

# A Legislative and Political History of ERISA Preemption, Part 4: The “Deemer” Clause

BY JAMES A. WOOTEN

*Shortly before the House of Representatives passed pension reform legislation in February 1974, Congressman John Dent added the deemer clause as a means of thwarting state initiatives to regulate noninsured medical plans and legal services plans. A close look at the clause’s origins raises doubts, however, about whether the deemer clause, by itself, could do what Dent wanted it to do. These concerns about the efficacy of the deemer clause appear to have been a major factor in Congress’s decision to*

*adopt the sweeping general preemption language in ERISA Section 514(a).*

ERISA and the law it replaced, the Welfare and Pension Plans Disclosure of 1958 (Disclosure Act), embody very different approaches to state regulation. Whereas the Disclosure Act gave states the primary role in regulating employee benefit plans, ERISA, “with narrow exceptions,” gave them no role at all. [Senate Committee on Labor and Public Welfare, *Legislative History of the Employee Retirement Income Security Act of 1974: Public Law 93-406*, 94th Cong., 2d sess., Committee Print (Washington: GPO, 1976) (hereafter *ELH*), 4670, 4744] As I explained in Part 3 of this series, there were four stages in Congress’s swing from one extreme to the other. The first was the Disclosure Act, which, consistent with its aim of enhancing the regulatory capacity of the states, had very narrow preemption language. The second stage began in the mid-1960s, when federal officials proposed legislation to create *minimum* standards for benefit plans. These bills envisaged a system of dual sovereignty in which states might supplement standards set by federal law. The third stage took shape in the early 1970s, when the Nixon administration and Senator Jacob Javits (R, NY) concluded that it would be burdensome for plans to comply with overlapping federal and state regulations. The Nixon administration and, later, Senator Javits proposed bills to establish *uniform* standards for benefit plans. To ensure uniformity, these bills would preempt state laws that addressed matters regulated under federal law.

Although the preemption provisions in Nixon’s and Javits’s bills took a very different approach to state regulation than the Disclosure Act, they did not go nearly as far as ERISA. Nixon’s and Javits’s bills limited the scope of federal preemption in three important ways. First, the bills included a saving clause for state laws regulating insurance, banking, or securities. Second, the subject-matter preemption language in Nixon’s and Javits’s bills left states free to regulate matters federal law did not address. Third, Nixon’s and Javits’s bills included language preserving state laws involved in the enforcement of benefit claims. The final stage in the evolution of ERISA preemption emerged during the 93rd Congress, when legislators weakened or entirely eliminated these three limitations on federal preemption. This article traces the first of these developments, Congress’s adoption of the deemer clause, which prevents states from regulating an “employee benefit plan” or a “trust established

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under such a plan” in the guise of regulating insurance. Later installments will address Congress’s decisions to adopt the blanket preemption language in ERISA Section 514(a) and to completely preempt enforcement of benefit rights.

### Pension Reform in the 93rd Congress

The evolution of ERISA preemption in the 93rd Congress is a story of two bills: S. 4 and H.R. 2. The principal sponsors of S. 4 were Harrison Williams (D, NJ), who chaired the Senate Committee on Labor and Public Welfare, and Jacob Javits, the committee’s ranking Republican. S. 4 derived from legislation Javits had introduced in 1967 and reintroduced with revisions in succeeding sessions of Congress. Like its precursors, S. 4 proposed a broad range of reforms, including reporting and disclosure amendments, fiduciary, vesting, and funding standards, termination insurance, and a portability program. Like Javits’s more recent bills, S. 4 called for uniform federal standards for benefit plans. To this end, Section 609(a) of the bill provided that:

the provisions of this Act or the Welfare and Pension Plans Disclosure Act shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the subject matters regulated by this Act or the Welfare and Pension Plans Disclosure Act. . . . [S. 4 (as introduced), 93rd Cong. (1973), § 609(a), *ELH*, 186]

S. 4 also included language limiting the scope of federal preemption. The prefatory language in Section 609(a) saved state law in suits to enforce benefit rights, while the saving clause in Section 609(a)(2) preserved “any law of any State which regulates insurance, banking, or securities. . . .” [*Id.*, *ELH*, 186-187]

In the House, John Dent (D, PA), the principal sponsor of H.R. 2, introduced two pension reform bills. H.R. 2 included proposals that had ceased to excite strong opposition—reporting and disclosure amendments, fiduciary standards, and minimum vesting and funding standards. Dent placed the most controversial reforms—termination insurance and a portability program—in H.R. 462. There was express preemption language in H.R. 2 but not in H.R. 462. The language in H.R. 2 derived from a bill the Nixon administration had proposed during the 91st Congress. Nixon’s bill had included only fiduciary, reporting, and disclosure reforms, so its preemption language addressed only these subjects. [*See* S. 3589,

91st Cong. (1970), § 14 (amending renumbered § 18 of the Disclosure Act).] The initial version of H.R. 2 did the same, providing that:

the provisions of this Act shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans; . . . [H.R. 2 (as introduced), 93rd Cong. (1973), § 114, *ELH*, 50-51]

Like S. 4, H.R. 2 preserved state insurance, banking, and securities laws and state laws relating to enforcement of benefit rights. [*Id.*]

