

THE REGULATION OF MULTIPLE EMPLOYER TRUSTS: PAST, PRESENT & FUTURE

EDWARD A. SCALLET*

INTRODUCTION

On Labor Day 1974 President Ford signed into law the Employee Retirement Income Security Act of 1974 (ERISA).¹ The title of the law, the statement issued by President Ford, and ERISA's "Findings and Declaration of Policy"² highlight what is generally considered the major intent of the law: to protect the retirement income of participants in and beneficiaries of this country's pension plans. For the first time, Congress recognized the impact of the private pension system on the economy of the country and the lives of millions of employees.

During the ensuing eight years, courts have been faced with the practical task of applying the words of the statute to the particular problems of pension plans. For the most part, this initial interpretation period has presented few major problems for the courts as ERISA's detailed provisions and comprehensive legislative history have provided considerable guidance.³ In short, it would be fair to say that there has been

* Thompson & Mitchell, Washington, D.C. A.B., 1972, Harvard College; J.D., 1975, Washington University. Member of the Missouri and Washington, D.C. Bar Associations.

1. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001 to 1461 (1976 & Supp. V 1981)).

2. ERISA § 2, 29 U.S.C. § 1001 (1976 & Supp. V 1981).

3. ERISA is divided into four Titles and numerous Parts. Title I is commonly referred to as the "Labor Provisions"; Title II contains amendments to the Internal Revenue Code; Title III deals with coordination between the Department of Labor and the Department of the Treasury; and Title IV establishes the Pension Benefit Guaranty Corporation, a quasi-governmental insurance system intended to guarantee a designated level of benefits to participants in certain types of pension plans.

Title I is further divided into five Parts. Part One contains reporting and disclosure requirements; Part Two mandates minimum structural standards for pension plans in the areas of participation, vesting and benefit accrual; Part Three deals with funding of pension plans; Part Four lays out rules of conduct for fiduciaries of plans; and Part Five deals with administration and enforcement. Title II, the tax amendments, largely repeats the minimum standards set out in Parts Two and Three of Title I.

ERISA as a whole represents the culmination of ten years of congressional hearings, studies and reports. It builds on a history of congressional and judicial experience with long-standing provisions of the Internal Revenue Code which granted favorable tax treatment to "qualified" pension plans. To a lesser extent, ERISA is also founded on the Welfare and Pension Plans Disclosure Act, Pub. L. No. 85-836, 72 Stat. 997 (1958), and certain provisions of the Labor Management

little dispute about either ERISA coverage of pension plans or the principles which Congress intended to apply.

The same cannot be said for the judicial experience with the other type of employee fringe benefit arrangement covered by ERISA—employee welfare plans.⁴ It can be persuasively argued that the recognized abuses in ERISA pension plans are no more severe than those appearing in welfare plans,⁵ and that welfare abuses have a significant adverse effect on millions of employees.⁶ Nevertheless, application of ERISA in this area has been hampered by several difficult issues, most of which are traceable to a lack of congressional precision in designing enforcement mechanisms specific to welfare plans, and more importantly, to inadequate coordination of state and federal responsibility in this area.

This article examines this problem by discussing the congressional, judicial and regulatory experience with one type of entity operating in the field of employee welfare benefit plans—the “multiple employer trust” (MET). Broadly defined, a MET is an arrangement through which groups of employers with small numbers of employees are brought together so that they may obtain medical coverage for the composite group as a whole at more favorable rates.

Despite this worthy goal, state insurance regulators fear abuse of the system. One enforcement official has stated that METs have “the potential to become the most sophisticated and profitable white-collar crime in America,”⁷ and most regulators would agree that the genesis

Relations Act, particularly § 302(c)(5), 29 U.S.C. § 186(c)(5) (1976 & Supp. V 1981). The record of hearings, prior legislation, studies and congressional reports relating to ERISA alone covers many thousands of pages.

4. Only Title I of ERISA contains requirements applicable to welfare plans, and of this Title's five Parts, only portions of Part 1, 4, and 5 apply to welfare plans. *See generally* Taggart Corp. v. Life & Health Benefits Admin., Inc., 617 F.2d 1208, 1210-11 (5th Cir. 1980); Wadsworth v. Whaland, 562 F.2d 70, 74 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

5. For example, Representative Claude Pepper, Chairman of the House Select Committee on Aging, stated that welfare plans “are being looted on a scale that few have dared to dream possible.” *See* Penn, *Organized Crime Finds Rich Pickings in Rise of Union Health Plans*, Wall St. J., Oct. 5, 1982, at 1, col. 6 (eastern ed.).

6. *See, e.g.*, S. REP. NO. 426, 96th Cong., 1st Sess. 1 (1979): “Few things are more important to the well-being and financial security of the millions of labor union members and their families throughout the Nation than the proper administration of their employee welfare as well as pension plans.” *Id.*

7. *Hearings Before the Subcomm. on Labor-Management Relations of the House Comm. on Education and Labor*, 97th Cong., 2d Sess. 6 (1983) (testimony of Tyrone Fahner, Attorney General of Illinois) [hereinafter cited as *March Hearings*].

of the problem is ERISA itself. As the same official has noted, the operators of METs have used ERISA "to play federal and state authorities off against each other while they [have] systematically drained the assets of the trust."⁸ This central problem of a seeming inability to enforce existing laws against a recognized abuse has sent Congress, the Department of Labor, state officials, the courts and various commentators into a confusing and often contradictory whirl of activity.

This article attempts to introduce a coherent, balanced, and, above all, comprehensive perspective on this issue. Part One examines both the economic importance of the MET as it relates to the private health care system in this country, and the general dimensions of the regulators' enforcement difficulties.

Part Two traces the legal enforcement controversy on both the state and federal levels. One issue which has received little or no notice by commentators and state regulators—the difficulties of the Department of Labor (DOL) in asserting jurisdiction in this area—is examined at length.

Part Three speculates about the future roles of the DOL and state insurance regulators concerning the exercise of jurisdiction over METs. This includes a discussion of the fundamental differences in approach of state and federal law. It concludes with a theoretical framework for coordinating these two legal systems, and offers some practical suggestions for improving coordination between state and federal regulators.

As noted, however, the MET issue is perhaps more important because of its influence on the broader issue of employee welfare plans generally. Questions about the scope of ERISA's preemption of state law, the interpretation of ERISA's fiduciary provisions, and other uncertainties surrounding ERISA may have found their first expression in the MET context, but may now reach beyond that area and influence the future regulation of more traditional types of welfare plans.

I. THE DIMENSIONS OF THE MET PROBLEM

A. *The Rise of Group Health Insurance*

The dramatic increase in the number of persons covered by private pension plans was well documented by Congress in its consideration of ERISA.⁹ Less documented, but equally dramatic, was the increase in

8. *Id.* at 11.

9. *See, e.g.*, S. REP. NO. 127, 93d Cong., 1st Sess. 3 (1973).

health insurance coverage. In 1948, only 24% of the population had health insurance; by 1977, that figure stood at 78%.¹⁰ Much of that increase can be attributed to the expansion of group health plans primarily offered in connection with employment. In 1950, only 49% of employees received health care coverage through their employer. In 1974, nearly 70% were covered.¹¹ The numbers underlying these percentages tell the story even more dramatically. By 1980, it was estimated that more than sixty-one million workers in the private nonfarm sector worked for establishments offering health benefits, while only seven million worked for establishments not offering such benefits.¹² The impact on the economy is substantial. From existing data, it has been estimated that well in excess of ten billion dollars is spent for coverage of employees through group health insurance in the private nonfarm sector.¹³

The specific mechanisms for underwriting these benefits vary. Most establishments (approximately 92%) underwrite benefits through insurance contracts. Of this percentage, 29% contract with Blue Cross/Blue Shield, 57% contract with commercial insurance carriers, 3% use a combination of both, and 4% contract with health maintenance organizations.¹⁴ Only 8% of establishments in the nonfarm sector "self-insure" benefits without contracting with a third party to guarantee benefits; that is, those employers promise to provide specific benefits without contracting with a third party to guarantee payment of claims or provision of health services.¹⁵

B. The Role of the MET in Group Health Insurance

A basic function of insurance is apportioning risk.¹⁶ The role of the insurer is essentially to "assume the risk of an event whose happening is uncertain or unknown at the time of the making of the promise."¹⁷

10. Carroll & Arnett, *Private Health Insurance Plans in 1977: Coverage, Enrollment, and Financial Experience*, in 1 HEALTH CARE FINANCING REV. 2-3 (1979).

11. Skolnik, *Twenty-Five Years of Employee-Benefit Plans*, in SOCIAL SECURITY BULL. 3, 4 (1976).

12. MALHORTA, McCAFFREE, WILLS & BAKER, 2 EMPLOYMENT RELATED HEALTH BENEFITS IN PRIVATE NONFARM BUSINESS ESTABLISHMENTS IN THE UNITED STATES 17 (1980) [hereinafter cited as BATTELLE STUDY].

13. *Id.*

14. *Id.* at 78.

15. *Id.*

16. R. MEHR & E. CAMMACK, PRINCIPLES OF INSURANCE 19 (6th ed. 1976).

17. Hellner, *The Scope of Insurance Regulation: What is Insurance for Purposes of Regula-*

To fulfill this function, the insurance contract must be part of a general arrangement "to distribute actual losses among a large group of persons bearing somewhat similar risks."¹⁸ The critical variable for the insurer is to determine when risk has been apportioned to "a sufficient number of exposure units to make . . . individual losses collectively predictable."¹⁹

Because of this essential nature of insurance, the cost to the insured bears a direct relationship to the size of the group covered by the contract. Assuming such variables as age, occupation and socio-economic status stay the same, the general rule is that the larger the group of insureds, the smaller the premium. This has the effect of compelling smaller employers to pay a higher per-insured premium.

Even before the passage of ERISA, many insurance companies recognized that there was a need for a mechanism enabling smaller employers to reduce the cost of insurance coverage. Accordingly, these companies formed trusts to collect premium payments from a large number of small employers. The trusts would then purchase a contract covering this combined pool of insureds. Since the risk could be distributed across the pool, the cost to each trust participant was considerably lower than the cost would have been for each employer individually.

Insurance companies were not alone in recognizing the advantages of this approach. Many independent agents in the insurance industry also formed their own "multiple employer trusts," and purchased coverage from a licensed insurance company for the trust as a whole at rates based on the large pool of insureds.

C. The Uninsured MET

If METs had been structured so that benefits ultimately would be underwritten by a licensed insurance carrier, it is doubtful that much attention would have been paid to these entities. Since the states clearly had authority to regulate the insurance company underwriting benefits, there was some assurance that promised benefits would be

tion?, 12 AM. J. COMP. L. 494, 496 (1963). See generally R. KEETON, BASIC TEXT ON INSURANCE LAW § 1-2(b)(4), at 6 (1971).

18. W. VANCE, HANDBOOK ON THE LAW OF INSURANCE 2 (3d ed. 1951).

19. R. MEHR & E. CAMMACK, *supra* note 16, at 32. See generally *Helvering v. Le Gierse*, 312 U.S. 531, 539 (1941).

paid.²⁰ This, however, was not to be the case. Beginning in 1975, a new phenomenon began to appear—the uninsured or self-insured MET. Instead of contracting with an insurance company to pay benefits, these METs promised benefits directly from the trust fund itself.

As is the case with many of the controversies surrounding METs, considerable disagreement abounds as to the reason for the proliferation of uninsured METs. Representatives of these METs claim that the impetus for their creation came from the fact that in 1975-76 many insurance companies decided not to underwrite small employers.²¹ The insurance industry generally denies this accusation, claiming that there is vigorous competition among companies for this business.²² Whatever the reason, there is little dispute that many insured METs become uninsured because the carrier cancels coverage, and it is difficult to find a new carrier to take the business without increasing rates.²³

On the plus side, supporters of the MET industry boast substantial cost savings for small employers, particularly in the area of reduced administrative costs.²⁴ On the minus side, however, even they admit their industry is rife with unsavory persons who regularly charge exorbitant commissions and administrative fees.²⁵ There is also substantial agreement within and without the MET industry as to why these unscrupulous MET operators have appeared. Ironically, the primary reason for the appearance of these unscrupulous MET operators was the passage of the first federal legislation specifically intended to control this type of abuse.

In 1978, the National Association of Insurance Commissioners (NAIC) complained to Congress about the sudden and alarming ap-

20. See Brummond, *The Legal Status of Uninsured, Noncollectively Bargained Multiple-Employer Welfare Trusts Under ERISA and State Insurance Laws*, 28 SYRACUSE L. REV. 701, 702 (1977).

21. See Letter from George T. de Heuck & Associates, June 7, 1977, reprinted in II NAIC PROCEEDINGS 395 (1977) [hereinafter cited as *de Heuck Letter*]. The author claims that 88% of the commercial insurers abandoned small employer coverage between June 1975 and September 1976. *Id.* at 396.

22. See II NAIC PROCEEDINGS 400-01 (1977).

23. The METs claim that the necessity for establishing reserves and overall inexperience with the insured group causes insurers to overestimate initial premiums. *See id.* at 396. The insurance industry attributes the reluctance of companies to take on MET business to a distrust of the administrative and compensation structure set up by the MET operators. *See id.* at 400-01.

24. For example, Mr. de Heuck claims that METs, on the average, use 70% of the contributed money for the payment of claims—a figure considerably larger than that applicable to insurance companies generally. *See id.* at 398.

25. *Id.*

pearance of uninsured METs. As the NAIC painstakingly documented, far too many uninsured METs had become insolvent and left millions of promised benefits unpaid.²⁶ In 1978, the NAIC estimated that there were three million persons covered by thirty uninsured METs with an annual contribution base of \$300 million.²⁷ In the eighteen months preceding the NAIC testimony, at least five of these METs had become insolvent; the first two of them had unpaid claims exceeding \$7.5 million.²⁸

The NAIC returned to Congress four years later, the situation having improved little. Frank Damon, Chief Deputy Insurance Commissioner for the State of California, testified that the number of METs operating in California alone had grown to 150.²⁹ Between 1977 and 1982 forty-five METs in California went out of business; eighteen of these left unpaid claims.³⁰ The Illinois Attorney General estimated that more than \$1.2 million in claims were left unpaid when several METs in that state became insolvent.³¹ The Indiana Insurance Department's Deputy Commissioner for Legal and Financial Services expressed similar concern about the economic and social costs of uninsured METs.³²

In discussing the various states' enforcement programs, several themes with important implications for the future regulation of METs emerged. The first was the differences among states in their laws covering METs. At one extreme was Indiana, whose representative reported good success under the summary investigative proceedings and insurance agent responsibility provisions of that state's insurance laws.³³ At the other extreme was California where, despite some criminal convictions, at least one court had held that METs were not even within the

26. *See Oversight on ERISA: Hearings Before the Subcomm. on Labor Standards of the House Comm. on Education and Labor*, 95th Cong., 2d Sess. 656 (1978) (statement of the National Association of Insurance Commissioners by Herbert W. Anderson, Commissioner of Insurance of the State of Iowa and Chairman, NAIC ERISA Preemption Task Force) [hereinafter referred to as *NAIC Testimony*].

27. *Id.* at 658.

28. *Id.* at 659.

29. *See Hearings Before the Subcomm. on Labor-Management Relations of the House Comm. on Education and Labor*, 97th Cong., 2d Sess. 12 (1983) (statement of Frank Damon) (obtained from page proofs of hearing transcript) [hereinafter cited as *October Hearings*].

30. *Id.*

31. *March Hearings*, *supra* note 7, at 6.

32. *Id.* at 61 (statement of Emil J. Molim).

