coverage must comply with individual market rating rules.

Until 2018, DOL regulations provided that working owners of small businesses and their spouses were not considered “employees” for purposes of ERISA.³⁶⁵ This meant that coverage issued to sole proprietors and sole shareholders was considered individual coverage under federal law unless the business also employed at least one person who was not the owner or the owner’s spouse.³⁶⁶ However, the AHP Rule amends that definition to allow a working owner to be treated as his or her own employee, for the limited purpose of participation in an AHP, as long as the owner either works in the business for at least 20 hours per week or 80 hours per month, or earns enough from the business to pay for the coverage.³⁶⁷

³⁶⁴ 45 CFR § 144.102(c).

³⁶⁵ 29 CFR § 2510.3-3(c). *See supra* note 232.

³⁶⁶ HIPAA made group insurance available to some working owners through statutory exceptions treating partners as “employees” of the partnership for the limited purpose of buying group health insurance, and allowing those sole proprietors who qualify as “employers” to be covered as “participants” under their group policies. 42 U.S.C. § 300gg-21(d). Some state laws permit self-employed individuals to obtain coverage as “groups of 1” even if they have no other employees. The ACA also lowered the minimum small group size from 2 to 1, but the impact was more limited because a “group of 1” under federal law means one “employee” within the ERISA definition.

³⁶⁷ 29 C.F.R. §§ 2510.3-5(b)(2) & (e)(2)(iii).

Group Market Coverage

Employment-related coverage, on the other hand, is classified as either small group coverage or large group coverage, depending on the size of the employer. Under the ACA, the “small group market” consists of coverage obtained “through a group health plan maintained by a small employer,”³⁶⁸ regardless of whether the employer has purchased that coverage directly or through some other arrangement, such as an association. However, because the ACA has imposed more stringent requirements on small group coverage, some association plans have sought treatment as large group plans so that they can continue offering health coverage to small employers without being subject to requirements such as modified community rating, restrictions on actuarial value (the metal tiers) and the essential health benefit package. The October 2017 Executive Order asserted that the high cost of small group insurance placed small employers at a disadvantage and that “Expanding access to AHPs can help small businesses overcome this competitive disadvantage by allowing them to group together to self-insure or purchase large group health insurance.”³⁶⁹ The AHP Rule was adopted to implement that goal.

Federal Guidance on Association Coverage

The status of association plans was addressed in a CMS Insurance Standards Bulletin (CMS Bulletin) published September 1, 2011. That bulletin stated that there is no distinct category of “association coverage” under the ACA. The CMS Bulletin explains: “Although the Affordable Care Act revised and added to Title XXVII of the PHS Act, it did not modify the underlying PHS Act framework for determining whether health insurance issued through associations was individual or group health insurance coverage.” The Bulletin acknowledged that there are limited exceptions to certain provisions of the guaranteed issue and guaranteed renewability laws for coverage offered through “bona fide associations,” but emphasized that “[t]he bona fide association concept has no other significance under the PHS Act, and, importantly, does not modify or affect the analysis of whether health insurance coverage belongs to the individual or group market.”

The CMS bulletin also discussed “mixed” associations. A “mixed” association exists where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member’s circumstances. In this situation, the members of the association cannot be treated as if all of them belonged to same market. For example, it is not permissible under the PHS Act for mixed association coverage to comply only with the large group market rules, even with respect to its individual and small employer members. Accordingly, each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer.

³⁶⁸ 42 U.S.C. §§ 300gg-91(e)(5). Similarly, laws in some states expressly base eligibility for “small group” coverage on employer size rather than group size. *See, e.g.*, 24-A Me. Rev. Stat. §§ 2808-B(1)(D) & (H) (defining “eligible group” to include a “subgroup,” defined as “an employer with 50 or fewer employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract.”)

³⁶⁹ EO 13813, *supra note* 229, § 1(b)(i).

The CMS Bulletin discussed how the look-through principle applies to “health insurance coverage offered to collections of individuals or employers through entities that may be called associations, trusts, multiple employer welfare arrangements (MEWAs), or purchasing alliances.” As discussed above, the statute classifies all such coverage, regardless of how it is structured, as either individual coverage, small group coverage or large group coverage, depending on whether it is sold to individuals and families, sold to small employers providing group health plans, or sold to large employers providing group health plans. But what, precisely, does the statute mean when it says that all coverage obtained “through a group health plan maintained by a small employer” is considered small group coverage, whether the employer purchases that coverage “directly or through any arrangement”? If a small employer purchases coverage through an association or other MEWA, is that the type of “arrangement” that must always be looked through?

The answer, according to the Bulletin, is “not always.” Look-through treatment is only required when there is a group health plan “maintained by a small employer,” so the key to the analysis is whether the plan is maintained at the employer level or the MEWA level. The guidance states: “CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level.”³⁷⁰ In those cases, the size of each employer determines whether the employer’s coverage belongs to the individual, small group or large group market. However, the guidance states further: “In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the ‘employer,’ the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules.”³⁷¹

Before the 2018 AHP Rule, this exception to the “look-through” principle was not particularly significant. As the CMS Bulletin phrased it, it applied only in “rare instances.” As a result, association coverage became less prevalent under the ACA because there was little advantage to be gained from buying and selling it through associations rather than directly. However, the AHP Rule has changed the landscape significantly. DOL has reaffirmed the interpretation that health insurance offered through a Plan MEWA is considered large group coverage under the ACA, and revised the criteria for Plan MEWA status to allow a wide range of associations to qualify. Thus, all small employers in a trade or geographic area where an AHP is operating now have the option of buying “large group” coverage, and so will self-employed individuals who devote sufficient time or earn sufficient income from their business to qualify as “working owners” under the AHP Rule.

³⁷⁰ See CMS Bulletin http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.

³⁷¹ That is not the only possible interpretation of the statute. ERISA does not say that an association establishing an ERISA benefit plan is “the employer”; it says it is “an employer.” The ERISA definition encompasses both direct and indirect “employers,” but the existence of an “indirect employer” depends on the existence of direct employers in whose interest it is acting. The direct employer continues to be the party employing the plan participants, paying for their health coverage, and deciding which coverage to buy every year after working with its broker to review all the different AHPs and non-AHP coverage options that are available in the market, so it is not clear why employee benefit plans cannot simultaneously exist at both the employer level and the AHP level.

If the AHP Rule fulfills its goal of making the ACA market optional for most small employers and self-employed individuals, the effect is to make the states once again the primary regulators of the group insurance market, as they were before the ACA. DOL has emphasized that the AHP Rule does not have preemptive effect.³⁷² For fully-insured AHPs, states can continue to apply their group insurance laws, such as benefit mandates,³⁷³ rating rules, and prohibitions against fictitious groups. However, state insurance laws may not prevent the application of controlling provisions of the ACA or PHS Act.³⁷⁴ Non-fully-insured MEWAs were already primarily regulated by the states, as they have always been generally exempt from all ACA requirements except the limited number that apply to self-insured plans,³⁷⁵ and DOL has reaffirmed states' broad authority to regulate these arrangements, either as insurers or as alternative risk-bearing-entities under some specialized licensing regime.³⁷⁶ States may choose to amend their group insurance laws or MEWA laws to take advantage of the increased flexibility the AHP Rule provides in their markets, to close perceived regulatory gaps left by the diminished scope of the ACA standards, or to combine both approaches. However, these choices have been left to the states.

Rating Requirements for Association Health Plans

If an association group policy is determined to be a “large group” policy, it is exempt from the ACA’s community rating requirements. This means the insurer is free to use claims experience and other underwriting factors when pricing the policy, except as prohibited by state law; and states do not generally regulate large group premium rates. The question then arises whether the exemption from community rating applies at the member employer level or at the association level. If the association as a whole can obtain favorable rates based on its purchasing power, but cannot deny membership or charge member employers higher rates based on health-related factors, the risk of a destabilizing impact on the community-rated market is reduced.

Large group status, as discussed above, means that all participating employees have been deemed to be employed by the “same employer” for health benefit purposes. If the association sponsors a single “group health” plan, that plan is subject to the PHS Act’s prohibitions against discrimination based on health status. In particular, “Health status,” “Claims experience,” or “Any other health status-related factor determined appropriate [*sic*] by the Secretary” may be used in calculating an employer’s aggregate premium, not to charge different premiums for similarly situated individuals covered through the same employer.³⁷⁷ The implementing regulation permits premiums or employee contribution rates to vary on the basis of “bona fide employment-based classifications,” such as “full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former

³⁷² See, e.g., Preamble to AHP Final Rule, 83 F.R. 28936, 28959.

³⁷³ See *id.* at 28934.

³⁷⁴ PHS Act § 2762; ACA § 1321(d). For example, CMS issued a letter in 2013 advising the State of Washington that a state law deeming association plans to be large group coverage, and thus purporting to exempt them from community rating, was preempted to the extent that the plans in question were small group coverage under the ACA.

³⁷⁵ With the exception of any entities that were treated as “health insurance issuers” by CMS before the adoption of the AHP Rule but will qualify as Plan MEWAs as of 2019. It is not clear whether any such entities are in operation.

³⁷⁶ See Preamble to AHP Final Rule, 83 F.R. 28936, 28959.