As recounted in Part 2 of this series, during the 92nd Congress the Senate Labor Committee clashed with the Finance Committee over jurisdiction of pension reform. Jurisdictional issues also made for tense moments in the Senate during the 93rd Congress, but the course of pension reform turned out to be relatively smooth. On September 19, 1973, the Senate passed a comprehensive bill, H.R. 4200, by a vote of 93-0. The bill had a House number because the Senate’s pension reforms included amendments to the tax laws. The Constitution requires tax legislation to originate in the House, so the Senate took up H.R. 4200, a two-page bill addressing the tax treatment of military pensions, and amended it by adding the text—300 pages!—of S. 4. [*See ELH*, 1570-1571, 1879-1882.] Except for a cosmetic change, the preemption provision in H.R. 4200 was identical to the language in Section 609(a) of S. 4. [H.R. 4200 (as passed by Senate), 93rd Cong. (1973), § 699(a), *ELH*, 2103]

In the House, the course of pension reform was anything but smooth. In July 1973, the Steelworkers union lambasted Congressman John Dent for failing to include termination insurance in H.R. 2. In early August, Dent introduced H.R. 9824, a revised version of H.R. 2 that included termination insurance. [James A. Wooten, *The Employee Retirement Income Security Act of 1974: A Political History* (Berkeley: University of California Press/Milbank Memorial Fund/Employee Benefit Research Institute, 2004) (hereafter *ERISA: A Political History*), 211-212] H.R. 9824 also added language to preempt state laws that “relate to the vesting of participant’s benefits in employee benefit plans, the funding requirements for employee benefit plans or the adequacy of financing of employee benefit plans.” [H.R. 9824, 93rd Cong. (1973), § 510(d), *ELH*, 777] When the House Education and Labor Committee

reported H.R. 2 in October 1973, the preemption provision in the bill was a revision of the language in H.R. 9824. [H.R. 2 (as reported), 93rd Cong. (1973), § 514, *ELH*, 2345-2346]

As it happened, the reporting of H.R. 2 triggered a long and bitter jurisdictional fight between the Labor Committee and the Committee on Ways and Means. The dispute, which some feared might kill pension reform, was not settled until January 1974, when the Labor and Ways and Means Committees compromised their jurisdictional claims by agreeing to place participation, vesting, and funding standards in both the tax code and the federal labor laws. [See Wooten, *ERISA: A Political History*, 223-233.] This deal cleared the way for H.R. 2, which passed the House on February 28 by a vote of 376-4. [*Id.* at 240]

Before H.R. 2 cleared the House, however, John Dent added another new clause to the preemption provision. The new language, which ultimately became the deemer clause of ERISA Section 514(b)(2)(B), addressed a much-debated semantic question that had important regulatory implications: Was an employee welfare plan that paid benefits *directly*, rather than purchasing coverage from an insurer, operating an insurance business and, thus, subject to regulation or taxation under state insurance law? The deemer clause aimed to settle this question in the negative.

### The Origins of the Deemer Clause

The deemer clause has its roots in a long-contested and financially consequential issue of benefit plan design: When an employer adopts a benefit plan to provide pensions or medical, life, or disability coverage to its employees, should the plan contract with an insurance company to provide the benefits or should it pay the benefits directly? In the 1950s, "noninsurance" (*i.e.*, direct payment) of pension benefits was very common. Writing in 1957, an insurance industry official reported that "more than two-thirds of all pension plans (based on number of employees covered) are noninsured." [1957 *A.B.A. Sec. Ins. Negl. & Comp. L. Proc.* 126] The prevailing practice among employee welfare plans was very different. The great majority of death and disability plans purchased coverage from an insurer, while most medical plans contracted with an insurer or a service corporation such as Blue Cross or Blue Shield. [*Id.*; Senate Committee on Labor and Public, *Welfare and Pension Plans Investigation*, 84th Cong. (1956), S. Rpt. 1734, 82]

Patterns of financing among welfare plans began to change in the mid 1950s; however, when a small

but growing number of large employee medical plans dropped group insurance in favor of paying benefits directly. The trend appears to have emerged first among multiemployer plans, but in the late 1950s and early 1960s, some single-employer (*i.e.*, employer-run) plans followed suit. [1957 *A.B.A. Sec. Ins. Negl. & Comp. L. Proc.* at 126-127, 140] The principal reason plans made the shift was tax avoidance. [1963 *Proc. Nat'l Ass'n Ins. Comm'rs*, vol. I, 75] State governments levied tax on premiums paid for group medical insurance. Although the tax rates seemed low—"only something in excess of 2%"—annual premium taxes for a large plan could be "hundreds of thousand of dollars" and account for "as much as half" of the cost of group insurance net of benefits paid. [*Id.*] By dropping group medical coverage and paying for benefits directly, a plan could eliminate the premium and, with it, the premium tax. A plan that "noninsured" also appeared to avoid the regulatory standards of state insurance law. [*Id.*; 1957 *A.B.A. Sec. Ins. Negl. & Comp. L. Proc.* 123; Raymond Goetz, "Regulation of Uninsured Employee Welfare Plans under State Insurance Laws," 1967 *Wis. L. Rev.* 319, 320]