33. *Id.* at 62.

jurisdiction of the insurance laws.³⁴ All regulators agreed, however, that their enforcement had been hindered by uncertainty about ERISA's possible preemption of state law.³⁵

Another theme which emerged was the elusiveness of MET operators. Mr. Damon from California expressed particular concern with the "rollover" phenomenon—on six occasions since 1977, operators who had been forced to close down in one place, simply reorganized somewhere else.³⁶ In one case, a MET operator "rolled over" his operation five times in five different states.³⁷ Closely related to the rollover phenomenon was another major state enforcement problem—the difficulty that the states had in acting before matters reached the crisis stage. For example, Illinois representatives reported some success in arranging for reputable insurers to continue coverage for employees previously covered by insolvent METs,³⁸ but decried the absence of an effective pre-operational review of METs.³⁹

Those testifying expressed near-unanimity about one thing—the "cavalier . . . attitude" of the DOL.⁴⁰ One charged that the DOL had "all but abdicated [its] responsibility" for METs; several charged that delay at the DOL in "certifying" METs was the root cause of the states' inability to regulate METs effectively.⁴¹ This comment was the result of the experience of several states when they had sought access to MET records, only to be met with the argument that the DOL had not yet ruled on the status of the entity under ERISA. Most regulators expressed an interest in working with the DOL, primarily in the area of delegating investigative authority to the states from the DOL,⁴² but the California representative expressed the thought that the DOL has not made a "good faith attempt" to work with the states.⁴³

34. See *October Hearings, supra* note 29, at 12. See *infra* notes 224-26 and accompanying text for a thorough discussion of enforcement of state insurance laws against METs.

35. *October Hearings, supra* note 29, at 13.

36. *Id.* at 12. For a thorough discussion of the implications of the "rollover" phenomenon on the MET enforcement program, see *infra* notes 240-45 and accompanying text.

37. *March Hearings, supra* note 7, at 54.

38. *Id.* at 6, 24. See *infra* notes 92-93 & 255-56 and accompanying text for a complete discussion of the pre-operational review requirement for METs.

39. *October Hearings, supra* note 29 at 20, 33; *March Hearings, supra* note 7, at 9, 13-14.

40. *Id.* at 22.

41. *October Hearings, supra* note 29, at 17, 36, 39.

42. *Id.* at 39-40. See *infra* notes 253-56 and accompanying text for a discussion of DOL-state coordination.

43. *Id.* at 13.

The 1982 hearings capsule the MET problem as it currently exists. Records reveal the story of widespread failure of arrangements designed to provide health coverage to millions of employees. Enforcement has been hampered in the first instance by uncertainty engendered by ERISA's provision preempting state law, and the tendency of some state courts to decline to act until the DOL rules on the status of these entities under ERISA. Once that obstacle has been passed, states have had varying success applying their particular laws to specific situations, and, on the whole, have been unable to prevent abuses before they have occurred. Even when the states have been effective, MET operators often have eluded authorities by moving to another state. Finally, there has been a breakdown in effective coordination between the states and the DOL.

Only partial blame for the lack of progress in halting MET abuses between 1977 and 1982 can be laid at the feet of the state insurance commissioners and the DOL. It must be understood that the ultimate responsibility for interpreting and enforcing the law lies in the courts. Both the NAIC and the DOL have furnished the courts with the theoretical framework for enforcing the law against METs, but the perceived ambiguities in the law and the failure of some courts to consider the consequences of their holdings on the entire industry have resulted in decisions encouraging METs to continue their operations. It is therefore necessary to discuss the development of the law as applied to METs.

II. THE ESTABLISHMENT OF JURISDICTION OVER METS

A. *Jurisdiction Over METs Under State Law*

1. *The ERISA preemption provision*

One of the goals of ERISA was to replace the pre-ERISA patchwork of limited federal oversight and varying state regulation of employee benefit plans with a scheme of exclusive federal control. This goal, implemented in part in section 514(a) of ERISA provides:

[T]he provisions of [ERISA] shall supercede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan [covered by ERISA].⁴⁴

The courts have generally held that this language evidences a congres-

44. ERISA § 514(a), 29 U.S.C. § 1144 (1976).

sional intent to preempt a wide variety of state laws which have an impact on the operation and establishment of employee benefit plans.⁴⁵

At the same time, however, Congress recognized that commercial entities, and particularly insurance companies, played a large part in providing services to employee benefit plans.⁴⁶ In the case of insurance companies, Congress has traditionally left the regulation of insurance in the hands of state insurance commissioners.⁴⁷ Although ERISA does regulate certain activities of insurance companies related to plans, for example, when such companies undertake to serve as plan fiduciaries,⁴⁸ ERISA clearly was not intended to make fundamental changes in the basic structure of federal-state relations in the field of insurance regulation. Thus, ERISA section 514 also provides:

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance⁴⁹

As will be seen, judicial interpretation of this clause, particularly in the area of what constitutes a law "regulating insurance," has important implications for METs and insured welfare plans generally.⁵⁰ In the early years of the regulatory experience with METs, however, another provision of the ERISA preemption provision assumed considerably more significance. That provision is the addition to section 514 of the following language (the "except as provided in subparagraph (B)" language quoted above):

(B) Neither an employee benefit plan [covered by ERISA] . . . 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 companies⁵¹

This has become known as the "deemer clause"—by its express terms, it prevents a state from calling a true employee benefit plan an insurance company so as to evade the preemptive intent of section 514.

45. See *infra* notes 185-94 and accompanying text.

46. See *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

47. See McCarran-Ferguson Act, 15 U.S.C. § 1011 (1976); *infra* notes 189-94 and accompanying text.

48. See *infra* note 198.

49. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1976).

50. See *infra* notes 157-83 and accompanying text.

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

The NAIC has consistently taken the position that uninsured METs constitute insurance companies under most state insurance laws.⁵² As it explained to Congress in 1978, however, the language of section 514, and particularly the “deemer” provision, has “created a climate of uncertainty which has been used by certain entrepreneurs to avoid state insurance laws.”⁵³ Specifically, MET operators claimed that their entity was an “employee welfare benefit plan” under ERISA, and thus could not be “deemed” to be an insurance company under state law.⁵⁴

Despite this problem, the NAIC acknowledged in 1978 that “a few test cases” established that most METs did not qualify as employee welfare benefit plans, thus clearing the way for state insurance regulation.⁵⁵ Indeed, the DOL filed an amicus curiae brief in one of the first MET cases arguing that METs are generally not employee benefit plans.⁵⁶ In its report following the hearings, the House Committee expressed its agreement with the DOL/NAIC interpretation,⁵⁷ and concluded that it was “most reluctant” to pursue legislative clarification of this issue.⁵⁸ Instead, it urged the NAIC and DOL “to take appropriate action to prevent the continued wrongful avoidance of proper state regulation by these entities.”⁵⁹

As discussed in the previous section of this article, the confidence of the Ninety-Fourth Congress has become the uncertainty of the Ninety-Eighth Congress which is still holding hearings on the problem of state regulation of METs. What has happened in the interim is a case study on the limitations of the judicial system when faced with a determined group of persons intent on taking advantage of that system to perpetuate a profitable—and illegal—business.

2. *The “Primary Purpose” Analysis*

It is often necessary to begin with the theoretical underpinnings of a

52. See I NAIC PROCEEDINGS 301 (1978).

53. See NAIC Testimony, *supra* note 26, at 656.

54. *Id.*

55. *Id.* at 661.

56. See Brief for Secretary of Labor, *Bell v. Employee Sec. Benefit Ass'n*, 437 F. Supp. 382 (D. Kan. 1977).

57. See ERISA Oversight Report of the Pension Task Force of the Subcomm. on Labor Standards of the House Comm. on Education and Labor, 94th Cong., 2d Sess. 10 (1977) [hereinafter cited as *Oversight Report*].

58. *Id.* at 11.

59. *Id.*

provision or, in the lexicon of statutory interpretation, congressional intent. Unfortunately, there is no legislative history on point for ERISA's "deemer" clause; therefore, it is necessary to look at the legal climate as it existed in this area just prior to congressional enactment of ERISA.

Both before and after ERISA, the primary funding vehicle for employers who established welfare plans for their employees was the purchase of health coverage from an insurance company. A few large employers, as well as some large employer-union jointly sponsored plans, however, had not used insurance companies to underwrite benefits. Instead, these plans paid benefits either out of general corporate assets or assets of a trust fund established by the plan sponsor or sponsors. This decision to forego purchase of insurance from an insurance company theoretically offered savings of as much as five percent.⁶⁰

In an interesting foreshadowing of the MET controversy, the NAIC initially complained of the "alarmingly accelerated trend" toward self-insurance, and suggested that such plans be regulated under state insurance laws.⁶¹ As two law review articles demonstrated several years later, however, the majority of states declined to take this position.⁶² It was thought significant that the "primary purpose" of these entities was not to make a profit through widespread solicitation of the public at large.⁶³ Rather, the plans served a closed group of employees, and therefore, the safeguards of state law were not needed because the employer and union sponsors had compelling employee-relations reasons to operate the plans fairly and efficiently.⁶⁴

While ERISA was being considered, the highest courts in New York

60. See, e.g., CODY, GROUP PREMIUMS AND EXPERIENCE RATING, LIFE AND HEALTH INSURANCE HANDBOOK 454, 468 (2d ed. 1964) (the insurer's decision to pass on the cost of state premium taxes); Eilers, *Minimum Premium Health Plan: Insured Non-Insured*, 36 J. INS. 63, 64-65 (1964) (the self-insured avoids the insurer's charges for commissions, risks and profits); Note, *Self-insured Employee Welfare Plans and the 501(c)(9) Trust: The Specter of State Regulation*, 43 U. CINN. L. REV. 325, 327 (1974) (the insurer's need to establish reserves). See generally Goetz, *Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws*, 1967 WIS. L. REV. 319, 320. But see Duesenberg, *The Legality of Noninsured Employee Benefit Programs*, 5 B.C. INDUS. & COM. L. REV. 231, 232-35 (1964) (disputing alleged savings of self-insureds because of increased administrative expenses on the fund level).

61. See I NAIC PROCEEDINGS 76 (1963).

62. See Duesenberg, *supra* note 60; Goetz, *supra* note 60.

63. See Duesenberg, *supra* note 60, at 239-40.

64. *Id.* at 238; Goetz, *supra* note 60, at 345.

and Missouri accepted cases presenting this issue.⁶⁵ Given the general intent of the ERISA preemption provision to save bona fide employee benefit plans from state regulation, the inference is inescapable that the underlying reason for the "deemer" provision was to resolve through congressional action, the controversy in the states concerning self-insured employee benefit plans.⁶⁶

In the early years of the judicial experience with METs, the courts adopted a "primary purpose" analysis in holding that METs were not employee benefit plans. This analysis had two parts. The first was conditioned on the reasoning that METs had, as a primary purpose, an intent to evade state regulation.⁶⁷ The second part of this "primary purpose" analysis borrowed from the considerations used in the pre-ERISA analysis of self-insured plans vis-à-vis insurance law, and held that the primary purpose of the MET was to be a profitmaking venture based on widespread public solicitation.⁶⁸ Neither of these purposes

65. See *State ex rel. Farmer v. Monsanto Co.*, 517 S.W.2d 129 (Mo. 1975); *Mutual Life Ins. Co. v. New York State Tax Comm'n.*, 32 N.Y.2d 348, 298 N.E.2d 672, 345 N.Y.S.2d 475 (1973). See also *California-Western States Life Ins. Co. v. State Bd. of Equalization*, 151 Cal. App. 2d 559, 312 P.2d 19 (Cal. Ct. App. 1957).

66. Not surprisingly, the METs offer an alternative interpretation of the "deemer" provision. They claim that the provision was intended to open up new arrangements for providing health benefits which could be operated outside the reach of state law. The only court which has responded to this argument has pointed out that there is no indication that Congress was even aware that METs existed, and more generally, there is no legislative history setting out an intention to encourage any particular form of employee benefit plan arrangement. See *National Business Conference Employee Benefit Ass'n v. Anderson*, 451 F. Supp. 458, 461-62 (S.D. Iowa 1977). See generally Comment, *Regulation of Uninsured Multiple-Employer Trusts Under ERISA: An Open Question Again*, 1979 B.Y.U. L. REV. 913.

67. For example, in *Wayne Chem., Inc. v. Columbus Agency Serv. Corp.*, 567 F.2d 692 (7th Cir. 1977), the MET was described as a "proprietary insurance venture designed to take advantage of the void created by ERISA's preemption of state regulation." *Id.* at 699. In *Hamberlin v. VIP Ins. Trust*, 434 F. Supp. 1196 (D. Ariz. 1977), the court stated:

Most importantly, by designating this an ERISA plan, they hoped to escape from direct supervision and auditing by the State Insurance Department and from its coverage and reserve requirements under the theory of federal preemption.

There has been substantial material concern over the increase in the numbers of uninsured multiple employer trusts such as this which have avoided state supervision and have failed, leaving sick or injured employees holding an empty bag.

Id. at 1198-99. And, in *Bell v. Employee Sec. Benefit Ass'n*, 437 F. Supp. 382 (D. Kan. 1977), the court stated: "Our conclusion is that just as a state cannot regulate an 'employee benefit plan' by calling it 'insurance', neither can defendants merchandise an insurance program, free of state regulation, by terming it an 'employee benefit plan'." *Id.* at 390.

68. See, e.g., *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), where the court, in holding that the MET involved was not an employee benefit plan, reasoned that it was an enterprise "established and operated by independent businessmen for their personal profit" consisting of "hundreds of unrelated subscriber customers." *Id.* at 1210. Accord *Wayne*

was consistent with the perceived purpose of “true” employee benefit plans—those rooted in the employment relationship and not operated for profit.

3. *The Organizational Impetus Analysis*

Had the courts continued to focus on this primary purpose analysis, it is doubtful that the MET controversy would be as troublesome as it has become in fact. Congress, however, also added a definition of “employee welfare benefit plan” in ERISA. Thus, the task of the regulators was complicated by a need to work around this definition as well, and that effort produced what can be called the “organizational impetus” analysis.

Section 3(1) of ERISA provides that an “employee welfare benefit plan” includes:

Any plan, fund or program which was heretofore or is hereafter *established or maintained by an employer or by an employee organization, or by both*, to the extent such plan, fund or program was established or is maintained for the purpose of providing for its participants or beneficiaries, through the purchase of insurance or otherwise, [health and welfare benefits]. . . .⁶⁹

It was the DOL which came up with a way to exclude METs from this definition. According to the DOL, the answer to the MET problem lay in the emphasized language above—the “established or maintained by an employer” phrase in the ERISA section 3(1) definition. The DOL reasoned that a multiple employer plan exists when a cognizable group or association of employers establishes a benefit program for the employees of member employers, or when several employers and one or more employee organizations jointly establish such a program, or when several employers contribute to a plan established by an employee organization. In each of these contexts, there is some organizational relationship among the employers, or the employees, or both in coming

Chem., Inc. v. Columbus Agency Serv. Corp., 567 F.2d 692 (7th Cir. 1977), where the Court of Appeals for the Seventh Circuit stated: “Congress would have had no reason to exempt from state regulation insurance programs that are established and maintained by entrepreneurs for their own profit.” *Id.* at 699.

The House Oversight Committee had emphasized the same considerations. In its *Oversight Report*, *supra* note 57, it noted that “certain entrepreneurs have undertaken to market insurance products to employers and employees at large” and that the “primary interest [of those persons] is in profit[s].” The Committee added that such “purpose for [the] establishment or maintenance” of the purported plans does not “meet the jurisdictional prerequisites of [ERISA].” *Id.* at 10.

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

together and establishing a single plan. But, in the case of METs, the organizational impetus comes not from the subscribing employers, but from the MET entrepreneurs. Accordingly, it cannot be said that METs are “established or maintained” by employers within the meaning of ERISA section 3(1).⁷⁰

As with the primary purpose analysis used by the courts in the early years, the DOL organizational impetus test—specifically, that METs were not “established or maintained by” employers within the meaning of ERISA section 3(1)—found favor in the courts⁷¹ and Congress.⁷² Unfortunately, no one had counted on the resourcefulness of the MET entrepreneurs.

4. *The METs Retrench and the Courts Waiver*

The Congress, NAIC and DOL were not the only ones watching these early cases; the MET promoters also were analyzing the decisions for possible approaches to avoid state regulation. Although the results of these cases had all been unfavorable to METs, there were some loopholes left for exploitation.