³⁷⁷ PHS Act § 2705 (42 U.S.C. § 300gg-4) (a)(1), (a)(3), (a)(7), (b)(1), & (b)(2).

employee status, and different occupations,”³⁷⁸ but the regulation expressly provides that “a classification based on any health factor is not a bona fide employment-based classification,”³⁷⁹ with an exception allowing favorable treatment for people with adverse health factors. Many regulators interpret these provisions as permitting the use of claim experience and other health factors only in the aggregate, at the policyholder level; and take the position that permitting association policies to be experience rated at the member employer level would contradict the premise that the association should be treated as if it were a single large employer. Insurers that seek to apply experience rating have responded that the prohibition against using claims experience applies only to “similarly situated” individuals and that treating each a member employer as a separate rating unit is permitted when it is a bona fide employment-based classification within the AHP.

In the 2018 AHP Rule, DOL established nondiscrimination requirements that prohibit experience rating at the member employer level for all “New Pathway” AHPs formed under the Rule. However, DOL indicated that it did not interpret the prohibition on experience rating as being required in all cases by the underlying statute, and that DOL would permit “Traditional Pathway” AHPs, qualifying under the pre-2018 regulatory guidance, to experience-rate at the member level, as long as it was not a pretext for discriminating against a particular employer or plan participant. DOL’s rationale is that the pre-2018 guidance “had a stronger employer nexus requirement.”³⁸⁰ Likewise, the AHP Rule does permit rating at the occupation or industry level, even if it is based on the claims experience of the different subclassifications within the AHP.³⁸¹

Comparing the Options for Association Coverage

The result is that DOL recognizes two different options for forming AHPs that qualify for federal recognition as large group ERISA plans. Each option is available regardless of whether the plan was formed before or after the effective date of the 2018 AHP Rule. The Traditional Pathway (“Pathway One”) has more stringent requirements for qualifying, while the New Pathway (Pathway Two”) has more stringent operational requirements. In either case, because both types of AHPs are MEWAs, they must also comply with applicable state laws; DOL has made clear that the AHP Rule does not have preemptive effect.³⁸² Associations may also choose to operate outside either Pathway, either intentionally or because they fail to meet the applicable requirements. The three options are compared in the table below (for simplicity, it will be assumed that the association covers more than 50 employees in the aggregate, and that the members are all small employers or self-employed individuals):

³⁷⁸ 29 CFR § 2590.702(d).

³⁷⁹ *Id.*

³⁸⁰ Preamble to AHP Final Rule, 83 F.R.28928 n.40.

³⁸¹ 29 CFR § 2510.3-5(d)(5), Examples 7–9.

³⁸² Preamble to AHP Final Rule, 83 F.R. 28937–39.

	Traditional Pathway (“Pathway One”) AHPs	New Pathway (“Pathway Two”) AHPs	Non-Plan MEWAs
Status under ERISA	Group health plan at MEWA level. Eligibility for AHP status determined under pre-2018 DOL and case law standards.	Group health plan at MEWA level. Eligibility for AHP status determined under 2018 AHP Rule	MEWA not directly regulated under ERISA, but must file Form M-1 and may be subject to indirect regulation based on role in participating employers’ ERISA plans
Status under state law – fully insured	State may regulate insurer and insurance policy; AHP itself may only be regulated with regard to reserves and contributions	State may regulate insurer and insurance policy; AHP itself may only be regulated with regard to reserves and contributions	No restrictions other than HIPAA/ACA “federal floor”
Status under state law – not fully insured	State may regulate the plan as an insurer or may adopt a MEWA-specific law	State may regulate the plan as an insurer or may adopt a MEWA-specific law	No restrictions other than HIPAA/ACA “federal floor”
Coverage of self-employed individuals with no employees	May not participate in the group health plan.	If they meet the “working owner” time or earnings test	Subject to ACA individual market requirements
ACA market sector	Large group or self-insured plan	Large group or self-insured plan	“Look through” to member’s status as small group or individual
Control by members	Employer control of both the sponsor and the AHP must be present in form and substance	Employer control of both the sponsor and the AHP must be present in form and substance	Depends on state law
Commonality of interest	Must be based on common industry and meet “bona fide group or association of employers” analysis; underwriting for health risk prohibited	May be based on common industry or common geography (state or metro area); underwriting for health risk prohibited	Depends on state law
Can health coverage be the sponsoring entity’s primary purpose?	No	Yes, but must have some other substantial business purpose; this can be demonstrated if association would still operate if it didn’t offer the AHP.	Depends on state law.

Experience rating at member level	Subject to state law, permitted unless a pretext for discriminating against a particular employer or individual	No	No
Other rating factors at member or participant level	Subject to state law, may use any non-health-status rating factor (including gender, occupation, and industry) unless a facially neutral criterion is used as a pretext for health status discrimination; ACA restrictions on age and geography do not apply.	Subject to state law, may use any non-health-status rating factor (including gender, occupation, and industry), unless a facially neutral criterion is used as a pretext for health status discrimination; ACA restrictions on age and geography do not apply.	Modified community rating as required under ACA individual and small group rules
Mandated benefits	Only as required by federal law for large employers and self-insured plans, or by applicable state law; EHB requirement does not apply	Only as required by federal law for large employers and self-insured plans, or by applicable state law; EHB requirement does not apply	EHB and applicable state law mandates

What is a voluntary employees’ beneficiary association (VEBA)?

A voluntary employees’ beneficiary association (VEBA) is a tax-advantaged welfare benefits funding vehicle defined under the Internal Revenue Code (IRC).³⁸³ Its operations are substantially devoted to providing for the payment of life, sickness, accident, or other benefits to the VEBA’s members and their dependents and beneficiaries. Membership in the VEBA is voluntary. Further, the net earnings of the association cannot inure to any private shareholder or individual other than from the payment of the benefits.³⁸⁴

The VEBA can be established in a number of forms, such as a trust or a corporation, organized under state law. The trust or corporation must exist independent of the member employees or their employer.³⁸⁵ The employees are entitled to participate in the VEBA because of their employee status and because they have a common employment-related bond (such as covered by common employer or under one or more collective bargaining agreements or are members in a labor union).³⁸⁶ The organization must be controlled by its membership, independent trustees, or trustees designated by, or on behalf of, the members.³⁸⁷

³⁸³ 26 U.S.C. § 419(e)(3)(A) (2018); 26 U.S.C. § 501(c)(9) (2018).

³⁸⁴ 26 C.F.R. § 1.501(c)(9)-1 (2018).

³⁸⁵ 26 C.F.R. § 1.501(c)(9)-2(c)(1) (2018).

³⁸⁶ 26 C.F.R. § 1.501(c)(9)-2(a)(1) (2018).

³⁸⁷ 26 C.F.R. § 1.501(c)(9)-2(c)(3) (2018).

A VEBA may be, but is not always, associated with an employee welfare benefit plan under Title I of ERISA. To be an employee welfare benefit plan, a plan must be established or maintained by an employer or employee organization. A VEBA is not an employer association because its members are the employees, not their employers. A VEBA does not necessarily meet ERISA's definition of an employee organization either. The fact that a VEBA has been recognized under the Internal Revenue Code does not mean that it will be recognized as an employee organization under ERISA. IRC regulations clearly state that VEBAs are not coterminous with employee beneficiary associations within the meaning of ERISA.³⁸⁸

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

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

The phrase “Multiple Employer Trust (MET)” has no legal meaning under ERISA. An organization that calls itself an MET is usually a MEWA (unless it qualifies as a bona fide collectively bargained plan), and is subject to state regulation to the same extent as any other MEWA.

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

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

Following DOL's issuance of the AHP Rule in 2018, there have been many questions about whether the Rule has somehow changed this relationship between state and federal law, preempting state laws such as community rating or mandated benefit requirements, and laws limiting which types of association groups were eligible to purchase insurance coverage on a master-policy basis or to qualify under a MEWA-specific licensing law for exemption from the state's traditional insurance licensing laws.

In the Preamble to the AHP Rule, DOL discussed at length the provisions of ERISA saving state regulation of MEWAs from preemption, and clarified that the Rule has no new preemptive effect.³⁸⁹ Shortly thereafter, DOL issued a compliance pamphlet that includes the following FAQ:

Do the States have any authority over AHPs?

Yes. ERISA expressly provides both the Department and State insurance regulators joint authority over AHPs. In addition, States can regulate health insurance issuers and the health

³⁸⁸ 26 C.F.R. § 1.501(c)(9)-7 (2018).

³⁸⁹ Preamble to AHP Final Rule, 83 F.R. 28936–37.

insurance policies they may sell to AHPs, and they can regulate self-insured AHPs to the extent the regulation is not inconsistent with ERISA. The new rule does not diminish state oversight. Employers and plan administrators should check with the applicable state insurance department for more information on that state’s insurance laws.³⁹⁰

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

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

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

Whether a state has authority to regulate a MEWA that covers employees in a state when the employers are located in another state depends upon the laws of the state seeking to apply its laws. ERISA does not preempt a state’s insurance laws, including those that require an insurance company to be licensed in your state irrespective of the location of the employers and employees.³⁹¹

Is the term “fully insured” defined in ERISA?