Obviously, premium revenues fall when customers stop buying group insurance, so insurance companies were hostile to "self-insurance," as critics commonly labeled the practice. But insurance industry officials argued that more was at stake than market share. In their view, the trend toward "self-insurance" reflected a biased legal regime that discriminated against insurers. Insurers paid taxes for the privilege of doing an "insurance business," and they had to comply with a variety of regulations that protected consumers. [1957 *A.B.A. Sec. Ins. Negl. & Comp. L. Proc.* 122-123] Yet noninsured employee medical plans, which provided services that were all but identical to group insurance, operated free of taxation or regulation. "[W]hatever the legal niceties of the existing situation," an industry official complained, "the law ought to be such that the same legal rules apply uniformly to insured and uninsured plans alike." [*Id.* at 122; see also Harold van B. Cleveland, "The Status of Self-Insured Employee-Benefit Plans under the Insurance Laws," 27 *J. Ins.* 1, 15-16 (1960).]

The trend toward direct payment of employee medical benefits also worried insurance regulators, but precedents and practices in the field of insurance regulation made the legal status of noninsured employee benefit plans uncertain. One problem was that the concept of "insurance" was vague and multifarious, with the result that courts, attorneys general, or

insurance commissioners sometimes declined to treat as “insurance” or “the business of insurance” practices that satisfied one or another definition of the term. Moreover, even when insurance company officials and insurance regulators thought it was patently clear that a particular practice was and should be treated as “insurance,” courts or attorneys general sometimes concluded otherwise. [See Herbert S. Denenberg, “The Legal Definition of Insurance: Insurance Principles in Practice,” 30 *J. Ins.* 319, 321-322, 326-327 (1963).] Finally, the longstanding treatment of noninsured pension plans raised doubts about how noninsured welfare plans should be treated. Pension plans promised annuities to employees, and annuities were, by many accounts, “insurance,” yet noninsured pension plans covering millions of employees had long operated undisturbed by insurance regulation. [See *id.* at 321, 339; Richard W. Duesenberg, “The Legality of Noninsured Employee Benefit Programs,” 5 *B.C. Indus. & Com. L. Rev.* 231, 236 (1964).] Describing the situation in 1962, an industry advisory committee to the National Association of Insurance Commissioners (NAIC) observed that there was “the lack of a clear definition of when provision of employee benefits takes on fundamental insurance characteristics which should properly subject them to the supervision and regulatory authority of the state insurance departments.” [1963 *Proc. Nat’l Ass’n Ins. Comm’rs*, vol. I, 75]

The uncertain legal status of noninsured plans meant that state insurance authorities had three options if they wished to begin regulating or taxing noninsured medical plans. The most direct approach was to argue that welfare plans that paid medical benefits directly were engaged in “the business of insurance,” in which case these plans were violating state insurance law and could be prosecuted for the violation. [For this argument, see George N. Tompkins, Jr., “Employee Welfare Plans,” 31 *Notre Dame Lawyer* 276 (1956); 1957 *A.B.A. Sec. Ins. Negl. & Comp. L. Proc.* 127-136; Cleveland, 27 *J. Ins.* at 15-16.] Given the vagueness of the concept of “insurance,” however, courts might conclude that state insurance laws did not encompass noninsured plans. Accordingly, a second option was for regulators to propose legislation that would define such statutory terms as “insurance contract” or “business of insurance” to include the activities of a welfare plan that paid medical benefits directly. Finally, even if the activities of noninsured welfare plans were not “insurance” or “the business of insurance,” insurance companies and regulators believed there were good reasons for regulating and

taxing these plans. Employees needed the consumer protections available under state insurance law; states needed to protect their premium revenues; and insurers needed to compete on a level playing field. These considerations suggested a third option: State insurance authorities could propose legislation that would regulate or tax noninsured employee medical plans—preferably under the aegis of the state insurance department—without bothering to define these plans to be engaged in the business of insurance.

NAIC followed the third strategy in December 1963 when it approved five model bills addressed to noninsured welfare plans. Draft Bill A proposed a limited set of regulations for “non-insured employee welfare benefit plans” under the aegis of a state’s insurance commissioner. The premise of the bill, however, was that noninsured welfare plans were beyond the current scope of state insurance law. [Goetz, 1967 *Wis. L. Rev.* at 348] Explaining the need for legislation, Section 1 of the bill stated: “It has long been the policy of this state to protect the parties to and beneficiaries of insurance undertakings by regulatory law administered by the Insurance Department. However, this protection *does not extend to non-insured arrangements for employee welfare benefit plans.*” [1964 *Proc. Nat’l Ass’n Ins. Comm’rs*, vol. I, 59 (italics added)] Noting that such plans “incorporate insurance concepts . . . and, therefore, require regulatory protection of the substantial public interest involved,” Section 1 concluded: “It is the purpose of this enactment to provide the necessary regulation.” [*Id.*] The other NAIC model bills proposed one or another means of “tax equalization of insured and uninsured plans.” [*Id.* at 45] Three of the draft bills would have reduced premium taxes for insured plans. [Goetz, 1967 *Wis. L. Rev.* at 347] The other two draft bills proposed to tax benefits that a noninsured employee medical, disability, or death plan paid directly. [See 1964 *Proc. Nat’l Ass’n Ins. Comm’rs*, vol. I, 59 (Draft Bill A, section 2(4)), 63 (Draft Bill A—Supplement, section 9a(1)), 65 (Draft Bill E, sections 1 and 2).]