Most of the cases involved METs concentrating their marketing efforts on individuals. Their promoters argued and lost on the assertion that these individuals had established the METs as “employee organizations” within the meaning of the ERISA section 3(1) definition of employee welfare benefit plan. The courts had no difficulty refuting this argument,⁷³ so MET operators reversed their field and began soliciting only employers. It was less expensive to solicit a handful of employers than to market the MET to thousands of individuals, and a switch to employer solicitation by METs could produce more favorable results in terms of legal analysis. If the courts could be induced to concentrate solely on the “established or maintained by employers” language of ERISA section 3(1), then the METs might be able to rearrange their structure to fit within this definition. This goal could

70. See DOL Advisory Op. 77-59A (August 26, 1977).

71. See *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980); *Wayne Chem., Inc. v. Columbus Agency Serv. Corp.*, 567 F.2d 692 (7th Cir. 1977).

72. See *Oversight Report*, *supra* note 57, at 10.

73. In *Bell v. Employee Sec. Benefit Ass'n*, 437 F. Supp. 382, 394 (D. Kan. 1977), the court reasoned that individuals who happen to be employed by someone did not constitute an “employee organization”; there had to be some nexus between the employees. In *Hamberlin v. VIP Ins. Trust*, 434 F. Supp. 1196 (D. Ariz. 1977), the court also emphasized the fact that the solicited employees came from a variety of businesses, and were thus not employee organizations.

also be aided by the very broad definition of "employer" in section 3(5) of ERISA:

The term "employer" means 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.*⁷⁴

Accordingly, if a MET could restructure its operations to include an employer association with some involvement in the operation of the arrangement, then it might conceivably win an argument based on the literal words of the statute.⁷⁵ In the most recent case in this area, one MET came very close.⁷⁶

On July 23, 1979, the DOL sent a letter to Thomas Wilkie, Administrator of the Insurance and Prepaid Benefits Trust (IBT), informing him of the DOL's conclusion that IBT was not an employee welfare benefit plan.⁷⁷ The letter differed little from the standard DOL/MET letter, reasoning that IBT had not been "established or maintained by an employer."⁷⁸

Wilkie, however, immediately filed suit in federal court challenging the DOL conclusion. As brought out at trial, Wilkie represented the new breed of MET operators who had made a conscious decision to restructure his MET operation to exploit the loopholes in prior MET cases. Prior to 1976, Wilkie had operated METs for licensed insurance companies.⁷⁹ In 1976, however, he formed IBT and thereafter began to design the structure of IBT to fit within the ERISA definition of "employee welfare benefit plan." First, he separated IBT into five trusts in order to group the subscribing employers into industry classifications. He also formed a Benefit Committee for IBT by informing a few of the subscribers of a September 1977 meeting to "reestablish" IBT. Officers of two employers attended and became the only Committee members. Shortly thereafter, another person joined the Benefit Committee, and the three Benefit Committee members became trustees of IBT. In De-

74. ERISA § 3(5), 29 U.S.C. § 1002(5) (1976) (emphasis added).

75. Ironically, the NAIC has warned Congress of just this possibility. See *NAIC Testimony*, *supra* note 26, at 661-62.

76. See *Insurance & Prepaid Benefits Trust v. Marshall*, 90 F.R.D. 703 (C.D. Cal. 1981), *aff'd mem. sub nom. Insurance & Prepaid Benefits Trust v. Donovan*, 685 F.2d 443 (9th Cir. 1982).

77. *Id.*

78. *Id.* at 704-05.

79. See Appellee's Brief at 6, *Insurance & Prepaid Benefits Trust v. Donovan*, 685 F.2d 443 (9th Cir. 1982) (citing Record on Appeal) [hereinafter cited as Answering Brief].

ember 1977, the newly appointed trustees voted to approve a five-year agreement with Wilkie's company, Insurance Benefits, Inc. (IBI), to provide for virtually all of the operation of IBT.⁸⁰

The district court's subsequent opinion represented an encouraging "loss" for METs. Although the court held that IBT was not an "employee welfare benefit plan," its reasoning and general approach largely paralleled the IBT arguments. Most significantly, the court grounded its analysis in the bare statutory language by holding that the critical questions were whether: (1) IBT was "an association of employers"; (2) represented by the Benefit Committee; (3) which, in turn, actually controlled the entire arrangement.⁸¹ In the district court's view, the first criterion was satisfied because the employers had "joined together for a specific purpose"—namely, to provide health and welfare benefits to their employees.⁸² The second criterion was satisfied because the participating employers were informed of the formation of the Benefit Committee, invited to participate in its operation and therefore approved of the selection of the committee members.⁸³ As to the question of who controlled IBT, the court was "inclined to conclude that the Benefit Committee controlled the affairs of IBT," but for the IBT/IBI contract which gave control over all records and subscriber information to IBI. This, the court reasoned, placed IBT "in a highly disadvantageous position in its relationship with IBI" and led to the ultimate holding that IBT was not an employee benefit plan.⁸⁴

On appeal, the DOL, recognizing the danger of the district court's reasoning, urged a much broader analysis. First, it attempted to place the issue in its historical context by tracing the development of the law in Congress and the courts.⁸⁵ Instead of relying on the literal words of the statute, the DOL emphasized the primary purpose analysis and pointed out the danger of exempting these entrepreneurial profitmaking ventures from state regulation—a result which, in the DOL's view, was not intended by the "deemer" provision of section 514. Regardless of the form of the restructured IBT, it was still primarily a vehicle for allowing Wilkie to market his insurance products to a wide sector of

80. *Id.* at 7-8.

81. *Insurance & Prepaid Benefits Trust v. Marshall*, 90 F.R.D. 703, 706 (C.D. Cal. 1981), *aff'd mem. sub nom. Insurance & Prepaid Benefits Trust v. Donovan*, 685 F.2d 443 (9th Cir. 1982).

82. *Id.*

83. *Id.*

84. *Id.* at 706.

85. See Answering Brief, *supra* note 79, at 14-22.

the public, and was therefore not a nonprofit, limited purpose employee benefit plan serving only a closed group of employees.⁸⁶

The DOL also disputed the court's analysis of the specific statutory language. It pointed out that both the Fifth and Seventh Circuits had held that an otherwise unrelated group of employers did not become an "association" by subscribing to the same insurer.⁸⁷ With respect to Benefit Committee "representation" of the employers, the DOL cited the testimony of IBT employers that they had no idea who the members of the Benefit Committee were, as well as the testimony of the Benefit Committee members that they too had no idea who the employers were and had no contact with them.⁸⁸

Finally, the DOL sharply disputed the district court's conclusion respecting control of IBT. Even without the IBT/IBI contract, the DOL argued that it made little sense to believe that Wilkie had ceded control over IBT in 1977 to the three virtual strangers who became members of the Benefit Committee. On the contrary, IBI made virtually all operational decisions and IBT's marketing literature given to employers emphasized IBI's experience without once mentioning the Benefit Committee which supposedly controlled IBT.⁸⁹

86. *Id.*

87. *Id.* at 30 (citing *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980); *Wayne Chem. Corp. v. Columbus Agency Serv. Corp.*, 567 F.2d 692 (7th Cir. 1977)).

The status of true "employer association" plans is one of the least commented upon areas of the MET issue. Because of the inclusion of the "group or association of employers" language in the ERISA definition of "employer," it is apparent that Congress contemplated that some employee benefit plans would be organized around an employer association.

Prior to ERISA, those state insurance laws which had specifically exempted employee benefit plans from coverage on this basis had generally limited "association of employers" to companies under common control. See generally *Goetz, supra* note 60, at 327-28. The DOL has taken a somewhat broader view for purposes of ERISA. Judging from the occasions upon which the DOL has held that such an "association" exists, the critical factors seem to be that the organizational impetus for forming the association came from the employers and that the associations exist for purposes other than just to provide welfare benefits—in other words, the DOL has consistently applied the primary purpose and organizational impetus tests and found that some associations can meet that standard. See DOL Advisory Op. 81-76A (Oct. 14, 1981) (Texas Homebuilders Association); DOL Advisory Op. 81-51A (June 9, 1981) (American Association of Petroleum Landmen); DOL Advisory Op. 81-47A (May 28, 1981) (Iowa Bankers Association); DOL Advisory Op. 81-6A (Jan. 5, 1981) (Michigan Dental Association); DOL Advisory Op. 80-68A (Dec. 1, 1980) (Professional Insurance Agents Association); DOL Advisory Op. 80-40A (July 9, 1980) (Small Business Independent Trades Association); DOL Advisory Op. 79-49A (July 31, 1979) (Florida Osteopathic Medical Association).

88. See Answering Brief, *supra* note 79, at 37 n.18.

89. *Id.* at 33-37.

The decision on appeal left neither party satisfied. Despite the lengthy arguments made on the central issue of what constitutes an employee benefit plan in the MET context, the court essentially passed on the question by holding that the district court had no jurisdiction over the case in the first instance. Specifically, the court held that there was no jurisdiction to review this DOL advisory opinion on the status of METs under ERISA.⁹⁰ Its only comment on the merits was that the district court's conclusion that IBI, and not the Benefit Committee, controlled IBT was not clearly erroneous.⁹¹

The court's holding on the reviewability of advisory opinions is consistent with recent law in the Ninth Circuit, but not particularly consistent with other case law.⁹² The practical significance of the opinion is interesting, although clearly not intended by the court. On the one hand, the DOL and IBT had differed in their initial pleadings on the legal significance of the DOL's opinion. IBT had argued that the DOL was obligated to "certify" employee benefit plans upon request in a procedure somewhat analogous to the "qualification" of pension plans by the Internal Revenue Service.⁹³ The DOL had argued that there is no such procedure for welfare plans and, therefore, it was in no way obligated even to respond to IBT.

The Ninth Circuit resurrection of this argument—and particularly its holding of nonreviewability—may alleviate one of the problems of MET enforcement. As noted, some state courts, and even some insurance commissioners, believed that a DOL opinion, which stated that a MET failed to meet the definition of employee benefit plan, was a prerequisite to state action.⁹⁴ By holding that such DOL opinions cannot even be reviewed, the court certainly undercut any argument that there

90. *Insurance & Prepaid Benefits Trust v. Donovan*, 685 F.2d 443 (9th Cir. 1982) (mem.), *aff'g* 90 F.R.D. 703 (C.D. Cal. 1981).

91. *Id.*

92. *Compare* *Boating Indus. Ass'n v. Marshall*, 601 F.2d 1376 (9th Cir. 1979) *with* *National Automatic Laundry & Cleaning Council v. Shultz*, 443 F.2d 689 (D.C. Cir. 1971) *and* *Continental Airlines, Inc. v. CAB*, 522 F.2d 107 (D.C. Cir. 1974).

93. The growth of pension plans has been aided by favorable tax treatment; in general, an employer may deduct contributions to a pension plan and an employee may defer taxation on the contributions as income until he receives a distribution. In return, Congress requires pension plans to meet certain minimum standards which are now contained in Title II of ERISA. *See supra* note 3. It is routine procedure for plans to obtain determination letters from the Internal Revenue Service stating that the plan qualifies for favorable tax treatment. *See* 26 C.F.R. § 601.201(o) (1982); Rev. Proc. 80-30, 1980-1 C.B. 685; Rev. Proc. 80-24, 1980-1 C.B. 658.

94. *See supra* note 41.

is a "certification" process for welfare plans akin to the "qualification" process for pension plans.

If this aspect of the court's opinion represents a minor gain for MET enforcement, its failure to address the merits represents a loss. The district court's opinion was widely hailed in the MET community as a victory because, despite the ultimate holding, the court accepted most of the structural changes made by Wilkie to turn his MET into an employee benefit plan.⁹⁵ Instead of a definitive opinion on METs which could have followed the DOL argument that this restructured MET still did not match the "primary purpose" prerequisite of employee benefit plan status, the Ninth Circuit's opinion leaves that critical question unanswered. Whether this opinion sparks a new wave of restructured METs is not yet apparent, but the potential surely exists.

B. Jurisdiction over METs under ERISA

As the foregoing material suggests, most of the attention in the MET controversy has centered on state regulation of these entities. This section focuses on a development that has apparently eluded the attention of state regulators, and indeed, commentators as well. Until very recently, the DOL enforcement program against METs had been virtually stopped in its tracks by a little-publicized decision of the Court of Appeals for the Fifth Circuit.⁹⁶

1. The DOL Theory of ERISA Jurisdiction

Before discussing this decision and its subsequent history, however, it is necessary to return to the beginnings of the MET problem in 1976 and 1977. The task for the regulators then seemed to be to find a way to work around the "deemer" provision of section 514 in order to clear the way for regulation of METs under state insurance laws. The DOL solution was to devise a statutory interpretation that would provide that METs were not "employee welfare benefit plans" under section 3(1) of ERISA. This, of course, eventually became the "established or maintained by employers" analysis. Until the *IBT* decision, this seemed to be a successful strategy, and no court had held that a MET was an employee welfare benefit plan.

95. See *Business Insurance* 1, 26 (Aug. 3, 1981). Mr. Wilkie is quoted as saying, "We lost the battle, but won the war. We're disappointed we didn't win hands down, but it was a tremendous victory." *Id.* at 26.

96. *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980).

The “established or maintained by employers” analysis also seemed to have the advantage of being designed for one specific question—whether the MET itself was an employee benefit plan. Beginning in 1979, however, the DOL decided to give a more complete analysis—one not strictly necessary for the specific question of the MET’s status under state law, but one certainly more accurate concerning federal ERISA regulation of METs. Therefore, advisory opinions on METs began to appear with something added to the usual analysis. After declaring that the MET itself was not a plan, the opinions went on to state that, in the case of METs, the proper analysis was that each subscribing employer had established its own plan. The MET, therefore, was not itself a plan, but rather the funding vehicle for a number of smaller plans, which were covered by ERISA.⁹⁷

This was neither as contradictory nor as unprecedented as it might, at first glance, seem. After all, the entire MET arrangement was designed to provide health and welfare benefits to persons who were employees of subscribing employers. Given the recurring expressions of congressional intent in ERISA’s legislative history to provide comprehensive protection to employees in the area of their health and welfare benefits, it seemed apparent that ERISA should apply to METs in some fashion. Moreover, there seemed to be no reason to treat employers subscribing to METs any differently from employers contracting with insurance companies to provide benefits. The latter had always been understood to have established employee welfare benefit plans. Finally, this analysis did not jeopardize state regulation of the MET. Just as a state could regulate an insurance company providing services to an employee benefit plan, so could the states regulate a MET as a service provider to plans.

2. *The Taggart Decision*

On May 30, 1980, the Court of Appeals for the Fifth Circuit decided *Taggart Corp. v. Life and Health Benefits Administration*.⁹⁸ The sole employee of Taggart Corporation had arranged health insurance for himself and his family from a licensed insurance company through a

97. See, e.g., DOL Advisory Op. 81-84A (Dec. 9, 1981); DOL Advisory Op. 81-73A (Sept. 24, 1981); DOL Advisory Op. 80-10A (Feb. 11, 1980); DOL Advisory Op. 79-54A (Aug. 5, 1979); DOL Advisory Op. 79-46A (July 19, 1979); DOL Advisory Op. 79-41A (June 29, 1979).

98. *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), *aff’d sub nom. Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980).

MET.⁹⁹ When the employee's wife made a claim for benefits, the insurance carrier denied the claim based on an alleged misrepresentation in the insurance application.¹⁰⁰ The employee then brought suit under ERISA. The district court granted the defendants' motion to dismiss for lack of subject matter jurisdiction.¹⁰¹ The appellate court's reaction to this suit became apparent in the opening sentence of its reasoning: "Whether this insurance case belongs in federal court turns on whether [the MET] is covered by [ERISA]."¹⁰² The court then proceeded to dispose of plaintiff-appellant's contention that the MET was itself an employee welfare benefit plan. This portion of the opinion set out in conclusory, but accurate, terms the arguments against this proposition, stating that the MET was a "proprietary enterprise, established and operated by independent businessmen for their personal profit";¹⁰³ that it was marketed to "hundreds of unrelated subscriber customers";¹⁰⁴ and that it had not been established by employers as required by the section 3(1) definition of employee welfare benefit plan.¹⁰⁵

Up to this point, there was nothing unusual about the opinion. But when the court turned to a discussion of the DOL's expanded MET theory—that Taggart Corporation had established its own individual employee benefit plan when it subscribed to the MET—¹⁰⁶ the court broke new ground in the interpretation of ERISA. It stated: "Considering the history, structure and purposes of ERISA, we cannot believe that that Act regulates bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits."¹⁰⁷ The reasoning in support of this conclusion was, at best, sketchy. First, the court pointed out that most of ERISA deals with pension plans.¹⁰⁸ It then reasoned that the alleged plan had no assets and was not in the form of a trust.¹⁰⁹ Therefore, there were no assets to

99. *Id.* at 1210.