Yes. 29 U.S.C. §1144(b)(6)(D) states: “For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a state.”³⁹²

The term “benefit” when used in ERISA “uniformly refers only to payments due the plan participants or beneficiaries.”³⁹³ Accordingly, 29 U.S.C. §1144(b)(6)(D) requires that to be “fully

³⁹⁰ *Association Health Plans: ERISA Compliance Assistance*, Employee Benefits Security Administration, August 2018, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-publication-ahp.pdf>

³⁹¹ The NAIC’s 2009 white paper *States’ Treatment of Regulatory Jurisdiction Over Single-Employer Group Health Insurance* provides a useful discussion of the issues involved in regulating employment-based coverage when the employers and employees are located in different states.

³⁹² See Department of Labor Opinion 93-11A re: *Associated Builders and Contractors* (April 15, 1993).

³⁹³ *Mack Boring and Parts v. Meeker Sharkey Moffitt*, 930 F.2d 267, 273 (3d Cir. 1991).

insured” a MEWA must have a contract or policy of insurance, which guarantees payment of benefits to the plan participants. A MEWA or trust is not “fully insured” if it has an insurance contract or policy which obligates the insurer only to make payments to the MEWA or trust.

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

Both judicial decisions and DOL opinions support this literal interpretation of the language and the legislative history of the statute. In *Bone v. Ass’n Mgt. Services, Inc.*,³⁹⁴ the court pointed out that an insurer which has issued a stop-loss policy was obligated only to make payments to the employee benefit plan itself, and not to plan participants. The court concluded the plan was not an insured plan under the “deemer” clause. Similarly, the DOL has issued an advisory opinion that states a MEWA is not fully insured solely because it has a stop-loss policy.³⁹⁵ In an opinion issued to the Connecticut Commissioner of Insurance on an arrangement involving United Service Association for Health Care, the Department of Labor considered, and rejected, the contention that an insurance contract directed solely to a trust or arrangement renders the trust or MEWA “fully insured.” The Department concluded that an insurance contract creating only an obligation to the trust fails to “guarantee” directly the benefits of the participants. Also, the Department reiterated that “the question whether a MEWA is fully insured arises only if the arrangement constitutes an “employee welfare benefit plan” covered by ERISA.”³⁹⁶ Finally, note the literal language of 29 U.S.C. §1144(b)(6)(D), which states that a MEWA is “fully insured” only if the Secretary of Labor so determines.

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

A state insurance agency can subpoena an organization’s records or conduct and charge for a financial examination in accordance with its express and implied legislative authority. Because states do not have regulatory authority over single-employer plans and collectively bargained multiemployer plans, a state insurance agency does not have authority to subpoena those plan’s records or conduct and charge for a financial examination.

However, states do have authority to regulate plans that are MEWAs. State insurance departments, consequently, are authorized to subpoena MEWA plans consistent with the scope of the express and implied powers for insurance regulation granted by the legislature and subject to constitutional requirements.

³⁹⁴ *Bone v. Ass’n Mgt Services, Inc*, 632 F. Supp. 493 (S.D. Miss. 1986).

³⁹⁵ DOL Advisory Opinion 91-05A re: *AGC Health Benefit Trust* (January 14, 1991).

³⁹⁶ DOL Advisory Opinion 94-07A re: *United Service Association for Health Care* (March 14, 1994).

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

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

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

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

Not all contractual transactions between employers and managed care organizations involve insurance risk. The distribution of risk must be an essential characteristic of the transaction in order to invoke the issues that insurance regulation is designed to address. Premium payment mechanisms through which employers transfer and distribute their risk to managed care organizations include arrangements, such as capitation, whereby the managed care organization is paid a fixed payment per member per month to cover the cost of all or some of the employee's health care.³⁹⁷

Whether a state law that is applied to managed care organizations is preempted by ERISA depends upon whether that state law “relates to” an ERISA plan, and if so, if the law is “saved” as an insurance regulation. Laws that explicitly reference ERISA plans or that involve substantive ERISA requirements may “relate to” ERISA plans. Some laws that indirectly affect ERISA plans may “relate to” ERISA plans as well. However, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,³⁹⁸ the Court held that a statute which has an indirect economic influence that does not bind plan administrators to any particular choice, or preclude administrative practices or the provision of uniform interstate benefit packages, is not connected with employee welfare benefit plans and does not “relate to” such plans. A state law that imposes such high costs on plans that the law restricts an ERISA plan's choice of available insurers, or

³⁹⁷ For a broader discussion on other possible risk-sharing arrangements see NAIC's white paper, *The Regulation of Health Risk-Bearing Entities*, developed by the Risk-Bearing Entities Working Group of the State and Federal Health Insurance Legislative (B) Policy Task Force in 1996.

³⁹⁸ 514 U.S. 645 (1995).

forces an ERISA plan to adopt a certain scheme of coverage, may be held to “relate to” the ERISA plan.³⁹⁹

While ERISA prohibits states from regulating employee welfare benefit plans, it does not prohibit states from regulating the business of insurance or insurance contracts. In *Metropolitan Life v. Massachusetts*,⁴⁰⁰ the Supreme Court held that a state law that mandated that insurers cover certain mental health benefits was saved from ERISA preemption.⁴⁰¹ The Court based its analysis on the test developed under the McCarran-Ferguson Act to determine whether an entity was engaged in the business of insurance:

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

The Court held that the state statute was saved because the law regulated the spreading of risk; regulated an integral part of the policy relationship between the insurer and the insured; and applied only to entities within the insurance industry.⁴⁰²

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

A wide variety of health care reimbursement arrangements can be devised, so there is not always a clear line between receiving compensation for health care services and assuming risk as a health maintenance organization. Factors regulators may consider are the range of services encompassed within the scope of the arrangement, whether a regulated entity is also on the risk,⁴⁰³ and whether

³⁹⁹ *Id.* at 1683.

⁴⁰⁰ 471 U.S. 724 (1985).

⁴⁰¹ *Id.* at 743.

⁴⁰² *Id.* It should be noted that an arrangement need not meet all three of these criteria to be determined to be in the business of insurance. See *Union Labor Life v. Pireno*, 458 U.S. 119, 129 (1982).

⁴⁰³ See, e.g., 24-A Me. Rev. Stat. §§ 4331–4343 (2018), establishing a safe harbor within which an unlicensed “downstream entity” is permitted to assume a limited degree of risk if the upstream entity with direct responsibility for providing health benefits to enrollees is a licensed insurance carrier.

the provider or provider group will be performing all the covered services or whether financial risk is being assumed for services that might need to be performed by third parties. When a managed care organization sponsored by providers assumes insurance risk, the arrangement between the employer and the managed care organization is not substantively different from the arrangements employers enter into with HMOs that are not sponsored by providers. Regulators should be aware, however, that a few state courts have held that HMOs are not engaged in the business of insurance.⁴⁰⁴ Courts place significant weight on how a state's laws classify an entity's activities.⁴⁰⁵ States should become familiar with the case law on this subject involving HMOs and should be careful to classify as the business of insurance all insurance arrangements that involve the purposes of insurance regulation.

To what extent may states regulate third party administrators (TPAs) that provide administrative services to ERISA plans?⁴⁰⁶

The case law reviewing statutes that regulate TPAs is minimal. Of the few cases that involve state statutes that directly regulate third party administrators of ERISA plans, the majority of the courts have held that such statutes are preempted by ERISA. At least one court has upheld a TPA licensing statute that established minimal criteria. However, the analysis used in existing case law may be altered by the analysis used by the Supreme Court in *N.Y.S. Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*⁴⁰⁷

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

Prior to the consideration of *Travelers* by the Supreme Court, at least one court permitted licensing of TPAs of self-funded ERISA plans. This court applied an analysis similar to, but not as broad as, the analysis used in the *Travelers* opinion. In *Benefax Corporation v. Wright*,⁴⁰⁸ the TPA's motion for summary judgment was denied in an action for declaratory and injunctive relief from application of the Kentucky state insurance department's administrator licensing statute. The Kentucky statute at issue in that case requires that administrators, as defined by the statute, meet

⁴⁰⁴ See *New York State Health Maintenance Organization Conference v. Curiale* 18 Employee Benefit Cas. (BNA) 1446 (S.D.N.Y. 1994) *rev'd on other grounds*, 64 F.3d 794 (2d Cir. 1995); *but see Anderson v. Humana*, 24 F.3d 889 (7th Cir. 1994).

⁴⁰⁵ See *In the Matter of Estate of Medicare HMO*, 998 F.2d 436 (7th Cir. 1993); *In re Family Health Services*, 143 B.R. 232 (1992).

⁴⁰⁶ This discussion on TPAs relates to non-risk arrangements. To the extent that a contract involves the TPA assuming insurance risk on behalf of an employer, this analysis does not apply because the state unquestionably has the authority to regulate an entity acting as an insurer, even if it calls itself an "administrator."