A few months after NAIC proposed these model bills, the Missouri Department of Insurance opted for the more direct approach of attacking noninsured plans under current insurance law. One recent and much-discussed development in the field of welfare plans was an arrangement that insurance scholar Robert Eilers labeled “insured non-insurance.” [Robert D. Eilers, “Minimum Premium Health Plans: Insured Non-Insurance,” 36 *J. Risk & Ins.* 63 (1969)] Under this approach, a firm would drop group insurance

coverage for its employee medical plan, assume direct legal responsibility for paying plan benefits, and purchase excess insurance, usually from the same insurer that had provided the plan’s group medical coverage. Pioneered by Metropolitan Life, this arrangement greatly reduced insurance premiums (and, thus, premium taxes) while also protecting the sponsor from catastrophe risk. [*Id.* at 66] In 1963, Monsanto Chemical Company, a Missouri employer, contracted such an arrangement with Met Life. The new program took effect on January 1, 1964. Shortly thereafter, the Missouri Department of Insurance sued Monsanto as well as Schlitz Brewing Company, which had adopted a similar plan, for operating an unlicensed insurance business in violation of Missouri law. [*State ex rel. Farmer v. Monsanto Co.*, 517 S.W.2d 129, 130-131 (Mo. 1974); T. Nelson Parker, “State Regulation—Today’s Problems and Proposed Solutions,” 1964 *A.B.A. Sec. Ins. Negl. & Comp. L. Proc.* 132, 137; Goetz, 1967 *Wis. L. Rev.* at 324-325]

Not surprisingly, NAIC and Missouri initiatives triggered a reaction from interests that benefited from the trend toward noninsurance. Opposition from employers, unions, and the banking industry, which provided services to noninsured plans, stalled both initiatives through the remainder of the 1960s. Although one state, New Jersey, passed legislation to ease the tax burden on insured health plans, legislative efforts to regulate noninsured plans went nowhere. [Goetz, 1967 *Wis. L. Rev.* at 347-348; Eilers, 36 *J. Risk & Ins.* at 66-67; 1972 *Proc. Nat’l Ass’n Ins. Comm’rs*, vol. I, 487-488] The litigation against Monsanto and Schlitz followed a similar course. At a conference in 1968, an insurance regulator noted that the *Monsanto* case “ha[d] been languishing somewhere in the courts for five years at least.” At the same meeting, an official from Metropolitan Life, which had helped Monsanto set up its plan, described the *Monsanto* and *Schlitz* cases as “such a political thing that the insurance department, in my own opinion, might have preferred not to have started the cases in the first place . . .” [Audience Discussion Following Dr. Slater’s Talk, 37 *Tax Pol’y*, 10-11 (1969)]

In the early 1970s, however, state initiatives to regulate or tax noninsured plans revived. One impetus for the revival was that the number of noninsured medical plans continued to grow. What is more, changes in federal tax law in the late 1960s—in particular, liberalization of the taxation of voluntary employees’ beneficiary associations and employer-funded death benefits—threatened to accelerate the trend toward

noninsurance and expand it beyond medical benefits. [See Note, “Self-Insured Employee Welfare Plans and the 501(c)(9) Trust: The Specter of State Regulation,” 43 *U. Cin. L. Rev.* 325, 328-331 (1974); “Legal and Actuarial Aspects of 501(c)(9) Trusts,” 25 *Trans. Soc’y Actuaries*, part II D135-D154 (1973).] The progress of pension reform at the federal level likely also played a role in spurring the states to action. In the early 1970s, Senators Javits and Williams orchestrated a very successful campaign to convince the press, the public, and their congressional colleagues of the need for pension reform. From the perspective of state legislators, Javits and Williams also demonstrated that pension reform was an issue with potential appeal for voters. [Wooten, *ERISA: A Political History*, 204] At the same time, the gathering momentum for pension reform threatened state insurance officials with a federal takeover of the regulation of welfare plans if the states failed to act. [Werner Pfennigstorf and Spencer L. Kimball, “Employee Legal Service Plans: Conflicts between Federal and State Regulation,” 1976 *Am. B. Found. Res. J.* 787, 794]

By the time Wisconsin Insurance Commissioner Stanley DuRose appeared before the Senate Finance Committee’s Subcommittee on Private Pension Plans in May 1973, at least eight states, including Wisconsin, were considering legislation to regulate private pension plans. [Senate Committee on Finance, *Private Pension Plan Reform, Part 1: Hearings before the Subcommittee on Private Pensions*, 93rd Cong. (1973), 531] At the same time, a NAIC subcommittee, which DuRose chaired, was completing work on a model “Employee Pension and Welfare Fund Act” that would establish fiduciary and disclosure standards for benefit plans and authorize state insurance commissioners to deal with complaints from plan participants. [1973 *Proc. Nat’l Ass’n Ins. Comm’rs*, vol. II, 420] These initiatives are less important for understanding the deemer clause, however, than state insurance regulators’ concerns with noninsured employee medical plans and with a new phenomenon on the horizon—the recent rush of interest among unions and consumer groups for prepaid legal services arrangements.