100. *Id.*

101. *Taggart [sic] Corp. v. Efros*, 475 F. Supp. 124 (S.D. Tex. 1979).

102. 617 F.2d at 1210.

103. *Id.*

104. *Id.*

105. *Id.*

106. The DOL filed an *amicus curiae* brief in the case.

107. 617 F.2d at 1211.

108. *Id.*

109. *Id.*

be protected by ERISA.¹¹⁰ The court also cited section 105 of the Internal Revenue Code which supposedly distinguishes between “accident or health insurance” and “accident or health plan[s],” and concluded from this provision that “ERISA ‘plans’ are broader in concept than pure insurance transactions of the sort involved here.”¹¹¹

In the final paragraph of its short opinion, the court expressed no concern about its decision. The lack of jurisdiction under ERISA, the court reasoned, did not mean that plaintiff-appellant could not pursue its “insurance claims in an appropriate state court.”¹¹²

3. *The Implications of the Taggart Decision on Coverage of Employee Welfare Benefit Plans under ERISA*

A fair summation of the holding of the *Taggart* opinion is that an employer who merely purchases insurance to fund health and welfare benefits, and who thereafter does not exercise control over the administration of the contract, has not established an employee welfare benefit plan within the meaning of ERISA. Although this analysis was proffered in the MET context, it presumably would apply to all types of welfare plans. The problem with this analysis can be stated quite simply—the *overwhelming majority of welfare plans in America fit that description*. Approximately 92% of the 1.5 million companies with health and welfare plans purchase insurance to fund benefits,¹¹³ and 89% of these employers exercise little or no control over the administration of the plan.¹¹⁴

a. The Purchase of Insurance

The words of the statute and its legislative history repeatedly make mention of the fact that ERISA-covered welfare plans are created through the purchase of insurance. The most significant statutory language is in the section 3(1) definition of employee welfare benefit plan which specifically states that covered plans may be funded “through the purchase of insurance.” Moreover, six other statutory provisions assume that employee welfare benefit plans involve insurance.¹¹⁵

110. *Id.*

111. *Id.*

112. 617 F.2d at 1211.

113. See II BATTELLE STUDY, *supra* note 12, at 80.

114. See IV BATTELLE STUDY, *supra* note 12, at 42.

115. See § 103(a)(2), 29 U.S.C. § 1023(a)(2) (1976) (requiring an insurance company “which

In fact, this aspect of ERISA reflects the common understanding of how plans have been funded since at least the passage of the predecessor statute to ERISA—the Welfare and Pension Plans Disclosure Act of 1958 (WPPDA).¹¹⁶ The Senate Report explaining the WPPDA definition of “employee welfare benefit plan,” which is virtually identical to that of ERISA, notes that: “[m]ost employee welfare plan benefits are insured with a commercial insurance company or the Blue Cross-Blue Shield type of operation.”¹¹⁷ Partially in reliance on this legislative history, one of the few reported decisions under the WPPDA held that where an employer collected employee contributions, added company contributions and remitted these amounts for Blue Cross-Blue Shield coverage for those employees, the employer had established an employee welfare benefit plan.¹¹⁸

The legislative history of ERISA indicates that Congress not only was aware of this issue under the WPPDA, but also was concerned that the same controversy not jeopardize coverage of employee benefit plans under ERISA. As one House Report states, one of the objectives of ERISA was to extend the protections of the Act in situations in which the extent of existing law had been unclear:

First, a number of plans are structured in such a way that it is unclear whether the traditional law of trusts is applicable. Predominantly, these are plans, such as insured plans, which do not use the trust form as their mode of funding. Administrators and others exercising control functions in such plans under the present Act [the WPPDA] are subject only to minimal restrictions¹¹⁹

In light of the language and legislative history, it is virtually indisputable that Congress not only was aware of the insured nature of most plans, but also fully intended to subject such plans to ERISA.¹²⁰ Both

provides some or all of the benefits under the plan” to provide information for reporting purposes); *id.* § 103(e), 29 U.S.C. § 1023(e) (1976) (requiring disclosure if “some or all of the benefits under the plan are purchased from and guaranteed by an insurance company”); *id.* § 401(b)(2), 29 U.S.C. § 1101(b)(2) (1976) (describing requirements applicable to assets of a plan which consists of insurance contracts); *id.* § 408(b)(5), 29 U.S.C. § 1108(b)(5) (1976) (rules concerning the purchase of “life insurance [or] health insurance” by certain plans).

116. 29 U.S.C. §§ 301-309 (1958) (repealed by ERISA).

117. S. REP. NO. 1440, 85th Cong., 2d Sess., reprinted in 1958 U.S. CODE CONG. & AD. NEWS 4137, 4143.

118. *Wirtz v. Gulf Oil Corp.*, 239 F. Supp. 483 (E.D. Pa. 1965).

119. *Employee Security Benefit Act of 1974: Material Explaining H.R. 12906 Together with Supplemental Views*, 120 CONG. REC. 3977 (1974) [hereinafter cited as *Explanatory Material*].

120. In this connection, see *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978). The issue in that case was whether a state law mandating that all

before and after the *Taggart* decision, the commentators¹²¹ and courts¹²² had consistently found ERISA coverage of insured plans.

b. The Degree of Employer Involvement in Administration of the Plan

The second major reason advanced by the *Taggart* court in support of its holding was the lack of significant employer involvement in the day-to-day administration of the employee benefit plan. In other words, the court held, without supporting commentary, that Congress intended to subject to ERISA only those benefit arrangements administered by employers.

There is nothing in the section 3(1) definition of employee welfare benefit plan which supports this conclusion. The specific language is that the plan be "established *or* maintained" by the employer (or union or both). Even if it could be said that "maintained" is the equivalent of "administered,"¹²³ the section quite clearly is phrased in the disjunctive. Other statutory provisions confirm the fact that Congress assumed that persons other than the sponsoring employer often do all of the administrative work in connection with covered plans.¹²⁴ In fact, these third-party administrators have testified before Congress concerning

insurance companies must provide psychiatric care benefits was preempted by ERISA as indirect regulation of the employee benefit plan which purchased policies from those companies. The court held that the exception from ERISA's preemption provision for state laws regulating insurance sustained the applicability of that law. In its reasoning, the court stated that "Congress was fully aware of the functions and scope of employee benefit plans" and cited the inclusion of funding by § 3(1) of ERISA "through the purchase of insurance" as proof that Congress knew that most plans are funded through that method.

121. See, e.g., Little & Thrailkill, *Fiduciaries Under ERISA: A Narrow Path to Tread*, 30 VAND. L. REV. 1, 3 (1977); Comment, *ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws*, 78 COLUM. L. REV. 1536, 1537 (1978).

122. See *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978); *Corley v. The Hecht Co.*, 2 E.B.C. 2397 (D.D.C. 1982); *Austin v. General Am. Life Ins. Co.*, 498 F. Supp. 844 (N.D. Ala. 1980); *Lederman v. Pacific Mut. Life Ins. Co.*, 494 F. Supp. 1020 (C.D. Cal. 1980); *Cate v. Blue Cross & Blue Shield*, 434 F. Supp. 1187 (E.D. Tenn. 1977).

123. But see *Feinstein v. Lewis*, 477 F. Supp. 1256, 1260 (S.D.N.Y. 1979), aff'd, 622 F.2d 573 (2d Cir. 1980) (court held that "maintained" is the equivalent of "funded").

124. For example, ERISA § 3(16), 29 U.S.C. § 1002(16) (1976), defines "administrator" as the plan sponsor or "the person specifically so designated by the terms of the instrument under which the plan is operated." Similarly, ERISA § 3(14), 29 U.S.C. § 1002(14) (1976) defines "party in interest" to include the "employer" as well as the "administrator." ERISA § 103, 29 U.S.C. § 1023 (1976 & Supp. V 1981), requires disclosure by each covered plan of a change in administrator. None of these provisions is consistent with the notion that Congress thought that the employer administered all covered plans.

ERISA,¹²⁵ and have been involved in numerous cases arising under ERISA without a single court taking the position that the presence of third-party administration has defeated ERISA coverage.¹²⁶

Assuming, therefore, that "established" does not mean "administered," the question becomes what sort of action must an employer take to "establish" a plan. It has been demonstrated that in the MET area the DOL has used the employer (or union) establishment requirement to exclude METs on the theory that the organizational impetus comes from the MET entrepreneur and not the employees. But, this reading of the "established" requirement has no relevance to the question of whether the employer "establishes" an individual plan which then subscribes to the MET to administer benefits. On this individual plan level, the DOL always has viewed this language as primarily intended to distinguish between purchases of health insurance by individuals for themselves and such purchases by employers on behalf of a class of employees.¹²⁷ Viewed from this perspective, the "established by" language results only in a requirement that welfare benefits be provided by some action of an employer acting to benefit a *class* of his employees.¹²⁸

125. See *Hearings Before the Senate Comm. on Finance*, 94th Cong., 2d Sess. 33 (1976):

The great bulk of small plan sponsors are small business; businesses which have neither the in-house facilities nor the expertise to undertake the administrative and actuarial tasks necessary to properly establish and maintain an employee benefit plan. Accordingly, they retain firms like those represented by our association to handle *all aspects of administrative and actuarial functions, ranging from assistance in initial plan design to the full scope of continuing administration.*

Id. (emphasis added).

126. See, e.g., *Wadsworth v. Whaland*, 562 F.2d 70, 72 (1st Cir. 1977) (plaintiff described as the "administrators of various health and welfare funds which provide benefits chiefly through the purchase of group health insurance"), *cert. denied*, 435 U.S. 980 (1978); *Delaware Professional Servs. Corp. v. Hotel & Restaurant Employees Union*, 2 E.B.C. 2041 (N.D. Cal. 1981) (plaintiff was administrator of prepaid health and dental care programs for employee welfare benefit plans); *Boyer v. J.A. Majors Co. Employees Profit-Sharing Plan*, 481 F. Supp. 454 (N.D. Ga. 1979); *Barrett v. Thorofare Markets, Inc.*, 452 F. Supp. 880 (W.D. Pa. 1978); *Carter v. Montgomery Ward & Co.*, 76 F.R.D. 565 (E.D. Tenn. 1977).

127. See, e.g., 29 C.F.R. § 2510.3-1(j) (1982), which specifically excludes from coverage certain insurance arrangements where, among other things, a promoter solicits employees, not employers, and where the only involvement of the employer is, without endorsing the program, to permit the promoter to publicize the program to employees. Similarly, another regulation, codified at 29 C.F.R. § 2510.3-3(b) (1982) excludes from coverage any arrangement whereby an individual causes his sole proprietorship or wholly-owned corporation to purchase benefits for himself as the "employer's" sole "employee."

128. This distinction may partially explain the reluctance of the *Taggart* court to find coverage. In *Taggart*, the alleged plan had only one participant—the corporation's president and sole

c. The Significance of the Structure of the Plan Arrangement

The most fundamental error of the *Taggart* decision is its emphasis on the structure of the benefit arrangement as the determining factor in the question of coverage. To a certain extent, this may have been caused by the prior emphasis on the MET as an employee benefit plan. But, in the case of an insured MET (as in *Taggart*), there are three distinct structural entities operating on different levels. There is the entity at the employment level, the intermediate funding vehicle which is the MET itself, and the insurance company underwriting the benefits. The fact that one or more of these entities cannot be considered employee benefit plans (in this case, the insurance company and MET) does not mean that there are no covered plans. Title I of ERISA is essentially a labor-relations statute and it is on the employer-employee level where one could expect plans to be found.

The difficulty that arises in most welfare plan cases is that there is typically no formal written "plan" on the employment level—the employer generally simply signs a contract to provide benefits to his employees. But, this lack of a formal structure is not fatal. The first proof of this hypothesis lies in the phrase, "plan, fund, or program" in section 3(1). The use of the disjunctive suggests that Congress was not overly concerned with structure. Indeed, the courts have consistently held that this language expresses congressional intent to cover any procedure utilized by an employer to provide the benefits described in section 3(1), whether or not the procedure is memorialized in a separate document.¹²⁹ More specifically, the common understanding of "program" is "a plan or procedure for dealing with some matter."¹³⁰

employee. While that "employee" was only a minority shareholder of the corporation, thereby avoiding the exclusion from ERISA coverage provided in the DOL regulation, 29 C.F.R. § 2510.3-3(b) (1982), the *Taggart* court plainly had difficulty in accepting the notion that "the corporation" had made a decision to provide health benefits to its lone officer and worker, as opposed to the individual purchase of insurance through the corporate guise excluded by the DOL's regulations defining an ERISA-covered plan. That the court apparently perceived this as an attempted elevation of form over substance is shown by its characterization of the alleged corporate decision as one made "patently for tax reasons." See 617 F.2d at 1211.

129. For example, the courts have unanimously held that a few sentences in an employer's policy manual to the effect that an employee is entitled to severance pay to be paid out of the employer's general assets constitutes an "employee welfare benefit plan" under ERISA. See *Dependahl v. Falstaff Brewing Corp.*, 491 F. Supp. 1188 (E.D. Mo. 1980); *Pinto v. Zenith Radio Corp.*, 480 F. Supp. 361 (N.D. Ill. 1979); *Donnelly v. Aetna Life Ins. Co.*, 465 F. Supp. 696 (E.D. Pa. 1979).

130. WEBSTER'S NEW WORLD DICTIONARY 1135 (2d ed. 1974).

Viewed only on the level of employer-employee relations, it is difficult to believe that an employer subscribing to a MET could be thinking of anything more than establishing a program for providing welfare benefits for his employees. Furthermore, if a prospective employee were to ask the employer whether the company had a program for the provision of health benefits, it is hardly likely that the answer would be "no."

This statutory language of a "plan, fund, or program" also refutes the reasoning in *Taggart* that an employer does not establish a covered plan by subscribing to the MET because the alleged plan is not in the form of a trust.¹³¹ Even if the court were correct about the requirement of a trust, however, it seems to have overlooked one critical fact—the subscribing plans to a MET are cast in a trust form. To be sure, each plan does not embody a separate trust, but the plans do participate in a commingled trust fund—the MET itself. It is not at all uncommon in either the pension or welfare plan area for banks, insurance companies or others to offer participation in commingled trust funds as a means of funding benefits for the individual subscribing plans.¹³² There is also no question that Congress was well aware of this fact when it enacted ERISA.¹³³

When the MET is viewed in relation to other commingled trusts, the DOL theory that each subscriber establishes its own plan does not appear to be unprecedented. On the contrary, one of the ironies of the prior preoccupation with the status of the MET under state law is that the *Taggart* court lost sight of the fact that the same persons who were

131. See Cummings, *Purposes and Scope of Fiduciary Provisions Under the Employee Retirement Income Security Act of 1974*, 31 BUS. LAW. 15 (1975):

We ought to keep in mind several points with respect to this definition [of employee welfare benefit plan]. First, it is much broader than any other definition heretofore used in this context, either with respect to tax or disclosure. Second, it does not require a fund at all, but may simply involve a program. . . .

Id. at 19.

132. This is known as a "master plan" in the pension area. It operates exactly as a MET operates in the welfare plan area; that is, the commercial entity establishes a single trust or custodial account in which all the employers adopting the master plan participate. There is no question that each subscriber establishes its own covered plan although there is only one trust. See *Marshall v. Carroll*, 2 E.B.C. 2491 (N.D. Cal. Apr. 18, 1980), *aff'd*, No. 80-4361 (9th Cir. Feb. 11, 1982); 1 PENS. PLAN GUIDE (CCH) ¶ 17,004.