⁴⁰⁷ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

⁴⁰⁸ *Benefax Corporation v. Wright*, 757 F. Supp. 800 (W.D. Ky. 1990).

minimal eligibility criteria related to age, competency and reputation, level of financial responsibility, and education. The administrator must also have paid the established fee and have not had a previous license or application terminated for cause.⁴⁰⁹

The court rejected the TPA's argument that the state statute was preempted by ERISA and thus, the Commissioner lacked the authority to mandate a license as a requirement to conduct business in the state. The court held that ERISA did not preempt the state licensing statute. It reasoned that the statute did not "relate to" ERISA plans since the law applied to administrators irrespective of the type of plans they serviced (ERISA or non-ERISA). The court also explained that, even if the statute related to an ERISA plan in some respect, it fell within the "tenuous, remote and peripheral" exception to ERISA preemption recognized by the Supreme Court in *Shaw v. Delta Air Lines*.⁴¹⁰

Other cases, however, held that state laws relating to third party administrators of ERISA-covered plans are preempted. These cases involved more significant requirements than the Kentucky statute at issue in *Benefax*. In *Self-Insurance Institute of America v. Gallagher*,⁴¹¹ the court held that Florida statutes regulating plan administrators were preempted by ERISA because the laws did not regulate the business of insurance. In *Gallagher*, the Self-Insurance Institute of America (SIIA) objected to a series of state statutes that imposed various requirements upon contract administrators of ERISA employee benefit plans. Among other things, the regulations required that administrators enter into written agreements and identified what must be contained within such agreements. The regulations also required that administrators pay a bonding fee, obtain a certificate of authority to conduct business, and file extensive organizational and financial information.

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

In *E-Systems, Inc. v. Pogue*,⁴¹² the appeals court upheld a district court opinion that granted summary judgment to plan sponsors challenging the Texas Administrative Services Tax Act (ASTA), enjoined further enforcement of the statute as it applied to ERISA plans, and held that the act was preempted by ERISA. The ASTA placed a 2.5 percent annual tax on persons receiving administrative and service fees for services provided to what are essentially ERISA plans. The state claimed that the district court did not have the jurisdiction to enjoin a tax statute under circumstances where the state courts could evoke an efficient remedy under the Tax Injunction Act. The appeals court dismissed this reasoning and held that it was Congress's intent that any law that contradicted ERISA, including state tax law, was preempted by the federal statute.

⁴⁰⁹ Ky. Rev. Stat. § 304.9-052.

⁴¹⁰ *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).

⁴¹¹ *Self-Insurance Institute of America v. Gallagher*, 11 Employee Benefits Cas. (BNA) 2162 (N.D. Fla. 1989), *aff'd*, 909 F.2d 1491 (11th Cir. 1990).

⁴¹² *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir. 1991).

In *NGS American, Inc. v. Barnes*,⁴¹³ the court held that a Texas statute, which indirectly regulated ERISA plans by regulating and taxing third party administrators of such plans, was preempted by ERISA, and the court granted plaintiff's motion for summary judgment. The state argued that regulation of the administrators was permissible in this case because the administrators were engaged in the business of insurance. The court responded that the administrators were not engaged in the business of insurance and that the law at issue "related to" the plan. In *NGS*, the court distinguished *Benefax* as a "mere licensing statute," since the Texas statute's scope was considerably broader, incorporating a TPA tax and bonding requirement.

The appeals court affirmed the district court's grant of summary judgment in *NGS American, Inc. v. Barnes*.⁴¹⁴ It agreed that the administrators did not conduct the business of insurance, and therefore, the statute did not regulate the business of insurance. Further, the appeals court agreed with the district court's finding that the Texas statute was more than a mere licensing statute, unlike the statute at issue in *Benefax*. The Texas statute, insofar as it regulated administrators of ERISA-covered plans, impermissibly "related to" ERISA plans because of its intrusive nature, and thus, violated the Supremacy Clause of the United States Constitution.

In *Self-Insurance Institute of America v. Koriath*,⁴¹⁵ the state of Texas did not appeal the district court's holding that ERISA preempted the state law imposing a maintenance tax on contract administrators of ERISA plans in light of the court's ruling in *NGS*. The state did, however, successfully appeal the district court's award of attorneys' fees and the refund of taxes and fees paid by ERISA plans and administrators. The appeals court held that the association had standing with respect to seeking an injunction, but no standing with respect to the award of refunds and attorneys' fees. The court stated that the individual participation of association members would be needed to determine which association members were due the refunds since many members administered both ERISA and non-ERISA-covered plans.

The Supreme Court in the *Miller* opinion, which is not a case directly addressing ERISA preemption of TPA laws, does include a footnote that addresses whether a law that applies to HMOs that act as administrators of self-funded plans is still an "insurance law" within the meaning of ERISA's saving clause. The Petitioners argued that Kentucky's "any willing provider" law was not a law that regulated insurance within the meaning of ERISA's saving clause because it was not "specifically directed at the insurance industry" because it applied to HMOs not acting as insurers, but as administrators of self-funded plans. The Court stated that this argument was not persuasive because "noninsuring HMOs would be administering self-insured plans, which we think suffices to bring them within the activity of insurance for purposes of [ERISA's saving clause]."

Some may argue that this language gives states permission to regulate TPAs without fear of ERISA preemption. However, this language must be viewed in the context of the entire *Miller* opinion, as well as the rest of ERISA, and clearly, ERISA's deemer clause prevents states from enacting laws that have the effect of regulating self-funded ERISA plans. It does not appear that the *Miller*

⁴¹³ *NGS American, Inc. v. Barnes*, 805 F.Supp. 462 (W.D. Tex. 1992).

⁴¹⁴ *NGS American, Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993).

⁴¹⁵ *Self-Insurance Institute of America v. Koriath*, 53 F.3d 694 (5th Cir. 1995).

opinion has shed any light on the analysis for determining whether a state law regulating TPAs is preempted by ERISA. The status of the law remains unclear, and any preemption analysis is going to be particular to the details of a state's law. Overall, states should be mindful of the Supreme Court's opinion in *Travelers*, and draft laws that minimize the potential burden on self-funded ERISA plans. State laws that apply broadly and are not overly burdensome should not be preempted.

Can states prohibit the use of discretionary clauses in insurance policies that provide ERISA benefits?

After the Supreme Court suggested in *Firestone* that ERISA plan administrators could avoid *de novo* judicial review if the plan documents grant them discretionary powers, many insurers responded by adding clauses to their policies that purported to give them discretionary authority to interpret the terms of the policy and to pay or deny claims. Many states, through regulatory action or legislation, refused to permit such clauses, and the NAIC has adopted the *Prohibition on the Use of Discretionary Clauses Model Act*,⁴¹⁶ which prohibits the use of discretionary clauses in disability income and medical insurance policies.

The prohibition is based on the recognition that discretionary clauses are contrary to the nature and purpose of insurance. Discretionary clauses, as the *Firestone* Court recognized, are a feature of certain types of trusts, and the Court relied on the distinction between trust law and contract law. More specifically, as the Court subsequently explained in *Varity Corp. v. Howe*,⁴¹⁷ “The common law of trusts recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries.” Discretion is not inherent in all fiduciary relationships – no one would dream, for example, of allowing a bank the discretion to decide whether to keep or return deposited funds. But it is common to grant a trustee the discretion to choose between multiple deserving claims when a limited trust corpus has been set aside and every dollar that is paid to one beneficiary is a dollar that is unavailable to pay to any other beneficiary.

Insurance presents the opposite situation. It is appropriate for states to apply contract law to insurers, even if the policyholder is an employer with an ERISA plan, because insurance is a contract. An insurance policy is not an arrangement where an entity with a mission to help deserving people obtain health care has the discretion to decide who are the most deserving and how they can best be helped.⁴¹⁸ An insurance policy is an irrevocable commitment, made by a company that is in the business of assuming risk, to pay the specified benefits whenever a covered loss occurs during the policy term. The insurer does not have the discretion to decide the terms of that commitment after it has accepted the premium.

Nevertheless, some advocates contend that state laws prohibiting discretionary clauses are preempted by ERISA. One argument that has been made is that discretion is so fundamental to the

⁴¹⁶ NAIC Model Law No. 42, adopted 2002, amended 2004 to extend scope to include disability insurance.

⁴¹⁷ 516 U.S. 489, 514 (1996), citing RESTATEMENT (SECOND) OF TRUSTS §§ 183, 232.