In 1971, concern with noninsured medical plans led Connecticut legislators to pass a law taxing benefits paid out by noninsured welfare plans. [Note, 43 *U. Cin. L. Rev.* at 340] Other states were mulling the inequities of premium taxation and the need for regulation as well. [*Id.* at 340-343; Richard J. Mellman, “Some Pros and Cons of the 501(c)(9) Trust,” 73 *Best’s*

*Rev.*, Life & Health Edition, 12, 90 (Feb. 1973); 25 *Trans. Soc'y Actuaries*, part II D142-D144] Far more important than these initiatives, however, was the litigation against Monsanto. In January 1973, the court hearing the case issued what an American Bar Association committee called a "potentially landmark" decision. ["Voluntary Employees' Beneficiary Associations to Provide Medical, Disability and Other Benefits: A Legal Analysis," 8 *Real Prop. Prob. & Tr. J.* 666, 678 (1973)] The court found that Monsanto was running an illegal insurance business and "enjoined the company from operating the plan on a self-insured basis." [Note, 43 *U. Cin. L. Rev.* at 332 (quote); Janet Corrado, "Self-Insured Medical Plan Is Forbidden by St. Louis Court," *Nat'l Underwriter*, Life & Health Edition, at 1, 4 (Jan. 20, 1973)] In August 1973, the Commissioner filed another suit against Monsanto, asking the court to impose penalties of \$185 million. ["Mo. Dept. Sues for \$185 Million More From Monsanto Co.," *Nat'l Underwriter*, Life & Health Edition, at 4 (Aug. 18, 1973)] Missouri legislators quickly passed a law that "vetoed the insurance department's position and in essence reversed the *Monsanto* decision," but while the new law allowed an employer to noninsure medical benefits, it also gave the state insurance department limited regulatory authority over such plans. [Note, 43 *U. Cin. L. Rev.* at 341-342]

Alongside these developments affecting noninsured medical plans, NAIC was threatening action on prepaid legal-services plans. In June 1972, the organization established a Prepaid Legal Expense Subcommittee to investigate these plans and, if appropriate, draft model legislation. [1972 *Proc. Nat'l Ass'n Ins. Comm'rs*, vol. II, 13, 490] The subcommittee quickly resolved in favor of "affirmative regulation of both legal expense insurance and prepaid legal insurance" and, in June 1973, established an advisory committee "made up of representatives of organized labor, the American Bar Association, and the insurance industry, . . . to survey existing plans and to present recommended model legislation or model regulations . . ." [1973 *Proc. Nat'l Ass'n Ins. Comm'rs*, vol. I, 379 (first quote); 1973 *Proc. Nat'l Ass'n Ins. Comm'rs*, vol. II, 595 (second quote)] When the advisory committee got down to work in the fall of 1973, however, a dispute emerged that paralleled the conflict over noninsured medical plans.

Union representatives offered a raft of arguments against regulating collectively bargained legal services plans. [See 1974 *Proc. Nat'l Ass'n Ins. Comm'rs*, vol. I,

630.] Others on the advisory committee disagreed, contending that prepaid legal plans were insurance and that regulation of such plans should not provide for "exemptions based on the form and nature of the administration." [*Id.*] The upshot of the dispute was that, when the advisory committee reported back to the Prepaid Legal Expense Subcommittee in December 1973, it endorsed "some degree of state regulation of insurance" while recommending that "continued study" be given to "possible exemptions or limited forms of regulation for certain types of programs . . ." The report also recommended that the subcommittee authorize the advisory committee to continue its work with an eye to drafting model legislation. [*Id.* at 632] The subcommittee endorsed these recommendations. [*Id.* at 628]

### How the Deemer Clause Ended Up in ERISA

This is where matters stood when the Labor and Ways and Means Committees made peace and cleared H.R. 2 for passage in the House. A number of states were considering legislation to regulate or tax employee benefit plans. In *Monsanto*, "the first case to directly address the issue of the legality of self-insured employee welfare plans," a court had ruled that operating a noninsured employee medical plan amounted to running an insurance business. [Note, 43 *U. Cin. L. Rev.* at 333] And a NAIC subcommittee and advisory committee seemed on a path to (and, a few months later, would) produce model legislation that defined legal services provided via a noninsured welfare plan to be "legal insurance." [See 1974 *Proc. Nat'l Ass'n Ins. Comm'rs*, vol. II, 635 (Legal Insurance Model Act, § 2.3), 644.] The impending passage of H.R. 2 provided an opportunity to nip these threats in the bud. The deemer clause became the vehicle for accomplishing this objective.

On February 13, 1974, John Dent introduced H.R. 12781, yet another revision of H.R. 2. The revised bill added the following language:

No employee benefit plan subject to the provisions of this title (other than a plan established exclusively for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. [H.R. 12781, 93rd Cong. (1974), § 514(b)]

When the House passed H.R. 2 two weeks later, the deemer clause was identical except that the word "primarily" was substituted for "exclusively" in the parenthetical phrase concerning death benefits. [See H.R. 2 (as passed by House), 93rd Cong. (1974), § 514(b), *ELH*, 4058.]