133. The ERISA Conference Report states: "The conferees understand that it is common practice for banks, trust companies and insurance companies to maintain pooled investment funds for plans. . . ." H.R. REP. No. 1280, 93d Cong., 2d Sess. 316, *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 5038, 5096 [hereinafter cited as *Conference Report*].

arguing that the MET is not the plan itself also had generally added that the MET subscribers had themselves established covered plans. This includes the DOL well before its change in its advisory opinions,¹³⁴ the NAIC,¹³⁵ and the House Oversight Committee.¹³⁶ Indeed, the existence of ERISA-covered plans within the MET arrangement had been assumed by the large insurance companies which had first formed METs.¹³⁷

In short, the *Taggart* court's fundamental misperception was its belief that how a plan is funded or administered determines its coverage. Once again, a close reading of the section 3(1) definition of employee welfare benefit plan establishes the essential irrelevancy of those structural characteristics. The only language dealing with structure other than the "plan, fund, or program" phrase discussed above is the requirement that the benefits be provided "through the purchase of insurance or otherwise." It is difficult to accord any interpretation of the

134. See 29 C.F.R. § 2520.104-21 (1982), originally proposed on August 3, 1976. It provides a limited exemption from the reporting requirements of ERISA for welfare plans "which [have] fewer than 100 participants . . . are part of a group insurance arrangement . . . and provid[ed] benefits to the employees of two or more unaffiliated employers." *Id.*

135. See Brummond, *supra* note 20, at 734. At the time of the article, the author was counsel to the NAIC.

136. As noted, the House Oversight Committee had concluded that state insurance law could apply to the MET itself and is not preempted by ERISA. The concluding portion of the Committee's analysis is not as well known: "To the extent that such [METs] fail to meet the definition of an 'employee benefit plan,' state regulation of them is not preempted by section 514, *even though such state action is barred* [by ERISA § 514] *with respect to the plans which purchase these 'products.'*"

Oversight Report, supra note 57, at 10 (emphasis added).

137. In hearings concerning proposed ERISA regulatory action jointly conducted by the Internal Revenue Service and DOL in February 1977, Daniel Knickerbocker, Vice-President of the John Hancock Mutual Life Insurance Company, stated:

In still another case involving a great many small plans, these may be operated under some kind of master trust arrangement. I am not talking only of the master trust and prototypes which are used in welfare plans; and [an] insurance company in order to establish such arrangements may establish the trust, appoint the trustee or trustees and its salesmen will make available the participation in this trust to many, many small employee groups.

The groups are, in fact, groups of three to 49 employees. We have one such trust in the John Hancock, for instance, that . . . we established. *There are 3,200 participating employers and their plans.* And the coverage is afforded to some 23 and a half thousand employees.

In the Matter of: Hearing On Proposed Class Exemption For Insurance Agents and Brokers, Etc. at 161 (unpublished transcript available at Department of Labor) [hereinafter cited as *DOL Hearings*].

latter phrase other than a congressional direction that structural details, at least in the area of funding, are not relevant.

If the existence of an ERISA-covered welfare plan depended on how it is operated, each change in operation could put the coverage issue into dispute. More seriously, a focus on funding mechanisms could lead to a finding of noncoverage for plans which no one would dispute were subject to ERISA. For example, there could not be a serious question of the coverage under ERISA of plans set up in collective bargaining and jointly administered by employees and unions. The Supreme Court has held that such plans "must comply with the detailed and comprehensive standards of the ERISA,"¹³⁸ and the Court of Appeals for the Third Circuit has held that ERISA is "incontestably" applicable to these plans.¹³⁹ But, if such a plan were to subscribe to a MET, the logic of the *Taggart* reasoning would lead to a holding that no coverage existed. In sum, an analysis which focusses exclusively on how a benefit arrangement is funded or administered will inevitably lead to absurd and inconsistent results.

4. *The Dillingham Decision*

While the *Taggart* case was pending in the Fifth Circuit, the DOL filed a complaint in another MET case. In *Donovan v. Dillingham*,¹⁴⁰ the defendants were the trustees of a MET and certain other entities owned and operated by them. While a motion to dismiss the complaint was pending, the Fifth Circuit decided *Taggart* and the district court thereupon dismissed the complaint.

By the time the case on appeal was submitted for oral argument, the new Eleventh Circuit had been created. This fact, however, did not change the status of *Taggart* as controlling precedent in *Dillingham*. In its first en banc decision, the new Eleventh Circuit announced that it would follow the rules on precedent adopted by the Fifth Circuit.¹⁴¹ This meant that the new circuit would be bound by decisions of the Fifth Circuit issued prior to October 1, 1981, and that no panel could issue an opinion contrary to a previous panel decision of the Fifth Circuit.

138. *UMW Health & Retirement Funds v. Robinson*, 455 U.S. 562 (1982).

139. *Cutaiar v. Marshall*, 590 F.2d 523, 530 (3d Cir. 1979).

140. *Donovan v. Dillingham*, 668 F.2d 1196 (11th Cir.), *rev'd*, 688 F.2d 1367 (11th Cir. 1982) (en banc).

141. *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc).

Accordingly, the Eleventh Circuit panel in *Dillingham* affirmed the district court's dismissal of the DOL complaint solely on the authority of *Taggart*. Its brief opinion discussed only one point: the rejection of an attempt to distinguish *Taggart* on the ground that the alleged plan there had really been a disguised individual purchase of insurance by the corporation's sole employee.¹⁴²

The DOL thereupon filed a petition for rehearing en banc—the only way to remove the controlling significance of Fifth Circuit decisions in the Eleventh Circuit.¹⁴³ The court granted the petition and, in a decision with far-reaching significance for the future of METs, held that there is subject matter jurisdiction under ERISA for complaints against the promoters of METs.

The decision is a well-reasoned refutation of the essential holding in *Taggart*. In contrast to *Taggart*, the Eleventh Circuit examined in detail the section 3(1) definition of employee welfare benefit plan. Starting with the “plan, fund or program” language, the court held that a covered plan “implies the existence of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits.”¹⁴⁴ Where these factors are reduced to writing, a plan would clearly exist.¹⁴⁵ The court held, however, that coverage under ERISA does not depend on the existence of “a formal, written plan.”¹⁴⁶ As noted, this is significant because the subscribers to METs, and indeed employers who purchase insurance, do not ordinarily write up a formal plan for themselves. In welfare plans the MET trust document and insurance policy usually are the only written instruments. The court specifically held that these sources can be looked at to ascertain whether a plan exists.¹⁴⁷

According to the court, coverage ultimately depends on evidence of “events that record, exemplify or implement” an employer's decision.¹⁴⁸ These include “financing or arranging to finance or fund the intended benefits, establishing a procedure for disbursing benefits,

142. *Donovan v. Dillingham*, 668 F.2d 1196, 1198 (11th Cir. 1982), *rev'd*, 688 F.2d 1367 (11th Cir. 1982) (en banc).

143. *See Bonner v. City of Prichard*, 661 F.2d 1206, 1210 (11th Cir. 1981) (en banc).

144. *Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982).

145. *Id.*

146. *Id.*

147. *Id.* at 1372-73.

148. *Id.* at 1373.

[and] assuring employees that the plan or program exists. . . ."¹⁴⁹ In this connection, the court took exception to the views of *Taggart* on insurance funding. Instead of treating purchases of insurance as a factor militating against ERISA coverage, the court held that "the purchase of a group policy or multiple policies covering a class of employees offers substantial evidence that a plan, fund, or program has been established."¹⁵⁰

The court then applied this standard to the facts of the case. It held that the purpose of the subscription to the MET was to provide benefits to participants,¹⁵¹ that the intended beneficiaries constituted a class of employees or union members,¹⁵² and that the subscribing employers financed those benefits "under circumstances tending to show an anticipated continuing furnishing of such benefits. . . ."¹⁵³

The final section of the opinion dealt with *Taggart*. The court distinguished *Taggart* on precisely the same ground that the panel earlier rejected. Thus, the court held that the alleged plan in *Taggart* was actually an individual purchase of insurance by the corporation's sole employee.¹⁵⁴ The court did, however, state that the reasoning of *Taggart* "encourages too broad an interpretation,"¹⁵⁵ and concluded:

[I]f *Taggart* implies that an employer or employee organization that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot be said to have established or maintained an employee welfare benefit plan, we disagree. To that extent *Taggart* shall no longer be binding in the Eleventh Circuit.¹⁵⁶

149. *Id.*

150. *Id.*

151. *Id.* at 1374.

152. *Id.*

153. *Id.* at 1375.

154. *Id.*

155. *Id.*

156. *Id.* The status of *Taggart* in the Fifth Circuit is now unclear. It remains to be seen whether the circuit will also distinguish *Taggart* on the basis that the alleged plan there was really an individual purchase of insurance. Considering that the author of *Taggart*, Judge Hill, was part of the unanimous *Dillingham* court, it would appear likely that the Fifth Circuit will in some subsequent MET case take the same approach to *Taggart* the Eleventh Circuit has.

III. THE FUTURE OF MET REGULATION

A. Introduction

The foregoing traced the somewhat tortuous development of legal principles establishing the jurisdiction of the states and federal government over METs. Despite some lingering uncertainties, it appears likely that the courts will adopt the general reasoning that a MET is not an employee benefit plan (and is thus not excluded from state regulation by the ERISA "deemer" provision), but that the individual subscribing employers do establish such plans (which are thus subject to ERISA). In short, both state and federal law have roles to play in the area of METs.

Nevertheless, little has been accomplished in the past five years. In going after METs under state insurance laws, there is an impressive amount of case law holding that a MET is not an employee benefit plan, but that is not the same thing as saying that a MET is an insurance company. Considering the variation in state insurance laws, METs may be insurance companies in some states, but not in others. Once that question is settled, the more important question of how the insurance law should be enforced against METs arises. Moreover, the same questions can be applied to regulation of METs under ERISA. Assuming the court in *Dillingham* has effectively overruled *Taggart* and cleared the way for the DOL to enforce ERISA against METs, there is still no law on how ERISA should be interpreted in the MET area. The next two sections examine the probable contours of future regulation of METs under state, and then federal law.

This future regulation will also be affected by MET legislation enacted during the final session of the Ninety-Seventh Congress. This legislation responds to many of the problems uncovered by Congress in its hearings, and should be a benefit to state and federal enforcement officials, particularly on the issue of jurisdiction over METs. Nevertheless, while the intent of the legislation is clear, the actual language is ambiguous and does not address many of the difficult unresolved issues in this area.

Therefore, the legislation will not clear up the MET area. That will require better coordination of state and federal law. Although it is hardly unprecedented for both state and federal law to apply to a particular situation, ERISA and state insurance laws proceed from two very different premises. In the third section of this Part, a framework

for applying both state and federal law in a coordinated fashion is developed.

At that point, the final and perhaps the most difficult problem shall be considered—devising a practical enforcement strategy. As the historically rocky relationship between the NAIC and DOL illustrates, very little progress has been made on this score. Therefore, the concluding section of this article makes detailed recommendations for an effective, coordinated enforcement strategy.

B. The Status of the MET under State Insurance Law

1. Insurance Law Generally

For many years courts have held that the business of insurance is subject to substantial state regulation.¹⁵⁷ Undeniably, insurance is a business with which the states have always had a "special relation."¹⁵⁸ Correspondingly, states have been granted the authority to control who engages in the business of insurance. Knowledge of the conditions under which insurance companies may operate in a given state dictates company policy.¹⁵⁹

Although yielding varied results, state insurance laws do contain protections in two general categories. One regulates the "relationship between insured and insurer."¹⁶⁰ Underlying this category is the approval of the policy to be issued,¹⁶¹ the rates to be charged,¹⁶² subsequent interpretation of the policy,¹⁶³ and the selling and advertising of policies.¹⁶⁴ Grouped together in the other category of laws are the sol-

157. See, e.g., *California State Auto. Ass'n Inter-Ins. Bureau v. Maloney*, 341 U.S. 105, 109-10 (1951); *Eckenrode v. Life of Am. Ins. Co.*, 470 F.2d 1 (7th Cir. 1972).

158. See, e.g., *Osborn v. Ozlin*, 310 U.S. 53, 65 (1940).

159. See *Western & S. Life Ins. Co. v. State Bd. of Equalization*, 4 Cal. App. 3d 21, 84 Cal. Rptr. 88 (1970); *State Farm Mut. Auto. Ins. Co. v. Duel*, 244 Wis. 429, 12 N.W.2d 696 (1944) *aff'd*, 324 U.S. 154 (1945).

160. *SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969).

161. The NAIC has promulgated a model law in the health coverage area. See *Uniform Individual Accident and Sickness Policy Provisions Law*, in I NAIC PROCEEDINGS 414 (1950). Thirty-two states have adopted this law. See *Official NAIC Model Insurance Laws, Regulations and Guidelines*, at 10-3 (1980), [hereinafter cited as *Model Laws*]. See generally Henson & Obenberger, *Mail Order Insurers: A Case Study in the Ability of the States to Regulate the Insurance Business*, 50 MARQ. L. REV. 175, 182-86 (1966).

162. See, e.g., *SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969); Henson & Obenberger, *supra* note 161, at 182-86.

163. Henson & Obenberger, *supra* note 161, at 185.

164. *Id.* See also *FTC v. National Causalty Co.*, 357 U.S. 560, 564 (1958) (per curiam); Kimball & Jackson, *The Regulation of Insurance Marketing*, 61 COLUM. L. REV. 141 (1961). All states

gency of insurers and the requirements for, among other things, initial capitalization, surplus accounts, reserves and investments.¹⁶⁵ In short, the state “has a legitimate concern with the financial soundness of companies writing insurance contracts with its citizens,”¹⁶⁶ and is charged with maintaining control “against fly-by-night operators and the grosser forms of profiteering and financial mismanagement all too common in unregulated insurance activity.”¹⁶⁷

2. *Resolving the Question of METs and the Business of Insurance*

Armed with the record of MET insolvencies and the resulting inability to pay claims for medical expenses,¹⁶⁸ one could argue that the traditional state concern with the solvency of insurers is quite apt for METs. Realizing that the general purpose of insurance law can be, or perhaps even should be applied to METs does not, ipso facto, mean that METs are engaged in insurance. Doubtless, the state regulators must still show that the activities of the MET fit within the definition of insurance used in that state.

Unfortunately, this is not a simple task because most states lack a statutory definition of insurance.¹⁶⁹ Nevertheless, there are certain principles which have been identified as characterizing insurance. As noted, the primary function of insurance is to assume the risk of a contingency by spreading that risk over a large class of similarly situated persons.¹⁷⁰ Each of these factors may be said to be present in a MET: the promised health and welfare benefits are provided only when an employee becomes ill or disabled; the MET is solely responsible for compensation in the event the contingency of sickness or accident arises; and the provision of a mechanism for risk distribution is the overriding reason for the existence of the MET.¹⁷¹ Other attributes of the typical insurance relationship also exist. It is recognized that em-

regulate marketing practices, most of them pursuant to another NAIC model law. *See All Industry Fair Trade Practices Act*, in I NAIC PROCEEDINGS 150 (1960); *Model Laws*, *supra* note 161, at 20-22.

165. *See generally* Henson & Obenberger, *supra* note 161, at 190-91; Annot., 17 A.L.R.4th 16 (1982).

166. *State Farm Mut. Auto. Ins. Co. v. Duel*, 324 U.S. 154, 158 (1945).

167. *Robertson v. California*, 328 U.S. 440, 458 (1946).

168. *See supra* notes 26-32 and accompanying text.

169. *See* Goetz, *supra* note 60, at 321.

170. *See* 1 COUCH, INSURANCE § 1.3 (2d ed. 1959).