⁴¹⁸ Actually, neither is a self-funded health plan. Implicitly recognizing this reality, Congress has now prohibited the enforcement of discretionary clauses in health benefit plans. See ERISA § 715; PHS § 2719(b)(2)(B) (requiring self-insured ERISA plans to submit disputed claims to independent external review).

obligations of ERISA fiduciaries that an implicit exception to the saving clause must be inferred in order to allow insurers to fulfill their fiduciary responsibilities. This is “[p]ure applesauce.”⁴¹⁹ It is an argument the Supreme Court emphatically rejected in *Firestone*, holding that any grant of discretionary power must be explicit and the default presumption is that no such power has been granted.⁴²⁰

Another argument is that because the Supreme Court made a “clean break” with the *MetLife* “common sense” methodology in *Kentucky Health Plans v. Miller*, common sense must now be disregarded entirely, and the saving clause must be interpreted so narrowly that laws prescribing the provisions of insurance policies do not really “regulate insurance.” However, three federal Circuit Courts of Appeals have considered that argument, and all three have rejected it and upheld the states’ authority to prohibit discretionary clauses,⁴²¹ observing that the Supreme Court made clear in *Kentucky Health Plans* that a law that “dictates to the insurance company the conditions under which it must pay for the risk that it has assumed” is one of the paradigmatic examples of the type of law that regulates insurance because it substantially affects risk pooling.⁴²²

The courts also rejected other techniques designed to bring discretionary clauses outside the scope of the saving clause. For example, in *Fontaine v. MetLife*, the Seventh Circuit dismissed an argument that the Illinois regulation “is not specifically directed toward entities engaged in insurance because it prohibits a plan sponsor, like Mayer Brown, from delegating discretionary authority to the insurer of an employee benefit plan.”⁴²³ The argument is too clever, and without merit.⁴²⁴ In that case, the discretionary clause appeared in a side agreement between the employer and the insurer in its capacity as plan administrator, rather than in the terms of the policy itself, but the court held that relying on that distinction was “another too-clever argument” that if taken seriously would “virtually read the saving clause out of ERISA” and “nullify the evident purpose” of the state regulation.⁴²⁵ As the Sixth Circuit summarized the underlying issue in *ACLI v. Ross*, “If, as *Glenn* reaffirms, there is a conflict of interest when the same plan administrator decides the merits of a benefits plan and pays that claim, and if, as *Glenn* also holds, it is consistent with

⁴¹⁹ *King v. Burwell*, 576 U.S. ____ (2015).

⁴²⁰ See *supra* page 18; see also *ACLI v. Ross*, 558 F.3d 600, 608 (6th Cir. 2009); *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 846 (9th Cir. 2009) (“While it is true that the Commissioner’s practice will lead to *de novo* review in federal courts, this is hardly foreign to the ERISA statute. Indeed, *de novo* review is the default standard of review in an ERISA case.”), *cert. denied sub nom. Standard Ins. Co. v. Lindeen*, 560 U.S. 904 (2010).

⁴²¹ *Fontaine v. Met. Life Ins. Co.*, 800 F.3d 883 (7th Cir. 2015); *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009) (upholding administrative practice not expressly required by state law); *ACLI v. Ross*, 558 F.3d 600 (6th Cir. 2009); accord, *Ravannack v. United HealthCare Ins. Co.*, 2015 U.S. Dist. LEXIS 63922 *5 (E.D. La. 2015) (in a case that did not involve a preemption challenge, noting that “every federal decision that this Court could locate has enforced state law bans on discretionary clauses against ERISA plans”). These three cases were also cited in *Adele E. v. Anthem Blue Cross and Blue Shield*, 2016 U.S. Dist. LEXIS 57055 (D. Me. 2016), where an insurance policy had a discretionary clause but the court conducted *de novo* review after concluding that the clause violated the Maine Insurance Code.

⁴²² See *Fontaine*, 800 F.3d at 888; *Standard v. Morrison*, 584 F.3d at 845; *ACLI v. Ross*, 558 F.3d at 607, all quoting *Kentucky Health Plans v. Miller*, 538 U.S. at 339 n.3.

⁴²³ Furthermore, that argument begs the question because a policyholder never has any discretion over insurance claims that it could “delegate” to the insurer – no insurer would ever write a policy on such terms.

⁴²⁴ 800 F.3d at 887.

⁴²⁵ *Id.* at 887, 891–92 (citations and internal punctuation omitted).

ERISA to account for that conflict of interest in reviewing a plan administrator's decision, it is difficult to understand why a State should not be allowed to eliminate the potential for such a conflict of interest by prohibiting discretionary clauses in the first place."⁴²⁶

⁴²⁶ 558 F.3d at 609.

ACA CHANGES INCORPORATED INTO ERISA

Historical Background: HIPAA and the ACA

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. Amendments to the Affordable Care Act made through the Health Care Education and Reconciliation Act (Reconciliation Act) were signed into law on March 30, 2010, and some additional amendments have been made since that date, notably the Protecting Affordable Coverage for Employees Act (PACE Act),⁴²⁷ enacted in 2015, which preserved the pre-ACA upper limit of 50 employees for “small employer” status, unless a state chooses to raise its threshold to 100 employees.⁴²⁸ In 2017, Congress considered several initiatives to repeal or substantially revise the ACA, but at this writing, all the major ACA provisions remain in effect.

Generally, the ACA’s market reform provisions amend title XXVII of the Public Health Service Act (PHS Act), which is administered by the Department of Health and Human Services. The Affordable Care Act also adds a new section 715 to ERISA, administered by the Department of Labor, Employee Benefits Security Administration, and a new section 9815 to the Internal Revenue Code (IRC), administered by the Department of Treasury, Internal Revenue Service (IRS). These sections incorporate most of the health benefit standards of the PHS Act into ERISA and the IRC, and make them applicable to group health plans and health insurance issuers providing group health insurance coverage.

Title XXVII, as originally enacted by HIPAA, required health insurance issuers to make all health coverage guaranteed renewable, limit pre-existing condition exclusions on group coverage to at most one year, and offer all their small group health plans on a guaranteed-issue basis to eligible employers. The ACA introduced a much more extensive federal role in insurance regulation. It extended guaranteed issue to apply to the individual and large group markets, required modified community rating in the individual and small group markets (limiting variation based on age to 3:1 for adults, and prohibiting all other rating factors except geography, tobacco use, and the number of covered family members), and phased out the use of pre-existing condition exclusions entirely. Small employers are also now eligible for an annual open enrollment period in which they are exempt from otherwise applicable minimum participation and contribution requirements, and those requirements may no longer be applied to large employers at any time. The ACA also enacted a number of additional, more detailed requirements, as discussed below.

The PHS Act sections that have been made applicable to ERISA plans are sections 2701 through 2728, except that self-insured plans are not subject to provisions that specifically relate to insurance, such as community rating and minimum medical loss ratio.⁴²⁹ Sections 2701 through

⁴²⁷ Pub. Laws 111-148 (PPACA), 111-152 (Reconciliation), 114-60 (PACE).

⁴²⁸ Under the ACA as originally enacted, states were given the option to retain the 50-employee threshold until a uniform 100-employee threshold took effect in 2016. *See supra* note 359.

⁴²⁹ Guaranteed issue was also extended from the small group market to the individual and large group markets, but there have not been reports of any significant impact on the large group market.

2719A incorporate, in revised form, the basic portability framework originally enacted by HIPAA, and add many new protections. Sections 2722 through 2728 are sections of prior law renumbered with some, mostly minor, changes. Thus, all these ACA provisions now apply to both insured and self-insured health benefit plans, with one noteworthy exception. Certain plans existing on the date of enactment of the ACA, March 23, 2010, are designated as “grandfathered plans” and are exempt from many of the new provisions of the PHS Act if they remain in force without material changes.⁴³⁰ In addition, these provisions do not apply to retiree-only or excepted benefits plans (See ERISA Section 732). The USDOL, HHS, and the Treasury (the “Tri-Agencies”) have been issuing guidance and regulations on an ongoing basis since May 2010.

Generally, the relationship between ERISA and state law is unchanged. Section 731 (formerly numbered 704) of ERISA mirrors Section 2724 of the PHS Act, and provides that the requirements of the ACA are not to be “construed to supersede any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent such standard or requirement prevents the application of a requirement” of the ACA. Accordingly, state laws that exceed the ACA’s minimum standards for health insurance or impose additional requirements will generally not be superseded by the ACA. However, ERISA § 734(a)(2) clarifies that state laws that apply directly to “group health plans” are still preempted. The ACA’s definitions must be read carefully. In particular, a “group health plan” is not a type of “health plan.” The term “group health plan” includes both insured and self-insured group health plans, but does not include the insurance policies issued to insured plans, leaving them subject to state regulation. The term “health plan,” on the other hand, includes individual and group health insurance coverage, but does not include self-insured group health plans that are exempt from state regulation under ERISA.

Incorporating these new sections into ERISA is significant because for the first time a comprehensive structure of benefit mandates was added to ERISA requirements. Although HIPAA had added a few provisions to ERISA and the IRC that echoed similar language in the PHS Act, notably the limitations on pre-existing condition exclusions,⁴³¹ those had been the exception rather than the rule. Traditionally, ERISA did not dictate to employers what benefits and protections had to be contained in employer health plans. A good example of this is the Mental Health Parity and Addiction Equity Act of 2008, which provides: **IF** the employer offers any mental health benefits, then those benefits must meet the requirement of full parity with physical health benefits generally.

⁴³⁰ ACA § 1251 (42 U.S.C. § 18011), as modified by ACA § 10103 and Reconciliation Act § 2301. The specific federal provisions that apply to grandfathered plans depend on whether the plan is an individual or group plan, and whether it is insured or self-insured. Through administrative guidance, CMS has also allowed insurers, if permitted by state law, to continue renewing certain non-grandfathered insurance policies that were ACA-compliant when issued but do not comply with certain additional requirements that took effect on January 1, 2014. These policies are popularly known as “grandmothered” policies. The guidance specifies that “grandmothering” is allowed only as a transitional measure, but at this writing, CMS has always extended the deadline for terminating these policies or modifying them to bring them into compliance

⁴³¹ See ERISA § 701 (29 U.S.C. § 1181); IRC § 9801 (26 U.S.C. § 9801); *former text of PHS Act § 2701* (42 U.S.C. 300gg).