The addition of this language initiated a new stage in the evolution of ERISA preemption. To this point, pension reform laws and bills with express preemption language had conditioned preemption on a link between the content of state law (what a state law did) and the content of federal law (what federal law did). For example, the Disclosure Act preempted some state laws that required a plan to submit information that the plan also had to disclose under the Disclosure Act. [*Welfare and Pension Plans Disclosure Act*, Public Law 836, 85th Cong., 2d Sess. (August 28, 1958), § 10(a)] Similarly, the Johnson administration's fiduciary standards bill called for preemption of state laws that purported to "relieve any persons of the obligations, duties, responsibilities, and standards provided in this Act." [S. 1024, 90th Cong. (1967), § 18(b)] And the general preemption language in the Senate bill would override state laws "relat[ing] to the subject matters regulated by this Act or the Welfare and Pension Plans Disclosure Act." [H.R. 4200 (as passed by Senate), 93d Cong. (1973), § 699(a), *ELH*, 2103] Dent's new clause went beyond these measures. It overrode certain state laws on the basis of what those laws did, for example, deeming a plan to be an insurer or engaged in the business of insurance, *without regard to the content of federal laws regulating employee benefits*.

On March 4, the Senate passed its own version of H.R. 2, which struck the text of the House version and inserted the text of H.R. 4200. [*ELH*, 3597-3598] This set the stage for a congressional conference committee to work out the differences between the two bills. Recognizing that the conference committee would be their last chance to influence the legislation, NAIC officials wasted no time in registering their objections. Less than a week after H.R. 2 passed the House, a NAIC representative wrote to Mike Gordon, then a member of Senator Javits's staff, to report the group's "great concern" over the clause. [Shamberger to Gordon, March 5, 1974, Senator Jacob K. Javits Collection, Frank Melville, Jr. Memorial Library, Stony Brook University, series 4, subseries 3, box 131, Pension Reform Leg., Technical Comments on Pending Legislation 1974 folder] Ten days later, the president of NAIC, Kansas insurance commissioner

Fletcher Bell, reiterated the message in a letter to Javits himself.

"[T]he potential impact" of the deemer clause, Bell wrote, "goes far beyond the consideration of pension plans, the principal subject of the legislation." "There is no indication," he complained, "that federal regulation would apply if [state insurance] laws are rendered inapplicable. Instead the effect would free [prepaid legal plans and noninsured welfare] plans from any form of meaningful oversight." In what was surely the first reference of this sort, Bell warned that the deemer clause "will create a regulatory vacuum in areas in which the remainder of the bill does not focus (*i.e.*, health maintenance organizations, prepaid legal plans and self insured arrangements)." He urged Javits to keep the deemer clause out of the final bill. [Bell to Javits, March 15, 1974, Senator Jacob K. Javits Collection, Frank Melville, Jr. Memorial Library, Stony Brook University, series 4, subseries 3, box 131, Pension Reform Leg., Technical Comments on Pending Legislation 1974 folder] Insurance companies also weighed in against the clause. The American Life Insurance Association, a trade association of life insurance companies, and Aetna Life and Casualty, along with NAIC, contacted Congressman John Erlenborn (R, IL) and urged him to strike the deemer clause from the legislation. [Positions on House and Senate Versions of H.R. 2, shipment 2, box 3 of 60, no folder, at 38, John N. Erlenborn Congressional Collection SC-101, Archives and Special Collections, Benedictine University, Lisle, IL]

In fact, the deemer clause did generate discussion and debate during the conference proceedings. Some staffers questioned whether Congress should preempt state regulation of welfare plans when neither the House nor Senate bill did much to regulate these plans. This concern made its way into the *Summary of Differences between the Senate Version and the House Version of H.R. 2*, which congressional staffers prepared for the conferees. Besides describing the differences between the two bills, the *Summary* also included comments and recommendations about how the conferees might resolve the differences. The general preemption language in the House and Senate bills was similar, calling for subject-matter preemption, and both bills included a saving clause for state laws regulating insurance, banking, or securities. On these points, the staff suggested that "[t]he conferees may wish to merge the provisions of the House bill and the Senate amendment." [*ELH*, 5283] There was disagreement about the deemer clause, however. "Some of the staff

believe the House provision should be adopted,” the *Summary* reported, “and other staff believe it should not be adopted.” As a compromise, “[s]ome of the staff... suggested” the conferees might include the deemer clause in the final bill with a sunset provision, so that the clause would lapse after “a limited period of time, such as 3 years.” In the interim, a commission comprised of “representatives of State insurance commissioners, the Secretaries of Labor and Treasury, and representatives of labor, management, and the general public” would study “whether preemption in this area should be continued for more than 3 years.” [ELH, 5283-5284]

When the conferees took up preemption at their meeting on June 17, 1974, they followed the staff suggestions to merge the House and Senate provisions on subject-matter preemption and to adopt the savings language for insurance, banking, and securities laws. [June 17, 1974, Pension Conference, Senator Jacob K. Javits Collection, Frank Melville, Jr. Memorial Library, Stony Brook University, series 4, subseries 3, box 127, Pension Reform Leg., Pension Conference 1974 folder] The conferees delayed addressing the deemer clause, however, and did not take it up until their meeting on June 20. In preparation for this meeting, Mike Gordon laid out the issues in a memo to Senator Javits.