171. *See* Brummond, *supra* note 20, at 706-09.

employers have an "insurable interest" in the lives and health of their employees.¹⁷² From the perspective of the employer and employee, the MET has made a "legally binding promise" to provide benefits in the case of valid claims. The existence of such a "legally binding promise" generally indicates the presence of a bona fide insurance contract.¹⁷³

For the most part, the weight of authority in the decided cases indicates that METs are in the business of insurance. Unfortunately, however, no court has yet articulated a convincing rationale for such a holding. On the federal level, the courts have been more concerned with whether the MET is an employee benefit plan. Once that has been determined, the court either assumes that the MET is in the business of insurance¹⁷⁴ or the MET declines to make the further argument that it is not.¹⁷⁵ There has been considerably more activity in state courts, but most of the decisions involve unpublished opinions, decisions without hearings, or brief memoranda on preliminary motions.¹⁷⁶

Those states which make the most careful distinctions about insurers have had difficulty with this issue. Prominent among them is California. According to Mr. Damon, Chief Deputy Commissioner for California, METs are not considered to be insurers under that state's laws.¹⁷⁷ Although Damon did not articulate the basis for his contention, it is likely that the structure of particular METs raises the possibility that they are not insurers.

For many years, courts have drawn distinctions among entities involved in the health care area. The leading case in this area is *Jordan v.*

172. "Insurable interest" refers to the requirement that the actual purchaser of insurance be subject to a risk of loss if the insured suffers some injury. *See, e.g.,* R. KEETON, *supra* note 17, at § 3.5(b); W. VANCE, *supra* note 18, at 156-208.

173. Hellner, *supra* note 17, at 498.

174. *See, e.g.,* Wayne Chem. Corp. v. Columbus Agency Serv. Corp., 567 F.2d 692, 699-700 (7th Cir. 1977).

175. *See, e.g.,* National Business Conference Employee Benefit Ass'n v. Anderson, 451 F. Supp. 458, 459 (S.D. Iowa 1977) (court noted that the MET admitted that there was no distinction between it and a health insurance company).

176. *See, e.g.,* Washington Am. Life Ins. Co. v. Texas, 545 S.W.2d 291 (Tex. Civ. App. 1977) (conclusory statement that MET was either an insurance company itself or agent for reinsurers and thus was subject to state law in any event). *See also* Arizona v. Barry, No. C341253 (Ariz. Super. Ct. Jan. 9, 1976) (temporary restraining order); People v. 3133 Group Benefit Trust, No. 727-751 (Cal. Super. Ct. Sept. 7, 1977) (same); Colorado v. Kuhre, No. C-69407 (Colo. Super. Ct. Sept. 27, 1977) (consent decree); Georgia v. Marketing Consultants of the South, Inc., No. 93840 (Ga. Super. Ct. Jan. 7, 1977) (temporary restraining order).

177. *See March Hearings, supra* note 7, at 57.

Group Health Association.¹⁷⁸ The defendant there was a corporation which solicited members who each paid a monthly fee. If the subscriber needed health care, the Association arranged for providers to deliver that care. According to the court, the Association did not guarantee to pay the subscriber's bills; there would not be a charge to the subscriber only if the Association could find a provider that would charge through the Association.¹⁷⁹ In the court's view, the purpose of the insurance code was not to "regulate all arrangements for assumption or distribution of risk,"¹⁸⁰ and this particular arrangement was better characterized as a "consumer cooperative" engaged in the mass purchase of medical care.¹⁸¹

This reasoning has been used to exclude many entities which operate without technically indemnifying subscribers against loss from medical contingencies. Instead of providing indemnification, these entities are considered to be "service organizations."¹⁸² Thus, to the extent a MET may not assume the ultimate risk of loss, but rather agree to use its best efforts to find a provider who will agree to be paid through the MET, it may not be considered to be in the business of insurance. Although figures on this are not currently available, the experience in California indicates that at least some METs may be cast in that form.¹⁸³

178. 107 F.2d 239 (D.C. Cir. 1939).

179. *Id.* at 246-47.

180. *Id.* at 248.

181. *Id.* at 247-48.

182. See generally *Fechteler v. Jordan*, 218 F.2d 865 (D.C. Cir. 1955) (per curiam); J. APPLEMAN, *INSURANCE LAW & PRACTICE* §§ 699-700 (1948).

The best known example of these "service" entities are the various Blue Cross/Blue Shield organizations. While the actual practice of these entities may not differ from traditional insurers, most states have separate statutes outside the insurance code which regulate their activities. See generally Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 972-82 (1971). Another variant of this "indemnity vs. service" distinction for insurance regulation purposes involves so-called health maintenance organizations which are also generally regulated by states outside the insurance code. See generally Anderson, *HMO's and The Insurance Industry: From Strangers to Friends to . . . ?*, 22 A. OF LIFE INS. COUNS. PROC. 795 (1972).

183. This distinction between insurers and nonindemnifying health care plans has complicated California's enforcement effort considerably. Under California law, health care plans which do not technically indemnify against loss are regulated by the Commissioner of Corporations and not the Commissioner of Insurance. Thus, when California attempts to enforce its laws against METs, it sometimes brings separate suit under both laws. For example, see the complaint filed by the Insurance Commissioner against American Benefits, Ltd., No. C426549 (Superior Court for County of Los Angeles) and the companion suit by the Corporations Commissioner against the same MET, No. C426533 (Superior Court for County of Los Angeles).

3. *The Possibility of Special MET Legislation*

The problem of nonindemnifying METs under traditional state insurance law raises the question whether states should enact special legislation to clarify the status of those entities under state law. Indeed, some representatives of METs have urged that the states enact such special legislation.¹⁸⁴ There are, however, some risks to this approach.

The first is the ERISA preemption provision. In this context, the critical question is a more sophisticated variant of the previously discussed issue of whether a MET is an employee benefit plan itself which cannot be "deemed" an insurer because of ERISA section 514(a)(2)(B). Even if the MET is not a plan itself (but rather a funding vehicle for individual subscribing plans), it could be argued that state regulation of the MET is precluded because such regulation "relates to" the subscribing plans within the meaning of section 514(a) generally.

This line of argument is particularly troublesome for state laws outside the insurance code because such laws cannot take advantage of the exclusion from the preemption provision for laws regulating insurance. One example is the legislation enacted by California apart from the insurance code, for health care service plans which do not technically exercise the insurance function of "indemnifying" the covered individual against loss.¹⁸⁵ One court already has held that this law is preempted by ERISA,¹⁸⁶ and while that holding can be limited somewhat,¹⁸⁷ it does suggest that state efforts to regulate METs outside the insurance code may be subject to preemption by ERISA as indirect regulation of the ERISA-covered plans which subscribe to the MET.¹⁸⁸

184. See *de Heuck Letter*, *supra* note 21.

185. See Knox-Keene Health Care Service Plan Act of 1975, CAL. HEALTH & SAFETY CODE §§ 1340 to 1399.64 (Deering 1982).

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

187. In *Hewlett-Packard*, the plaintiffs were not METs, but true employee benefit plans established by employers to serve a closed group of their employees. Moreover, the application of the Knox-Keene Act to them would have necessitated changes in their structure and operation. The district court held that the state law was preempted. It declined, however, to explore the "outer boundaries of ERISA's preemption provision" or to discuss the permissibility of state regulation over non-employee benefit plan providers of health care services to plans. 425 F. Supp. 1295, n.10.

188. The courts' hostility to special legislation which may have an impact on plans is illustrated by *Provience v. Valley Clerks Trust Fund*, 509 F. Supp. 388 (E.D. Cal. 1981). There, the court held that the California common law of fraud and intentional infliction of emotional distress was not preempted by ERISA, but California statutes affording remedies for defrauded consumers and unfair business practices were preempted. This holding appears to have resulted from the

Inclusion of special MET legislation in the insurance code, however, may not be a guarantee of safety from preemption. Since most plans purchase insurance to fund benefits, it is relatively easy for states to affect employee benefit plans by changing their insurance laws. This issue was litigated in *Wadsworth v. Whaland*.¹⁸⁹ At issue was a state insurance law compelling licensed insurance companies to offer mental health coverage in all health policies. The court held that this law "relate[d] to" employee benefit plans which purchase insurance to fund benefits, but was saved from preemption because it was a law regulating insurance. On the other hand, the insurance industry,¹⁹⁰ employee benefit plan community,¹⁹¹ and commentators generally¹⁹² have argued that these laws do not regulate insurers as much as they indirectly regulate employee benefit plans. Efforts to undercut *Wadsworth* judicially¹⁹³ and legislatively¹⁹⁴ are underway. If successful, even the validity of state insurance regulation which is perceived to be aimed at

court's deference to the "judge-made" common law over "legislation-made" law—a distinction that does not appear in the ERISA preemption provision. See ERISA § 514(c), 29 U.S.C. § 1144(c) (1976), which defines "state law" as including all laws, regulations and decisions.

The scope of ERISA preemption of state laws with peripheral effect on plans is unclear. For example, another judge in the same California court which decided the *Provence* case has held that California common law claims are preempted by ERISA. See *Ziskind v. Retail Clerks Int'l Ass'n*, 3 E.B.C. 1012 (E.D. Cal. Feb. 1, 1982). The same inconsistencies plague other courts. Thus, the Ninth Circuit has held that the administrative inconvenience for plans compelled to honor state court community property divisions does not constitute a sufficiently direct effect to mandate preemption. The same court has also held that administrative inconvenience does compel preemption for state efforts to collect income taxes. Compare *Stone v. Stone*, 632 F.2d 740 (9th Cir. 1980) (no preemption), cert. denied sub nom. *Seafarer's Int'l Union v. Stone*, 453 U.S. 922 (1981) with *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 679 F.2d 1307 (9th Cir. 1982), vacated on other grounds, 103 S. Ct. 2841 (1983). See generally Note, *ERISA Preemption of State Law: The Meaning of "Relate To" in § 514*, 58 WASH. U.L.Q. 143 (1980).

189. 562 F.2d 70 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978).

190. See generally Okin, *Federal Preemption of State Law Under ERISA: An Examination of the Effects of the Federal Mandate in the Light of Authoritative Precedent Under the Supremacy Clause, the McCarran-Ferguson Act & the Legislative History*, 24 A. OF LIFE INS. COUNS. PROC. 115 (1976); Younger, *Mandated Insurance Coverage—the Achilles Heel of State Regulation*, 24 A. OF LIFE INS. COUNS. PROC. 765 (1978).

191. See *Hearings on S.2125 Before the Subcomm. on Labor of the Senate Comm. on Human Resources*, 95th Cong., 1st Sess. 543 (1977) (testimony of ERISA Industry Committee).

192. See Manno, *ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action*, 52 TEMPLE L.Q. 51 (1979); Note, *ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws*, 78 COLUM. L. REV. 1536 (1978); Comment, *Regulation of Employee Welfare Benefit Plans: The Scope of ERISA's Preemption and the State Power to Regulate Insurance*, 4 U. DAYTON L. REV. 177 (1979).

193. This attempt failed before the Supreme Court of Massachusetts which held that, although it was wary of an approach which would allow states to regulate plans through their insurance

regulating employee benefit plans that purchase coverage from insurers could be questioned.

There are indications, however, in ERISA and its legislative history that Congress intended to accord states responsibility over special types of insurers that might not be technically "insurance companies" under state law.¹⁹⁵ But, there are two reasons why states should be cautious about special MET legislation beyond the possible preemption problems. First, METs compete against conventional insurers, and there certainly has been no showing that they are entitled to less comprehensive control than their competitors. Thus, the states should be cognizant of the competitive effect on insurance companies of specialized MET legislation.¹⁹⁶ The second reason for caution is the effect MET legislation would have on the enforcement of ERISA. Understanding this issue, however, necessitates a discussion of the future regulation of METs under ERISA.

laws, a Massachusetts insurance law similar to that at issue in *Wadsworth* was not preempted. *See* Attorney General v. Travelers Ins. Co., 385 Mass. 598, 433 N.E.2d 1223 (1982).

The insurance industry had considerably more success in Maryland, where an intermediate appellate court held that a minimum benefit insurance law of that state was preempted by ERISA. *See* Metropolitan Life Ins. Co. v. Insurance Comm'r, 51 Md. Ct. Spec. App. 122, 441 A.2d 1098 (1982). Interestingly, this court reasoned that ERISA § 514's exclusion of laws regulating insurance from preemption "is not devoid of obscurity and free from ambiguity when applying it to a particular law." *Id.* at 1457.

194. Legislation has been introduced to overrule *Wadsworth*, but has never moved beyond the committee stage. *See, e.g.*, S. 209, 96th Cong., 1st Sess., 125 CONG. REC. 927, 930-48 (1979). The current thinking in Congress is unclear. In discussing recently-enacted legislation overruling prior case law holding that a Hawaiian health care statute was preempted by ERISA, Congressman Erlenborn, ranking minority member on the House Committee of Education and Labor, cautioned that the legislation was not "intended in any way either to overturn or endorse the decision" in *Wadsworth*. He added that "[r]esolution of that issue should be dealt with in separate legislation after a full opportunity for both sides to present their views." *See* 127 CONG. REC. H9609 (daily ed. Dec. 13, 1982).

195. First, there is the language of the deemer clause of the preemption provision. It refers to state laws regulating an "insurance company or other insurer." ERISA § 514(a)(2)(B), 29 U.S.C. § 1144(a)(2)(B) (1976). This provision corresponds to the definition of "insurer" in ERISA § 401(b)(2)(A), 29 U.S.C. § 1101(b)(2)(A) (1976), which includes within that term "an insurance company, insurance service, or insurance organization, qualified to do business in a State." The legislative history indicates that this broad definition was intended to cover non-indemnifying health service organizations which may technically not be considered insurance companies under various state laws. *See Conference Report, supra* note 133, at 297.

196. The insurance industry has expressed considerable concern for the competitive advantages currently accorded METs because of the absence of state regulation applicable to insurers generally. *See October Hearings, supra* note 29, at 37; Okin, *supra* note 190, at 178. The Supreme Court has also noted the need for equal treatment under state law of competitors in the insurance area. *See Osborn v. Ozlin*, 310 U.S. 53 (1940).

C. *The Fiduciary Provisions of ERISA and Their Impact on METs*

At the outset, it is necessary to discuss again how METs are structured. The MET is a trust fund which holds moneys contributed by employers (and occasionally employees) to provide health and welfare benefits. The promoters of the MET generally are the trustees of this trust; even if they are not, they enter into arrangements with the trust to provide administrative services. In the case of insured METs, the promoters also choose the insurance company to underwrite the benefits. In uninsured METs, the promoters design benefit and contribution levels and provide for payment of claims out of the trust. The promoters' compensation comes from the trust either in the form of fees for service or sales commissions.

In *Dillingham*, the court declined to comment on whether the MET promoters, who were also the trustees of the MET trust fund, were fiduciaries under ERISA.¹⁹⁷ The expansive ERISA definition of "fiduciary" would, however, seem to apply to these promoters; in the words of the statute, they exercise both "discretionary authority or discretionary control respecting management of [the] plan" or "authority or control respecting management or disposition of its assets."¹⁹⁸ Indeed, the legislative history of ERISA¹⁹⁹ and a significant amount of case law²⁰⁰

197. *Donovan v. Dillingham*, 688 F.2d at 1375.