Another example is the Newborns' and Mothers' Health Protection Act: **IF** the health plan covers maternity benefits, it has to include the "minimum stay" requirements.

The Large Employer "Shared Responsibility" Requirement

By contrast, the ACA applies relatively extensive requirements to employer health plans. Because substantial parts of the ACA have been incorporated into ERISA, the nature of ERISA has been changed. In addition, even though the ACA preserves the employer's right to decide whether to offer a health plan at all, the ACA includes an employer "shared responsibility" provision, sometimes called "play or pay," that gives certain employers (those with 50 or more fulltime or fulltime equivalent (FTE) employees) a strong incentive to provide "affordable" health plans to employees and their child dependents.⁴³² The Tax Code uses the phrase "applicable large employer" to describe the employers that are subject to this requirement, and they are commonly referred to by the abbreviation "ALE" because the definition of ALE is not quite the same as the definition of "large employer" for other ACA purposes. For example, an employer with exactly 50 employees is an ALE even though it is a "small employer,"⁴³³ and the AHP Rule operates from the premise that the association is a "large employer" but not an ALE, so that small employer members remain exempt from "shared responsibility."⁴³⁴ This requirement took effect in 2015, subject to transitional measures that reduced the impact of the penalties until 2017. Employers with fewer than 50 FTE employees are not subject to the "shared responsibility" requirement;⁴³⁵ however, because states may apply different counting rules, it is possible to be a "small employer" with fewer than 50 employees under state law and still be an ALE. Also, even though an AHP is considered a "large employer" under the ACA, the IRS does not consider an AHP to be an ALE, so membership in an AHP does not subject a small employer to the "shared responsibility" requirement.⁴³⁶

Although this law is sometimes referred to as the "large employer mandate", it does not literally mandate that ALEs offer such plans. However, even though ALEs do not violate any ACA requirement by choosing not to offer insurance, they may be subject to substantial financial penalties under the "shared responsibility" law. Specifically, the penalty is triggered if one or more of an ALE's full-time employees is enrolled in subsidized coverage on the Exchange.⁴³⁷ There are

⁴³² IRC § 4980H (26 U.S.C. § 4980H), *added by* ACA § 1513.

⁴³³ The threshold is 50 FTE employees regardless of the state's applicable small group threshold. On the other hand, another difference that was expressly intended by the drafters of the ACA was eliminated by CMS regulation. The FTE methodology is a measure of the size of the business, whereas rating methodologies focus on the number of covered lives. The ACA counts employees on an FTE basis "Solely for purposes of determining whether an employer is an applicable large employer" under the shared responsibility law, IRC § 4980H(c)(2)(E), but CMS regulations now apply this methodology to determine group size for community rating purposes. As a result, group insurance policies with very few covered lives might be subject to experience rating, despite the lack of a credible rating pool, if the employer also has many uncovered part-time employees.

⁴³⁴ *See* Preamble to AHP Final Rule, 83 F.R. 28917, 28933.

⁴³⁵ The ACA does provide a two-year tax credit as an incentive for certain small employers to establish health plans. IRC § 45R (26 U.S.C. § 45R), *added by* ACA § 1421.

⁴³⁶ *See* Question 18 in the IRS Shared Responsibility FAQ, at <https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act#Employers>

⁴³⁷ Although employer size is calculated on the basis of the number of "full-time equivalent" employees, only

three ways an employee might qualify for premium tax credits or cost-sharing reductions: (1) if the employee is not eligible for “minimum essential coverage” outside the Exchange; (2) if the employer offers minimum essential coverage but it is not “affordable” (*i.e.*, costs more than 9½% of the employee’s household income); or (3) the employer’s coverage fails to provide a “minimum value” (MV) of at least 60%.⁴³⁸ MV is an actuarial value standard, but it is never⁴³⁹ referred to that way, in order to avoid confusion with the actuarial value (AV) calculation used to determine a health insurance policy’s ACA “metal level” (bronze, silver, gold or platinum). AV and MV are calculated using software programs that produce different numerical results because they incorporate parameters derived from different assumptions.

The amount of the penalty depends on the reason the employer has employees who qualify for subsidies. A penalty based on the size of the entire full-time workforce applies unless the employer offers a plan qualifying as “minimum essential coverage” to at least 95% of its full-time employees and to their children under age 26.⁴⁴⁰ (The statute refers broadly to “dependents,” but the implementing regulation defines the term to mean children, other than stepchildren, foster children, and children who are not U.S. citizens.)⁴⁴¹ On the other hand, if coverage is offered, but it is unaffordable or does not provide 60% MV, the penalty is based only on the number of employees receiving subsidized coverage.⁴⁴² Under a provision often referred to as the “family glitch,” the affordability test compares the cost of employee-only coverage to total household income. The consequences include making spouses and dependents ineligible for Exchange subsidies if they are offered coverage even if the employer contributes nothing at all. The dependent coverage requirement of the shared responsibility law would appear to reward ALEs for imposing this burden on families. However, as long as an employer offers affordable employee coverage with 60% MV to each of its full-time employees, they will not be eligible for subsidies, so the penalty for failing to offer dependent coverage will be zero even if the employer is an ALE.

Another complication arises from the flexibility that large employers and self-insured small employers have in structuring their benefit designs. The ACA has established some minimum standards that apply to all individual and group plans, but the ACA’s requirements to include all “essential health benefits” (EHBs)⁴⁴³ and provide at least a “bronze” level of coverage (60% actuarial value) apply only to the individual and small group insurance markets.⁴⁴⁴ CMS has

employees actually working at least 30 hours a week are counted when calculating the penalty. IRC § 4980H(c)(2)(E) (26 U.S.C. § 4980H(c)(2)(E)).

⁴³⁸ IRC §§ 36B(c)(2)(B) & (C).

⁴³⁹ Well, hardly ever. *But see* ACA §§ 1311(d)(4)(I)(ii)(II) & 1412 (a)(2)(B)(ii).

⁴⁴⁰ 26 CFR § 54-4980H-4(a). The penalty is \$2000 per year, times the number of full-time employees in excess of 30 employees, calculated on a monthly basis for each month the employer is subject to the penalty. IRC § 4980H(a). (The law does not call this “payment” a penalty, since the employer is technically in full compliance if it “chooses” to make a payment in lieu of offering coverage, but that is not the way employers typically view this obligation.)

⁴⁴¹ 26 CFR § 54-4980H-1(a)(12).

⁴⁴² \$3000 per year, times the number of full-time employees receiving subsidies, calculated on a monthly basis, but capped at the amount the employer would pay if it failed to offer coverage at all. IRC § 4980H(b).

⁴⁴³ The ten essential benefit categories are: outpatient services, emergency services, hospitalization, maternity and newborn care, mental health/substance abuse disorder services, prescription drugs, rehabilitative/habilitative services and devices, laboratory services, preventive benefits and chronic disease management, and pediatric services, including dental and vision. ACA § 1302(b)(1) (42 U.S.C. § 18022(b)(1)).

⁴⁴⁴ PHS Act § 2707(a) (42 U.S.C. § 300gg-6(a)). Catastrophic plans in the individual market are also exempt from

required other plans to provide comparable value in order to meet MV requirements by designing its calculator to measure the extent to which the plan covers such categories as prescription drugs, maternity, mental health, and hospital and physician services. But what if an ALE decides not to try to provide MV, and instead to offer the least expensive plan that will allow employees to satisfy their requirement to buy “minimum essential coverage,” and hope that few of them would prefer to buy subsidized coverage on the Exchange? Although the ACA deems any “group health plan” to qualify as minimum essential coverage, the drafters sought to prevent abuses by adding an exception for insurance coverage consisting only of “excepted benefits” as defined in the PHS Act.⁴⁴⁵ However, the concept of “excepted benefits” was created long before the ACA, for a completely different purpose. When HIPAA was enacted in 1996, it was recognized that many plans providing only limited or incidental benefits should not be regulated under the same framework as comprehensive health plans, so those plans were exempted from the requirements of PHS Act Title XXVII. Nobody contemplated at the time that anyone would have a motive to design around the list of excepted benefits in order to keep a limited-benefit plan off the list, so we are now seeing innovative plan designs, such as coverage consisting of outpatient preventive services only, offered with the representation that they are sufficient to meet minimum essential coverage requirements.

Additional concerns have been raised that a provision intended to encourage employers that previously did not offer coverage to begin providing this benefit might have the opposite effect in practice. To prevent employers from circumventing the law by reducing the normal work week to 39 hours, the ACA defines all employees who work at least 30 hours a week to be “full-time” employees for shared responsibility purposes. However, there are reports that some employers have responded by reducing hours even further, though some ERISA experts argue that this could violate ERISA Section 510, which makes it unlawful for a person to interfere with the attainment of any right a participant may become entitled to under a plan. At the time of this writing, some stakeholders are urging Congress to eliminate or modify the “play or pay” law, and one frequent proposal is to raise the “full-time” threshold to 40 hours.