Everyone agreed that the legislation “should preempt state law completely on pension plans,” Gordon reported. “The controversy arises in connection with H.R. 2’s provision preempting the states from regulating non-insured welfare plans.” [Mike G. to Senator, June 20, 1974, Senator Jacob K. Javits Collection, Frank Melville, Jr. Memorial Library, Stony Brook University, series 4, subseries 3, box 132, Pension Reform: Staff Memos 1971-74 folder (underlining in original)] The unions, Gordon said, were “furious” about the *Monsanto* case and NAIC’s initiative “to treat pre-paid legal services funds now authorized under Section 302 [of] Taft-Hartley as subject to state insurance regulation . . . .” [*Id.*] For their part, insurers and NAIC acceded to preemption for pension plans because H.R. 2 provided detailed regulation of pension plans. H.R. 2 would do little to regulate welfare plans, however, so insurance regulators and the insurance industry argued that states should not be prevented from regulating in this area. [*Id.*]

When the conferees returned to the issue of preemption on June 20, they reportedly followed the staff recommendation, agreeing to adopt the deemer clause for three years while “[a] congressional task

force . . . stud[ie]d whether this preemption should be continued beyond the initial three years.” [“Pension Conferees Wrap Up Decisions on Fiduciary Standards, Enforcement,” *Daily Lab. Rep.* (BNA), June 21, 1974, A-10] A few days later, however, the conferees briefly and very consequentially revisited the issue. At their June 24 meeting, the conferees decided the deemer clause should not sunset after three years, and the task force, rather than reporting on whether the deemer clause “should be continued,” would report on “whether pre-emption of [welfare] plans should be terminated.” [Conference Day June 24, 1974, Senator Jacob K. Javits Collection, Frank Melville, Jr. Memorial Library, Stony Brook University, series 4, subseries 3, box 127, Pension Reform Leg., Pension Conference 1974 folder] And so, the deemer clause, with no sunset provision, took its place in ERISA.

### The “Original Intent” of the Deemer Clause

Before concluding, it is worth exploring two further points. First, it should be noted that when the conferees made their decision to adopt the deemer clause, they likely understood it to operate very differently than it does under ERISA. In the jurisprudence of ERISA preemption, the deemer clause plays a dependent or reactive role in relation to the saving clause in Section 514(b)(2)(A) in the sense that the deemer clause operates to reverse or undo the effect of the saving clause. As Justice Scalia puts it in *Kentucky Association of Health Plans v. Miller*, the deemer clause “has effect only on state laws saved from pre-emption by § 1144(b)(2)(A) that would, in the absence of § 1144(b)(2)(B), be allowed to regulate self-insured employee benefit plans.” [538 U.S. 329, 336 n. 1 (2003)] Similarly, in *Metropolitan Life Ins. Co. v. Massachusetts*, Justice Blackmun refers to the saving clause and “the ‘deemer clause’ *which modifies it*.” [471 U.S. 722, 746 (1985)(italics added)] In this analysis, the deemer clause applies only to state laws that fall within the scope of the general preemption language in ERISA Section 514(a) and have been saved by Section 514(b)(2)(A).

This line of reasoning only makes sense in light of the great breadth of the general preemption language in Section 514(a) of ERISA. As it happened, the ERISA conferences agreed to the deemer clause *six weeks before* they adopted the sweeping general preemption language in ERISA. As recounted above, the conferees agreed on June 17 to merge the subject-matter preemption language in the House and Senate bills. Several days later, on June 20, they adopted the deemer

clause with a sunset provision. And on June 24, they eliminated the sunset provision. The conference committee did not adopt the much broader preemption language that appears in Section 514(a) of ERISA until its final meeting on July 31. [See Wooten, *ERISA: A Political History* 264-265.]

This sequence of events suggests that, at the time they adopted the deemer clause, the conferees anticipated a preemption provision with three key components: (1) general preemption language that called for subject-matter preemption; (2) the saving clause for state laws regulating insurance, banking, or securities; and (3) the deemer clause. Under this version of the preemption provision—I will call it the “June 1974 version”—the deemer clause would have had the same effect as under ERISA, but the relationships among the three component parts of the preemption provision would have been different.

The deemer clause in the June 1974 version would have had the same effect as under ERISA in the sense that any law overridden by ERISA’s deemer clause also would have been preempted by the deemer clause in the June 1974 version. Specifically, under either ERISA or the June 1974 version, the deemer clause would preempt any state law “purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies” that deemed a covered “employee benefit plan . . . (other than a plan established primarily for the purpose of providing death benefits)” or a “trust established under such a plan . . . to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking . . .” [H.R. 2 (as passed by House), 93rd Cong. (1974), § 514(b), *ELH*, 4058; ERISA § 514(b)(2)(B)]

At the same time, the relationship among the three components of the preemption provision under the June 1974 version would have been very different than under ERISA in the following sense. As Justice Scalia explained in the quote above from *Kentucky Association of Health Plans v. Miller*, under ERISA, the sole function of the deemer clause is to override certain state laws that, in the absence of the deemer clause, would be preserved by the insurance saving clause. Under the June 1974 version, by contrast, many laws overridden by the deemer clause *would not have been saved by the saving clause* because they *would not have been within the scope of the subject-matter preemption language* the conferees had approved on June 17.