198. See ERISA § 3(21), 29 U.S.C. § 1002(21) (1976).

199. See, e.g., *Explanatory Material*, *supra* note 119, where the House Committee noted that one of the deficiencies of prior law was that, in the case of insured plans, "[a]dministrators and others exercising control functions in such plans under the present Act are subject to only minimal restrictions." Senator Bentsen, arguing to the Senate in favor of the passage of ERISA, noted a case which "precipitated much of the original Congressional interest in Federal legislation imposing fiduciary standards on pension and welfare funds." 120 CONG. REC. 29951 (1974). The case involved a trustee who misappropriated thousands of dollars from money contributed to pay benefits by forming his own "management firm to administer these funds." *Id.*

200. In *Marshall v. Robbins*, No. 79-20008 (7th Cir. 1980), the court held that the selection of a claims administrator is a fiduciary function under ERISA and that the trustees with the power to make that choice must comply with the fiduciary provisions of ERISA. In *Marshall v. Snyder*, 572 F.2d 894 (2d Cir. 1978), the court approved the appointment of a receiver based, in part, upon allegations that a trustee had diverted money contributed to pay welfare benefits to himself through the plan's contract administrator which he controlled. In *Gilliam v. Edwards*, 492 F. Supp. 1255 (D.N.J. 1980), the court held that a union business manager who participated with others in the decision to appoint himself as the administrator of a welfare plan violated ERISA because, among other things, the contract was "markedly one-sided." And, in *Brink v. DaLesio*, 496 F. Supp. 1350 (D. Md.), *rev'd in part*, 88 F.R.D. 610 (D. Md. 1980), *aff'd in part*, 667 F.2d 420 (4th Cir. 1981), the court held that a person who selects an insurance company to fund welfare benefits is a fiduciary subject to ERISA. See also *Eaton v. D'Amato*, 3 E.B.C. 1003 (D.D.C. 1980) (administrator as fiduciary).

would support the proposition that these promoters must comply with the fiduciary provisions of ERISA.

Unfortunately, the analysis is not quite as simple as it may appear because Congress and the DOL have enacted special rules in the fiduciary area concerning insured plan arrangements. The first category of such rules deals with the concept of "plan assets." In the case of the ordinary insured welfare plan—where the employer simply purchases a group insurance policy—it would appear from the ERISA definition of "fiduciary" that the insurance company owes fiduciary obligations to the plan. But, Congress provided in ERISA section 401(b) that, where a plan purchases a "guaranteed benefit policy"²⁰¹ from an insurer, the premiums paid by the purchaser cease to be "plan assets" when they reach the insurer. Therefore, the insurer need not comply with the fiduciary provisions when it makes decisions concerning disposition of its assets, notwithstanding that those assets came from employee benefit plans covered by ERISA.

This is when the status of METs as "insurers" under state law comes into play. On the strength of the argument that contributions to METs funding health benefits are functionally indistinguishable from premiums paid to insurance companies for the same purpose, it could be held that the MET should not be considered to be holding "plan assets." But, neither the statute nor the DOL proposed regulations would support this reasoning. ERISA section 401(b) carefully confines this exemption to plans where a policy is "issued" by an "insurer," that, as noted, is defined as an "insurance company, insurance service, or insurance organization, qualified to do business in a state." Thus, an uninsured MET could not take advantage of this exemption because it is, by definition, not licensed as an insurance company by a state. An insured MET fails under this provision, as well, because it (as opposed to its insurer) does not "issue" any insurance contracts. Thus, to the extent states enact special legislation to deal with METs, they must be aware that that legislation may carry with it the seeds for excluding MET promoters from ERISA's fiduciary provisions.²⁰²

201. This term is defined as "an insurance policy or contract to the extent that such policy or contract provides for benefits the amount of which is guaranteed by the insurer." *See* ERISA § 401(b)(2)(B), 29 U.S.C. § 1101(b)(2)(B) (1976).

202. The DOL has commented that the "plan asset" exemption for a licensed insurer was based on a Congressional recognition that such an entity "is subject to state regulation designed to assure the entity's ability to pay benefits specified in the policies when due." *See* 44 Fed. Reg.

The inapplicability of section 401(b) to METs does not end the “plan asset” problem. Consider, for example, the case of a plan purchasing stock directly from a company. That stock obviously is a plan asset, and its value is dependent upon the efforts of the company’s management to realize earnings from the plan’s investment. Does this mean that the company’s managers are fiduciaries with respect to the plan’s investment? According to the DOL, it does not. In proposed regulations defining “plan assets,” the DOL has taken the position that, where a plan purchases stock of an “operating company,” it merely exchanges one plan asset (cash) for another (stock), and only the latter is to be considered a plan asset.²⁰³

This issue is relevant to METs: the MET may argue that the subscribing plans are merely exchanging one asset (cash contributions) for another (the right to receive benefits).²⁰⁴ Therefore, the argument would continue, the MET promoter does not hold plan assets and could do anything with them as long as there is fulfillment of the contractual (not fiduciary) pledge to deliver promised benefits. If the promoter is considered to be holding plan assets, however, a fiduciary obligation extends well beyond the promise to provide benefits—any surplus not needed to pay benefits would still have to be held for the exclusive benefit of the subscribers.²⁰⁵

The answer to this problem lies in an examination of the arrangement as a whole. It could be argued that the subscribers are only interested in purchasing the right to receive benefits and do not expect to get anything more. But, the MET promoter is not just selling that product; there is also the sale of expertise in administering and managing a benefit plan arrangement. Indeed, the MET promoter is essentially operating a commingled trust fund designed to underwrite employee benefits, and the law on this subject holds that operators of such funds are plan

50,363, 50,364 (1979). Therefore, specially enacted MET legislation will have to be tested against this standard.

203. See 45 Fed. Reg. 38,084, 38,085 (1980).

204. This analysis finds some support in the ERISA § 401(b) plan asset exclusion for insurers. The section provides that plan assets in the case of insured arrangements include the insurance policy or contract, but do not include the assets of the insurer. Thus, Congress seems to have treated a purchase of insurance by a plan as an exchange of assets (money for policy).

205. As one court has stated: “The language of ERISA makes abundantly clear that plan monies, whether in the nature of a surplus or not, shall be applied for the exclusive benefit of the participants and beneficiaries of the plan.” *Marshall v. Snyder*, 255 PENS. REF. (BNA) D-8, D-12 (E.D.N.Y. 1979).

fiduciaries.²⁰⁶ Finally, whatever doubt there might be on this issue should be resolved by emphasizing one central fact about METs—they are designed as trusts. Thus, to hold promoter-trustees to a fiduciary responsibility could hardly come as a surprise.

The “plan asset” problem is not the only fiduciary issue raised by METs. Even assuming that ERISA’s fiduciary provisions apply to MET promoters, there is a further question of how these provisions, particularly the self-dealing and conflict of interest provisions of ERISA section 406²⁰⁷ should be interpreted.

As a general matter, the ERISA fiduciary provisions codify the common law of trusts,²⁰⁸ “including the familiar requirement of undivided loyalty to beneficiaries.”²⁰⁹ This is apparent from the language of ERISA section 404, which commands that each fiduciary “shall discharge his duties with respect to a plan *solely* in the interest of the participants and beneficiaries and . . . for the *exclusive* purpose of . . . providing benefits to participants and their beneficiaries.”²¹⁰

The requirement of absolute loyalty set forth in ERISA section 404 corresponds to the identical long-established principle of the common law of trusts.²¹¹ After nearly a decade of hearings on the special problems faced by employee benefit plan participants and beneficiaries, however, Congress saw the need for expansion of the common law in a number of critical areas.²¹² One such area was in the relationship of

206. See 1 PENS. PLAN GUIDE (CCH) ¶ 5691; *DOL Hearings, supra* note 137. The Conference Report on ERISA also states that persons who operate commingled trusts “are, of course, plan fiduciaries.” *Conference Report, supra* note 133, at 316.

207. ERISA § 406, 29 U.S.C. § 1106 (1976).

208. See *Conference Report, supra* note 133, at 306.

209. *Eaves v. Penn*, 587 F.2d 453, 457 (10th Cir. 1978). See also *NLRB v. Amax Coal Co.*, 453 U.S. 322 (1981):

[U]nder principles of equity, a trustee bears an unwavering duty of complete loyalty to the beneficiary of the trust, to the exclusion of the interests of all other parties. . . . To deter the trustee from all temptation and to prevent any possible injury to the beneficiary, the rule against a trustee dividing his loyalties must be enforced with “uncompromising rigidity.” *Meinhard v. Salmon*, 249 N.Y. 458, 464, 164 N.E. 545, 546 (Cardozo, C.J.). A fiduciary cannot contend “that, although he had conflicting interests, he served his masters equally well or that his primary loyalty was not weakened by the pull of the secondary one.” *Woods v. City National Bank & Trust Co.*, 312 U.S. 262, 269.

453 U.S. at 329-30 (citation omitted).

210. ERISA § 404, 29 U.S.C. § 1104 (1976).

211. See *RESTATEMENT (SECOND) OF TRUST § 170* (1959); H. BOGERT, *TRUSTS & TRUSTEES* § 543 (rev. 2d ed. 1978).

212. See *Cutaiar v. Marshall*, 590 F.2d 523 (3d Cir. 1979), where the court prefaced its analysis of a case presenting § 406 issues by noting: “It is important to understand that this case involves no taint of scandal, no hint of self-dealing, no trace of bad faith . . . Uncontradicted testimony

plans to those persons whose ties to the plan or its fiduciaries were so close that they raised the possibility that plan assets might be used on their behalf. The solution chosen by Congress was simple, but far-reaching. First, it adopted a comprehensive definition of who constitutes an “insider” or “party-in-interest” to the plan in ERISA section 3(14).²¹³ These “parties-in-interest” include any fiduciary, service provider to the plan, employer or union employing or representing any participant. In addition, the statute contains a series of attribution rules which include in “party-in-interest” status owners, relatives, employees, officers, directors, and partners of the above general categories.

Having identified who is a party-in-interest to a plan, Congress next provided per se prohibitions of certain transactions between plans and those parties. ERISA section 406(a) generally provides that a fiduciary may not engage in any transaction which involves an exchange of assets or property between a plan and a party-in-interest.²¹⁴ Once a court makes the determination that fiduciaries have engaged the plan even indirectly in a transaction with parties-in-interest in any of the ways set forth in section 406(a), its inquiry is essentially over and a violation has occurred.²¹⁵

This provision causes problems for METs and the insurance industry generally because it is customary for both to provide multiple services to plans. For example, MET promoters typically serve as trustees of the MET trust fund, as well as providing administrative services. In the insurance industry generally, brokers will typically advise plans on the purchase of insurance in exchange for a commission—arguably making them fiduciaries under ERISA²¹⁶—and also provide other services. Since these MET promoters and insurance agents or brokers are parties-in-interest, the literal language of ERISA section 406 would seem to preclude any compensation from the plan for these services.

before the district court established that the terms of the transaction were fair and reasonable. . . .” Nevertheless, the *Cutajar* court had no trouble in finding that a violation had occurred, reasoning that “Congress intended to create an easily applied *per se* prohibition of the type of transaction” specified in § 406. *Id.* at 529. See also *Brink v. DaLesio*, 496 F. Supp. 1350 (D. Md. 1980); *M&R Inv. Co. v. Fitzsimmons*, 484 F. Supp. 1041 (D. Nev. 1980), *aff’d*, 685 F.2d 283 (9th Cir. 1982); *Marshall v. Kelly*, 465 F. Supp. 341 (W.D. Okla. 1978).

213. See ERISA § 3(14), 29 U.S.C. § 1002 (14) (1976).

214. ERISA § 406(a), 29 U.S.C. § 1106(a) (1976).

215. See *supra* note 212.

216. The ERISA definition of “fiduciary” in § 3(21)(A) includes any person who “renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property” of the plan. 29 U.S.C. § 1002(21)(A) (1976).

The DOL has recognized that it is often, as a practical matter, essential or at least beneficial for plans to allow multiple services by persons who may be considered fiduciaries. ERISA provides two methods for modifying the strictures of section 406, and the DOL has used both to grant relief in this area. First, the DOL has used its rulemaking authority²¹⁷ to issue regulations interpreting ERISA section 408(b)(2). This provision contains an exemption from section 406 allowing plans to contract with parties-in-interest for services.²¹⁸ In the specific area of insurance agents and brokers, the DOL has issued a "class exemption"²¹⁹ allowing these entities to provide services to plans for a fee.²²⁰ Both regulatory efforts allow for the performance of multiple services to employee benefit plans, provided the compensation and contractual arrangements are reasonable, and that a fiduciary independent of the contracting person approves the arrangement.

The future application of ERISA's fiduciary provisions to METs will evolve from these standards. Thus, the courts will be looking at the cost and form of the MET promoter's relationship to the plans subscribing to the MET. At a minimum, all service and compensation provisions will have to provide for termination on reasonably short notice without penalty.²²¹ The compensation for services must be "reasonable," but the DOL has not provided much guidance as to what that means.²²² Neither of these requirements, however, should cause much problem for the honest MET promoter.

The requirement for approval by an independent fiduciary is another matter because, in theory, someone independent of the service provider, who is fully subject to the fiduciary provisions, is required to provide an independent check on the arrangement. As a practical matter, however, there are no fiduciaries in the typical MET other than the

217. See ERISA § 505, 29 U.S.C. § 1135 (1976).

218. See 29 C.F.R. § 2550.408b-2 (1982).

219. ERISA § 408(a), 29 U.S.C. § 1108(a) (1976), grants two kinds of exemptive authority to the DOL. The first is authority for an individual exemption covering one specific transaction. The second is authority to exempt a *class* of transactions from § 406. The standard for both types of exemptions is the same—it must be administratively feasible, in the interest of participants and beneficiaries, and protective of the latter's rights.

220. See Amendment of Prohibited Transaction Exemption 77-9, 44 Fed. Reg. 1479 (1979).

221. See 29 C.F.R. § 2550.408b-2(c) (1982).

222. The § 408(b)(2) exemption discusses "reasonable compensation" by referring to another regulation, 29 C.F.R. § 2550.408c-2 (1982). The referenced regulation, however, is not particularly enlightening. It states that what is reasonable "depends on the particular facts and circumstances of each case." *Id.*

promoters.²²³ This would suggest that most METs are in structural violation of ERISA, even if their compensation arrangements are reasonable.

1. *The Coordination of Federal and State Enforcement*

As the foregoing discussion illustrates, both state and federal law can apply to METs. There are significant differences, however, between these two legislative schemes. Insurance law focuses on the MET entity itself as an insurer and its relationship to the insured, while ERISA focuses on the promoter as a fiduciary and his relationship to the trust beneficiaries. This requires consideration of the proper coordination between the laws.

a. *Protecting the Employer's Expectation of Health Coverage*

State insurance law is best suited to assuring that employees will actually receive the benefits promised by the MET. The law operates on two levels: it attempts to assure the solvency of the insurer, and it provides effective remedies for failure to pay benefits.

Virtually all states require insurers to fulfill certain financial requirements as a condition to conducting business within that state. In the words of one noted commentator, "It is thus not surprising that all systems of insurance regulation regard the financial solvency of the insurance enterprise as the central aim, for if nothing else, insurance must *insure*."²²⁴ Thus, to the extent the states are successful in subjecting uninsured METs to the financial solvency requirements of their laws, considerable protection may be afforded to employees in assuring that benefits will be paid.

Another significant attribute of state insurance regulation is its rehabilitative and protective mechanisms upon insolvency. State insurance commissioners generally are accorded wide-ranging powers to prevent

223. See *DOL Hearings*, *supra* note 137. The question whether the employer who establishes a plan by subscribing to a MET is a fiduciary is troublesome. The law thus far distinguishes between "settlor" or "sponsor" action by the employer and "fiduciary" action by him. Where the employer only establishes the plan and does not thereafter play a role in administering it, he is not a fiduciary. See *Boyer v. J.A. Majors Co. Employees Profit-Sharing Plan*, 481 F. Supp. 454 (N.D. Ga. 1979); *Barrett v. Thorofare Markets, Inc.*, 452 F. Supp. 880 (W.D. Pa. 1978); *Carter v. Montgomery Ward & Co.*, 76 F.R.D. 565 (E.D. Tenn. 1976). *Cf.* *Robinson v. UMW Health & Retirement Fund*, 455 U.S. 562 (1982).

224. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 480 (1961) (emphasis in original).

loss upon insolvency. These include the power to put a company into receivership and marshal sufficient assets to pay claims.²²⁵ On a more informal level, states are often successful in finding insurers who are willing to loan money or pick up coverage for insolvent insurers—an approach that Illinois has used effectively in protecting the benefits of some victims of MET insolvency.²²⁶

The fiduciary provisions of ERISA also provide some assurances in the area of solvency. Under ERISA, the MET promoter as a fiduciary is commanded to manage a plan's assets "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."²²⁷ At a minimum, this would seem to require the MET fiduciary to design the enterprise in a way calculated to provide assurances that benefits will be paid. Nevertheless, this general provision is neither as direct nor as developed as the solvency requirements of state law. To date, the DOL has brought only a few cases on the application of the "prudence" requirement to plan funding decisions, and none could be considered directly analogous to the kind of analysis required to assure the solvency of METs.²²⁸

On the level of the individual claim for benefits, state law again provides more effective redress than ERISA. Such claims traditionally have been handled in state courts, and Congress no doubt intended that practice to continue.²²⁹ More significantly, although Congress also intended to provide access to federal court for individual participant claims,²³⁰ the courts have been reluctant to take jurisdiction over what

225. See *Levy v. Lewis*, 635 F.2d 960 (2d Cir. 1980); *Washington Am. Life Ins. Co. v. State*, 545 S.W.2d 291 (Tex. Civ. App. 1977).

226. See *March Hearings*, *supra* note 7, at 6.

227. ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B) (1976).

228. The cases brought by the DOL have involved the choice of insurance funding for welfare plans, and specifically, whether death benefits should be funded through the purchase of whole life or term insurance. See *Donovan v. Smith*, No. 82-1325 (E.D. Pa.); *Donovan v. Tricario*, No. 79-914-Civ.-JWK (S.D. Fla.); *Donovan v. Gordon*, No. 79-5574-Civ.-JWK (S.D. Fla.); *Donovan v. Rubin*, No. 78-5749-Civ.-JAG (S.D. Fla.).

229. See ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1) (1976), which provides for exclusive federal court jurisdiction over all claims under ERISA except for suits by participants involving their own benefits under the plan; these suits may also be brought in state court.

230. *Id.* See also ERISA's Findings and Declaration of Policy, 29 U.S.C. § 1001(b) (1976), which states that one of the purposes of the Act was to provide participants and beneficiaries "ready access to the Federal courts."

is perceived to be typical claims under state insurance law.²³¹

This judicial attitude is best illustrated by comparing the district court and appellate court opinions in the *Wayne Chemical* case.²³² The plaintiff there sought payment of a claim for medical expenses from a MET. The district court held that this claim could be pursued under ERISA, but was then compelled to fashion a "federal common law" to justify judgment for the plaintiff.²³³ On appeal, the court reached the same result by employing state insurance law. It held that the MET was an unauthorized insurer under Indiana law; that the defendant insurance agent had assisted in the procurement of the unauthorized insurance; and that it was therefore liable to the insured under state law.²³⁴

In sum, despite the theoretical existence of remedies for protecting employees' expectations under ERISA, state insurance law provides more direct, effective and developed remedies in this area.

b. Protecting the Public Against Unscrupulous MET Promoters

DOL enforcement of ERISA is best suited to preventing individual MET promoters from continuing illegal activities once they have been found to be untrustworthy. This is particularly true in the area of insured METs, where a licensed insurance company provides assurance of benefit payment, but the MET administrator may engage in predatory practices from his position as a fiduciary that siphon off trust assets. Although states have occasionally expressed interest in such administrators,²³⁵ the NAIC has conceded that the existence of a licensed insurer in the arrangement dampens their enthusiasm for regulating the administrator.²³⁶

By contrast, the essential thrust of ERISA is the prevention of abuse of fiduciary position,²³⁷ whether that occurs in the insured or uninsured

231. See *Austin v. General Am. Life Ins. Co.*, 498 F. Supp. 844 (N.D. Ala. 1980); *Eversole v. Metropolitan Life Ins. Co.*, 318 PENS. REP. (BNA) D-8 (C.D. Cal. 1980); *Lederman v. Pacific Mut. Life Ins. Co.*, 494 F. Supp. 1020 (C.D. Cal. 1980); *Cate v. Blue Cross & Blue Shield*, 434 F. Supp. 1187 (E.D. Tenn. 1977).

232. *Wayne Chem. Corp. v. Columbus Agency Serv. Corp.*, 426 F. Supp. 316 (N.D. Ind.), *modified*, 567 F.2d 692 (7th Cir. 1977).

233. *Wayne Chem. Corp. v. Columbus Agency Serv. Corp.*, 426 F. Supp. 316 (N.D. Ind. 1977), *modified*, 567 F.2d 692 (7th Cir. 1977).

234. See *Wayne Chem. Corp. v. Columbus Agency Serv. Corp.*, 567 F.2d 692 (7th Cir. 1977).

235. See *NAIC Model Administrator Statute*, 1 NAIC PROCEEDINGS 319-21 (1977).

236. See *supra* note 20.

237. See *supra* notes 199-223 and accompanying text.

context. In addition, because of the ERISA exemption for administrative services,²³⁸ the DOL has developed considerable expertise in this area. Indeed, the DOL has brought numerous cases involving the propriety of particular administrative fee structures.²³⁹

Even in the case of uninsured METs, where the states have considerable interest, the state regulators have shown an inability to prevent individuals from continuing illegal activities. This is primarily the result of the MET "rollover" phenomenon—once a state has stopped a particular MET, it is often powerless to prevent the promoter from starting a new MET somewhere else.²⁴⁰ The best prospective mechanism available to a state in this area is its authority over the agents upon whom most METs rely to sell their coverage. While the states possess considerable authority over agents,²⁴¹ and portions of that authority are quite helpful in the MET area,²⁴² the agents themselves point to some convincing practical and equitable considerations which militate against state concentration on agents as a vehicle for solving the MET problem.²⁴³

As a general matter, however, the problems faced by state regulators in policing METs are the same as those which prompted the passage of ERISA. The legislative history of ERISA indicates that concern for multi-state abuse of welfare plan arrangements provided one of the compelling reasons for regulation on the federal level.²⁴⁴ Pursuant to

238. See *supra* note 218.

239. See *Marshall v. Snyder*, 572 F.2d 894 (2d Cir. 1978); *Marshall v. Knee*, No. C-3-77-93 (S.D. Ohio, Dec. 30, 1977), and the complaints recently filed in *Donovan v. Nave*, No. 82-C-2210 (N.D. Ill.); *Donovan v. Abercrombie*, No. C82-343A (N.D. Ga.).

240. See *supra* note 36.

241. See *FTC v. National Casualty Co.*, 357 U.S. 560 (1958); *Robertson v. California*, 328 U.S. 440 (1946); *Travelers Health Ass'n v. FTC*, 298 F.2d 820 (8th Cir. 1962).

242. As noted, some states provide that an agent is liable for benefits if it placed coverage with an unauthorized insurer. See *supra* note 234. In the area of agent marketing, the state regulators have called attention to the advertising material of some METs which mention ERISA in an attempt to give its plan an aura of government approval. See *NAIC Testimony*, *supra* note 27, at 657. Most state laws prohibit sales materials which suggest governmental affiliation. See generally *Henson & Obenberger*, *supra* note 161, at 194.

243. Stephen Shaw, President of the California Association of Life Underwriters, testified before Congress that an agent who has sold coverage to METs becomes "the person in the middle." He ordinarily has had no access to financial information, can expect little information from the states, and is often misled by the MET as to its insured status. See *October Hearings*, *supra* note 29, at 36-37.

244. See, e.g., *Hearings Before the House Comm. of Education and Labor*, 91st Cong., 1st Sess. 703, 723 (1970) (testimony of the Commissioner of Insurance for Wisconsin) (noting the need for federal legislation "in certain enforcement areas that normally would be beyond the effective

its enforcement powers under ERISA, the DOL is clearly authorized to seek injunctions against MET promoters²⁴⁵—injunctions which can cross state lines.

2. *The Effect of MET Legislation by Congress*

In the waning days of the Ninety-Seventh Congress, the Congress passed legislation aimed at closing the loopholes in MET enforcement.²⁴⁶ The bill amended ERISA in several respects. First, it added a new section 3(40) to the definitional provisions of Title I for “multiple employee welfare arrangements”—essentially METs.²⁴⁷ It then amended the preemption provision by adding a new section 514(b)(6). This section provides that any employee benefit plan which is a multiple employee welfare arrangement, whether insured or not, must comply with state insurance laws to the extent such laws set standards for reserves and contribution levels. In addition, *uninsured* arrangements must also comply with the full range of insurance laws to the extent they are not inconsistent with ERISA. The DOL has been granted authority to exempt uninsured arrangements from this latter requirement, but even with an exemption, the arrangement must comply with the state’s standards for reserves and contribution levels. Finally, the legislation clarifies that subscribers to a MET are employee benefit plans covered by ERISA, which should remove any doubts concerning ERISA applicability remaining after *Dillingham*.

These amendments are drafted in such a way to discourage METs from litigating the ERISA preemption question. For example, each mention of employee welfare benefit arrangement is preceded by the

reach of the states.”). See also *Hearings Before the Senate Comm. on Labor and Public Welfare*, 92d Cong., 2d Sess. 242 (1972) (testimony of Manuel Cohen, former Chairman of the Securities and Exchange Commission) (concerning the inadequacy of state enforcement mechanisms: “I was a member of a Presidential Committee and . . . we heard from state administrators, state officials who indicated in their opinion they were unable to cope with all the problems. . .”).

This is also true with respect to state enforcement mechanisms other than insurance regulation. As one House Committee stated, “the applicability of present state laws to employee benefit plans is sometimes unclear,” and “reliance on conventional trust law often is insufficient to adequately protect the interest of plan participants and beneficiaries.” 120 CONG. REC. 3977, 3983 (1974).

245. See ERISA § 409, 29 U.S.C. § 1109 (1976).

246. H.R. 5470, 97th Cong., 2d Sess., 128 CONG. REC. H9604-05 (daily ed. Dec. 13, 1982).

247. The term is defined to mean “an employee welfare benefit plan, or any other arrangement (other than an employee welfare plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) [the existing definition of “employee welfare benefit plan”] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries.” *Id.* at H9605.

term “employee benefit plan.” This leaves a MET wishing to contest state jurisdiction with Hobson’s choice. If it wishes to escape coverage under the amendments, it must argue that it is not an “employee benefit plan”; yet, METs traditionally have tried to argue that they are such plans to escape state regulation. If the MET claims to be an “employee benefit plan,” it would then be subject to state insurance law in some fashion pursuant to the new amendments. The primary accomplishment of the legislation is its removal of the barriers to state examination of METs.

There are, however, many questions left unanswered by the legislation. First and foremost, the bill does not give much guidance concerning enforcement of various state laws, particularly those laws outside the insurance code for “non-indemnifying” health care plans. The explanation of the bill by Congressman Erlenborn defines these laws broadly,²⁴⁸ but the actual language of the legislation refers only to “any law of any state which regulates insurance.”²⁴⁹ Moreover, it is not at all clear which state insurance laws could be applied to all insured or DOL-exempted METs. The legislation singles out standards, including reserves, which the entity “must meet in order to be considered under such law able [*sic*] to pay benefits in full when due.”²⁵⁰ Whether this would include initial capitalization requirements or restrictions on investments is not clear. The legislation also does not clarify the ability of the states to tax these entities in order to finance their enforcement efforts.

More generally, the bill underscores the fragility of the entire preemption concept. For those multiple employer arrangements which are true employee benefit plans within the meaning of ERISA, that is, those that are established by employer associations without the presence of the third-party profit-seeking entrepreneur who stands behind most METs²⁵¹—this legislation removes protection from state law regulation. Presumably, these entities which are uninsured may be granted exemptions by the DOL, but even in that case, a state may impose certain standards of their laws upon them. In short, the MET legislation

248. In discussing the requirements applicable to non-DOL exempted uninsured METs, Congressman Erlenborn states that these entities would be subject to “whatever State law [which] may apply to them.” *Id.* at H9611.

249. H.R. 5470, § 202(b)(6)(A)(ii), 128 CONG. REC. at H9605.

250. H.R. 5740, § 202(b)(6)(A)(i)(I), 128 CONG. REC. at H9605.

251. *See supra* note 82.

represents the first example of a Congress moving away from exclusive federal regulation of all employee benefit plans.²⁵²

3. DOL-NAIC Enforcement Strategy

Seventy-one years ago, Roscoe Pound observed:

[T]he means of making legal rules effective . . . has been neglected almost entirely in the past. We have studied the making of law sedulously. It seems to have been assumed that, when made, law will enforce itself But the life of the law is in its enforcement. Serious scientific study of how to make our huge annual output of legislation and judicial interpretation effective is imperative.²⁵³

In the final analysis, the real difficulties arising from METs represent proof that seventy years have not changed the essential accuracy of Mr. Pound's observation.

There are impressive legal mechanisms available to both the states and the DOL in enforcing their respective laws against METs. What is missing is not so much the single legislative stroke that will clear up the problems, but a realization on the part of all concerned that paramount attention must be paid to coordinating the regulatory response of both the states and the DOL.

First and foremost, there must be a change in attitude among regulators. Recent testimony of state regulators before Congress indicates that at least as much time is spent identifying the DOL as an enemy as is spent discussing METs. Yet, not one insurance official even seemed to be aware that the DOL enforcement program against METs had been stymied by the *Taggart* decision. At the same time, it is clear from this testimony that the DOL has not paid sufficient attention to helping the states. While federal-state conflicts in insurance areas are hardly new,²⁵⁴ there is nothing that prevents these two complementary systems of regulation from working together effectively.

For example, the DOL has specific authority under ERISA to make

252. As noted, the same bill which deals with METs also overrules a major preemption case to allow Hawaii's mandatory health care law to operate. *See supra* note 194. Having set this precedent, it may be difficult for Congress to resist further efforts to allow particular state laws to operate.

253. Pound, *The Scope and Purpose of Sociological Jurisprudence*, 25 HARV. L. REV. 489, 514 (1912).

254. *See* *FTC v. National Casualty Co.*, 357 U.S. 560 (1958); Henson & Obenberger, *supra* note 161.

cooperative arrangements with the state insurance commissioners.²⁵⁵ But such arrangements must be based on a thorough understanding of the differences in laws. Without that understanding, the current thinking at the DOL is to consider delegation of investigative authority under ERISA to the states.²⁵⁶ Although this may accord with the current Administration's concepts of federalism, that same lack of understanding backfires as state officials are not familiar with ERISA, and more important, are not inclined to view MET problems from the fiduciary perspective of ERISA.

The states and the DOL should consider regular channels of information exchange. When either a state or the DOL receives a complaint about a MET, there must be a formal system for notifying the other of that complaint. A decision can then be made as to which system of law should be pursued in the first instance. If solvency is an immediate problem, the states should proceed under their laws; if abuses in the administrative fee structure are uncovered, the matter should be referred to the DOL.

Even more important is a procedure for exchanging information after one branch has taken action. This becomes particularly crucial after a state has identified an unscrupulous MET promoter. The best way to prevent rollovers of METs is to obtain an injunction on the federal level. Once such an injunction has been obtained, the information would then be sent by the DOL to all state insurance commissioners. The information can then be sent to agents in the field in an effort to choke off the marketing mechanisms of most METs. When a previously enjoined MET promoter comes to the attention of any state insurance official, that official would refer the matter to the DOL for possible contempt proceedings.

CONCLUSION

Even in a world of perfect cooperation and information, the fact remains that the economic and social reasons behind the MET phenomenon still exist and probably will continue to impel the appearance of these entities. With health coverage an accepted part of most employment contracts, employers will continue to look for the least expensive provider of such services. Despite the press coverage of MET failures,

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

256. See *March Hearings*, *supra* note 7, at 40.

many employers will not look beyond the initial cost to examine the probability that the MET will actually deliver those benefits.

Therefore, the best defense against MET abuse is to increase the risk of doing business for MET entrepreneurs. It is time for the regulators to move beyond the jurisdictional issue and begin aggressive enforcement efforts with effective remedies. The cost of health care is an increasingly large factor in the economy, and how the state and federal governments react to it is of vital concern. What remains perhaps the most lasting legacy of the MET issue is the fact that it has forced Congress and government on all levels to address fundamental questions of policy. If, as now seems likely, the MET phenomenon has sparked a new awareness of the need for effective intergovernmental action in the health benefit area, perhaps the personal tragedies of MET victims may one day be considered important sacrifices toward a solution of this vexing problem of national significance.

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