Significant Regulatory Standards Applicable to Group Health Plans

The Tri-Agencies have issued a series of regulations implementing PHS Act Sections 2701 through 2719A.⁴⁴⁶ The first phase of these ACA requirements, known as the “immediate market reforms,” became effective on September 23, 2010, six months after the effective date of the ACA. Other provisions took effect later, primarily on January 1, 2014. Most apply only to non-grandfathered plans, but some apply to all individual and group health plans. Significant ACA provisions that only affect the individual and small group insurance markets, but do not apply to self-insured plans or large group insurance, include rating rules, the requirement to provide EHBs, and tiers of coverage based on actuarial value.

the 60% minimum AV requirement.

⁴⁴⁵ IRC § 5000A(f)(1)(B) & (2), *as modified* by IRC § 5000A(f)(3).

⁴⁴⁶ When a Tri-Agency Regulation is cited in this section, the version cited is the USDOL regulation found in CFR Title 29. The corresponding IRS and HHS regulations appear in Titles 26 and 45 respectively.

The following discussion of the significant benefit standards added to ERISA by the ACA is based largely on a compliance checklist prepared by the USDOL.⁴⁴⁷ For the most up-to-date USDOL guidance, see EBSA’s Website: <https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans> This guidance also includes information about other significant legislation such as COBRA, HIPAA, the Genetic Information Nondiscrimination Act of 2008 (GINA), Mental Health Parity Provisions, the Newborns’ and Mothers’ Health Protection Act, and the Women’s Health and Cancer Rights Act. Generally, it is the responsibility of the employer-sponsored group health plan to ensure that the plans it offers to employees meet all requirements. However, state insurance departments approve and regulate the group insurance policies that employers offer to their employees, and would include enforcement relating to these reforms.

1. *Grandfathered Status – (29 CFR § 2590.715-1251(f))*

If a plan is grandfathered, it is exempt from most provisions of the Affordable Care Act (ACA). Grandfathered status is intended to allow people to keep their coverage substantially as it existed on March 23, 2010. The grandfathering regulation protects individuals from significant reductions in coverage, while giving plans some flexibility to make “normal” changes while retaining grandfathered status, in addition to any changes that are required by law. An insurance policy’s grandfathered status under federal law does not preclude a state from making the policy subject to state regulatory reforms, but the state may not require the insurer to include the policy in the same risk pool as nongrandfathered policies.⁴⁴⁸

2. *Wellness Programs – (29 CFR §§ 2590.702 and 2590.715-2705)*

Wellness programs are programs of health promotion or disease prevention. Employers may provide a wide range of wellness programs, but the regulations generally prohibit discrimination based on health factors, with exceptions for benign discrimination (*e.g.*, making benefits specifically available to persons with designated health conditions) and participation incentives. “Health contingent” incentives (incentives that depend on health outcomes or on participation in specified activities such as exercise) are subject to financial limits and must provide an opportunity to earn the incentive through reasonable alternatives or to waive the standard for participants with medical limitations or, in some cases, with other limitations. Wellness programs are also regulated by the EEOC under the Americans with Disabilities Act (ADA) and GINA. A 2017 court decision has remanded the EEOC’s regulations and directed the agency to reconsider whether the ADA and GINA further limit the range of wellness program penalties otherwise permitted under the PHS Act if employees refuse to provide health information on themselves or their spouses. The regulations will be vacated if the agency does not act by January 1, 2019.⁴⁴⁹ The EEOC has announced its intention to propose new regulations, but not until later in the year, leaving it uncertain what incentives can lawfully be provided until these questions are finally resolved.

⁴⁴⁷ <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/cagappa.pdf>

⁴⁴⁸ ACA § 1312(c)(4).

⁴⁴⁹ *AARP v. EEOC*, 267 F. Supp. 3d 14 (D.D.C. 2017), *judgment amended*, 292 F.Supp. 3d 238 (D.D.C. 2017), *vacated in part and stayed*, 2018 U.S. Dist. LEXIS 27317 (D.D.C. January 18, 2018).

3. Mental Health Parity – (29 CFR § 2590.712)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits financial requirements (such as copayments and deductibles) and treatment limitations (such as visit limits) that are more restrictive for mental health or substance use disorder benefits than the predominant requirements or limitations applied to medical/surgical benefits.⁴⁵⁰ The regulations also requiring parity for “non-quantitative treatment limitations,” meaning actions such as pre-authorization requirements that discourage claims. An earlier law, the Mental Health Parity Act of 1996 (MHPA), already required parity for aggregate lifetime and annual dollar limits.

MHPAEA does not apply to plans that do not offer any mental health or substance disorder benefits. However, all non-grandfathered individual and small group health insurance policies required to include such benefits as part of the EHB package, and large group policies are required to include them under the laws of most states.

4. Dependent Coverage of Children Under Age 26 – (29 CFR § 2590.715-2714)

Applicable only to plans that provide coverage for dependent children. A child who is under age 26 must be eligible for coverage as long as the relationship between the child and the participant would generally entitle the child to coverage under the terms of the plan. Thus, plans cannot deny or restrict dependent coverage for a child who is under age 26 based on factors such as residency, absence of financial dependency, student status, employment or marital status. The terms of the plan cannot vary based on age, except for children who are age 26 or older. This provision applies to both grandfathered and non-grandfathered plans. Note that if an ALE (50 or more FTE employees) fails to offer coverage to employees’ children under age 26, it may be subject to a “shared responsibility” payment, as discussed earlier.

5. Rescission Provisions – (29 CFR § 2590.715-2712(a)(2))

Coverage may only be rescinded after it is in force if the covered individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

6. Prohibition on Lifetime and Annual Dollar Limits on EHB – (29 CFR § 2590.715-2711(a)(1))

A group health plan may not establish any annual or lifetime limits on the dollar amount of benefits for any “essential health benefit” for any individual. This applies to both grandfathered and non-grandfathered plans. USDOL and Treasury have issued guidance and FAQs on how this prohibition impacts Health Reimbursement Arrangements. For purposes of requirements that apply only to essential benefits, large group insurers and self-insured employers must define

⁴⁵⁰ The statute refers to “substantially all” medical and surgical benefits, but the implementing regulation redefines “substantially all” to mean “at least two-thirds.” 29 CFR § 2590.712(c)(3)(i)(A).

“essential health benefits” consistent with one of the state or federal-employee benchmark plans, supplemented as necessary to meet minimum coverage standards for all ten categories.⁴⁵¹

7. Limits on Cost Sharing – (PHS Act § 2707(b))

All group health plans (including self-insured plans) must comply with the ACA’s limits on cost sharing, which require the plan to have a Maximum Out-Of-Pocket expense (MOOP) that does not exceed a limit that is adjusted annually for inflation by CMS. In 2018, that limit is \$7,350 for “self-only coverage” and \$14,700 if additional individuals are covered. The regulations do not require the MOOP to apply to services that are provided out-of-network or to services that are not covered EHBs, but plans are not prohibited from counting such expenses.⁴⁵²

8. Prohibition on Pre-existing Condition Exclusions – (29 CFR § 2590.701-2)

Plans may not impose pre-existing condition exclusions, defined to include any limitation or exclusion of benefits applicable to an individual as a result of information relating to his or her health status before the effective date of coverage (or if coverage is denied, the date of denial), such as information obtained from a pre-enrollment questionnaire, a physical examination or a review of medical records. This provision applies to both grandfathered and non-grandfathered plans.

9. 90-day Waiting Period – (29 CFR § 2590.715-2708)

This provision prevents an otherwise eligible individual from being required to wait more than 90 days before group coverage becomes effective. The regulation specifies allowable exceptions to the 90-day waiting period, such as orientation periods or limited assessment periods, but does not permit extending the waiting period beyond 90 days to coincide with the end of a calendar month. This provision applies to grandfathered health plans and non-grandfathered plans.

10. Summary of Benefits and Coverage and Uniform Glossary – (29 CFR § 2590.715-2715)

The ACA created two standardized disclosure tools, the Summary of Benefits and Coverage (SBC) and Uniform Glossary, to help consumers better compare coverage options. Generally, group health plans and health insurers are required to provide the SBC and Uniform Glossary free of charge. HHS may update the SBC and glossary template periodically, to ensure that they reflect the status of current federal requirements, so employers and insurers should verify that they are using the current version.

⁴⁵¹ 29 CFR § 2590.715-2711(c). Any state’s EHB benchmark may be used, regardless of where the plan provides coverage.

⁴⁵² 45 CFR §§ 155.20, 156.130(c), The ACA set the maximum MOOP for 2014 to equal the corresponding limit for HSA-qualified high-deductible plans, but applies a different inflation-adjustment formula, so the limits are no longer the same. Compare ACA § 1302(c)(1)(B) with IRC § 223(g).

11. Choice of Healthcare Professional – (29 CFR § 2590.715-2719A(a)(1)–(3))

If a plan provides for the designation of a primary care provider, each participant or beneficiary must be permitted to designate any participating primary care provider who is available to accept the participant or beneficiary. The plan or issuer must permit the designation of any available physician who specializes in pediatrics and participates in the network as a child’s primary care provider. A plan that provides obstetrical or gynecological (OB/GYN) care may not require authorization or referral (including any otherwise applicable requirement for authorization by a designated primary care provider) for OB/GYN care provided by a participating health care professional who specializes in OB/GYN care, including a non-physician if authorized by applicable state law.

12. Emergency Services – (29 CFR § 2590.715-2719A(b)(2))

A plan that “provides any benefits with respect to services in an emergency department of a hospital” must cover medical screening for emergency conditions and such further services as are necessary to stabilize the patient. (Transportation and other services provided before the patient reaches the hospital are not considered “emergency services” for purposes of this provision.) A plan may not require prior authorization for emergency services. For emergency services received out-of-network, a plan may not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements that apply in network, and may not impose cost-sharing requirements that exceed the in-network requirements. However, the plan is not required to cover out-of-network charges that exceed the greatest of: 1) its network rate, 2) its typical out-of-network allowable charge (*e.g.*, the UCR rate), or 3) the Medicare rate. Unless prohibited by contract or applicable law, the provider may balance-bill the patient and such balance bills are not subject to the cost-sharing limitation.

13. Preventive Services – (29 CFR §§ 2590.715-2713(a)(1) & 2590.715-2713A)

Group health plans must provide coverage for all designated preventive care services,⁴⁵³ and may not impose any cost sharing requirements unless the services are provided out-of-network. The designated services are based on guidelines issued by United States Preventive Services Task Force and certain other federal agencies. A complete list of services that are currently required to be covered can be found at www.healthcare.gov/coverage/preventive-care-benefits. New requirements apply to all plan years beginning one year or more after the date the recommendation or guidance is issued. Plans must continue covering services removed from the list for the remainder of the plan year, with limited exceptions such as safety recalls. The plan may not apply cost sharing for office visits if designated preventive services are the primary purpose of the visit and no other services were provided that are billable as a separate encounter. Plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the preventive services to the extent not specified in the applicable federal guidelines. The Tri-Agencies have issued an extensive number of FAQs on preventive services.⁴⁵⁴

⁴⁵³ Except that employers may decline to provide or fund benefits for contraception if they have a sincerely held religious objection.

⁴⁵⁴ These may be found at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for->

14. Clinical Trials – (PHS Act § 2709)

Plans may not prevent individuals with cancer or other life-threatening conditions from participating in approved chemical trials if they have been referred by a participating provider or otherwise demonstrate that participation is appropriate. The plan is not required to waive “experimental/investigational” exclusions for the drug or other item that is the subject of the trial, but may not deny benefits for other services provided in connection with the trial that would otherwise be covered, or otherwise discriminate against participants in clinical trials.

15. Claims, Internal Appeals and External Review – (29 CFR §§ 2560.503-1 and 2590.715-2719)

The ACA requires all group health plans and group health insurance issuers to “implement an effective appeals process for appeals of coverage determinations and claims.” This requirement incorporates by reference the pre-ACA USDOL claims procedure rule, and adds some additional minimum standards, including an external review requirement. A federal external review process has been established for self-funded plans and for states that have not implemented processes consistent with the NAIC’s Uniform Health Carrier External Review Model Act, under which the insurer or plan sponsor must contract with at least three accredited Independent Review Organizations and assign them on a rotating, impartial basis. Self-funded plans may also opt into the state process if permitted by the state.

16. Qualified Small Employer Health Reimbursement Arrangements – (26 U.S.C. § 9831(d); PHS Act § 2791(a)(1))

The 21st Century Cures Act, enacted in December of 2016, includes a provision allowing businesses that are not ALEs and do not offer group health plans to establish Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs).⁴⁵⁵ A QSEHRA may reimburse workers up to \$4,950 per year for single coverage and up to \$10,000 per year for family coverage, adjusted for inflation, to pay for individual health insurance premiums and qualified medical expenses. Employees must provide proof of their actual medical costs to receive reimbursement. Qualified individuals with QSEHRAs do not automatically lose eligibility for Exchange-based premium tax credits, but they must report their QSEHRA and any tax credit is reduced by the amount of the QSEHRA. The IRS has issued guidance outlining the procedures employers must follow to maintain QSEHRA eligibility. QSEHRAs are deemed not to be group health plans, and it remains unclear at this writing what plan documents are required and what penalty scheme applies to violations. In addition, the Tri-Agencies proposed a new federal regulation in October of 2018 that would further expand the availability of HRAs and other options for individuals and employers, and which could give rise to additional interpretive and compliance questions.⁴⁵⁶

[employers-and-advisers/aca-implementation-faqs](#)

⁴⁵⁵ P.L. 114-255, § 18001.

⁴⁵⁶ NPRM, *Health Reimbursement Arrangements and Other Account-Based Group Health Plans*, 83 F.R. 54420, October 29, 2018.

GLOSSARY

1. COLLECTIVE BARGAINING AGREEMENT means an agreement between an employer and a labor union that regulates the terms and conditions of employment. *See Black's Law Dictionary.*
2. CONTRIBUTIONS means premiums, contributions or any other sums collected to pay health and welfare benefits whether paid by an employer or an employee.
3. EMPLOYEE means a person who works for salary or wages, under the control and direction of an employer. *See 29 U.S.C. § 1002(6).*
4. EMPLOYEE ORGANIZATION means a labor union or other organization representing employees concerning employment benefits. *See 29 U.S.C. § 1002(4).*
5. EMPLOYEE WELFARE BENEFIT PLAN means a plan, fund or program established or maintained to provide health care or other employment benefits to employees. *See 29 U.S.C. § 1002(1).*
6. EMPLOYER means a person who employs or hires other persons and who controls their performance and pays their salaries or wages. *See 29 U.S.C. § 1002(5).*
7. INSURANCE SERVICE ORGANIZATION means a type of medical service corporation or other entity assuming any risk of loss for benefits to be paid and qualified to conduct business in a state.
8. LABOR ORGANIZATION means an organization described in 29 U.S.C. § 1002(5) in which employees participate for the purposes described in that provision. *See 29 U.S.C. §§ 151 through 186.*
9. MULTIEMPLOYER PLAN means a plan maintained pursuant to collective bargaining agreements between one or more employee organizations and more than one employer and to which more than one employer is required to contribute. *See 29 U.S.C. § 1002(37)(a); 29 CFR § 2510.3-37.*
10. MULTIPLE EMPLOYER TRUST (MET) is a generic term used to market several types of health and welfare plans which may or may not be: (a) subject to ERISA; or (b) insured or self-funded.
11. MULTIPLE EMPLOYER WELFARE ARRANGEMENT (MEWA) means a plan, established by two or more employers to offer health and welfare benefits to their employees, but does not include arrangements established pursuant to bona fide collectively bargained agreements or a rural electric cooperative. *See 29 U.S.C. § 1002(40)(a).*

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

APPENDICES

Appendix 1 – Consumer Alert

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

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

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

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

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

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

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

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

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

Appendix 2 – Agent Alert

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

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

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

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

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

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

- The plan operates like insurance but claims that it is not.
- You are asked to avoid certain insurance terminology, even though the plan operates like insurance.
- The plan is covered only by “stop-loss insurance” or refers to “reinsurance.”
- You are asked to sell an “ERISA” plan or “union” plan.
- You are asked to sell an “employee leasing” arrangement with self-funded health coverage.
- The plan targets individuals or groups with employees that have pre-existing conditions.
- The plan advertises unusually low premiums and/or unusually generous benefits, low (or no) minimum requirements for participation, and loose (or no) underwriting guidelines.

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

[optional final paragraph]

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

Appendix 3 – Regulatory Alert to Stop-Loss Carriers and Third Party Administrators

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

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

Unlicensed MEWAs

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

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

Unlicensed Professional Employer Organizations (“PEOs”) Health Plans

Your company will not issue or purchase a stop-loss policy or undertake to administer an unlicensed “self-funded” health plan for a professional employer organization or employee leasing company based in this state or offering coverage to client employers in this state. These firms commonly refer to their clients’ employees as “co-employed” or as “leased” employees of the PEO. These self-funded health plans are Multiple Employer Welfare Arrangements under ERISA rather than single employer plans. Regardless of the employee’s status under state law, a business is a direct employer under ERISA only if the facts and circumstances of the case demonstrate that the employer actually controls and directs the individual’s work. As long as the participating workers are employed by the various client employers, the health plan covers multiple employers. That makes the plan a MEWA, even if the PEO is also an indirect employer or co-employer. As indicated above, MEWAs that are not fully insured are subject to state regulation as insurers, and state insurance laws applying to PEOs are not preempted by ERISA. Your company should exercise care that it does not assist a “self-funded” benefit plan of a PEO or employee leasing company that is an unlicensed insurer under the laws of this state.

Note: Some states have statutes allowing PEOs or employee leasing firms to self-fund health benefits or obtain a license allowing them to self-fund health benefits. Other states have laws expressly recognizing PEOs’ “co-employer” status but explicitly prohibiting self-funding. If

applicable, individual insurance departments should modify this paragraph to incorporate a description of the specific requirements of your state law.

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

Your company will not issue or purchase unapproved stop-loss coverage for employers located in this state through an out of state trust, and will not undertake to administer an unlicensed “self-funded” health plan for employers located in this state unless all stop-loss coverage has been approved by this state. Operators of these arrangements purport to be exempt from this state’s insurance laws because they solicit employers in this state to apply for stop-loss coverage through a trust established in an out of state bank. Often these schemes falsely characterize the stop-loss policy as “reinsurance.” They also represent that all claims will be paid under the “self-funded” plan in return for a fixed contribution.

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

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