Consider, for example, the mandate of mental health coverage at issue in *Metropolitan Life Ins. Co. v.*

*Massachusetts*. [471 U.S. 722 (1985)] Under the June 1974 version of the preemption provision, there would have been no cause to litigate the principal issue in the case—the scope of the saving clause—because a state law requiring group health policies to include mental health benefits would have been outside the scope of the subject-matter preemption language the conference committee had approved on June 17. The state law would have been outside the scope of the subject-matter preemption language because ERISA “does not regulate the substantive content of welfare-benefit plans.” [*Id.* at 732] But the deemer clause still would have preempted application of the Massachusetts law to a noninsured welfare plan if (as the Supreme Court suggested in a footnote) the law deemed a noninsured plan to be an insurer. [See *id.* at 735-736 n. 14.] To sum up, then, in contrast to the role played by the deemer clause under ERISA, the conferees’ understanding when they adopted the clause appears to have been that the deemer clause would operate independently of the general preemption language and saving clause, striking at laws that had not been preserved by the saving clause because they were not within the scope of the subject-matter preemption language in the June 1974 version of the preemption provision.

The second point is to note that some people involved in Congress’s consideration of the deemer clause appear (at least, initially) to have believed that the clause’s preemptive effect would be broader than its text warrants. When NAIC president Fletcher Bell wrote Senator Javits to object to the deemer clause, he claimed the clause would “free [self-insured] plans from any form of meaningful oversight” and “create a regulatory vacuum in areas in which the remainder of the bill does not focus . . .” [Bell to Javits, March 15, 1974. See also Shamberger to Gordon, March 5, 1974.] Similarly, in the memorandum Mike Gordon prepared to explain the deemer clause to Senator Javits, he wrote that “[t]he controversy arises in connection with [the House-passed version of] H.R. 2’s provision *preempting the states from regulating non-insured welfare plans.*” [Gordon to Javits, June 20, 1974 (underlining in original; italics added)] Later in the same memo Gordon reported that “the unions persuaded the House to preempt *in the field of welfare plans.*” [*Id.* (italics added)]

If one were to paraphrase Bell’s and Gordon’s descriptions of the scope of the deemer clause in the House-passed version of H.R. 2, the paraphrase might be something along the lines of “the deemer clause preempts any state law that relates to a noninsured

welfare plan to which this legislation applies.” But the language of the deemer clause is narrower than this. For one thing, the clause professes to apply only to state laws “purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.” Given that the general preemption language in the House-passed version of H.R. 2 called for subject-matter preemption, it would appear that, under the June 1974 version of the preemption provision, a state law that related to a noninsured welfare plan would not be preempted as long as that law neither related to a subject-matter addressed by H.R. 2 nor “purport[ed] to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.” How many laws might fit this bill?

As recounted above, in the years before ERISA’s enactment, insurance regulators pursued three different approaches to regulating noninsured welfare plans. One was to bring litigation in the hope that a court would hold that operation of a noninsured plan constituted “insurance” under existing law. The Missouri insurance commissioner took this approach in its case against Monsanto. Another approach was for insurance regulators to prepare model legislation that defined statutory terms such as “insurance business” or “insurance contract” to cover the operation of a noninsured welfare plan. NAIC took this tack in its “Legal Insurance Model Act.” Alternatively, insurance regulators could concede that operation of a noninsured welfare plan was not “insurance” and draft legislation that would regulate or tax these plans anyway. This was the approach taken by several of the model bills NAIC endorsed in 1963.

It seems clear that the deemer clause would foreclose the first two options because they required action by a court or legislature to “deem” a noninsured plan to be an “insurer . . . or to be engaged in the business of insurance . . . for purposes of [a state law] purporting to regulate insurance companies [or] insurance contracts . . . .” Indeed, this result is not surprising because the deemer clause appears to have been drafted with the *Monsanto* litigation and NAIC’s initiative to draft model legislation for legal services plans in mind. The third initiative, however, is a different matter.

The premise of NAIC’s 1963 model bills was that state laws regulating “insurance undertakings . . . d[id] not extend to non-insured arrangements for employee welfare benefit plans.” [1964 *Proc. Nat’l Ass’n Ins. Comm’rs*, vol. I, 59 (Draft Bill A § 1)] NAIC model bills that proposed to regulate or tax noninsured

welfare plans did not “purport[] to regulate insurance companies [or] insurance contracts” or “deem” such plans to be “insurer[s] . . . or to be engaged in the business of insurance.” Commentators who opposed applying state insurance laws to noninsured plans had argued that noninsured plans should not be considered to be “insurers” or engaged in the “insurance business” or makers of “insurance contracts.” [See Duesenberg, 5 *B.C. Indus. & Com. L. Rev.* at 237-243; Goetz, 1967 *Wis. L. Rev.* at 336-342, 345-347.] If, as these commentators implied, a noninsured welfare plan was neither an “insurer” nor engaged in the “insurance business” nor a party to “insurance contracts,” then it would seem to follow that a state law that applied only to noninsured welfare plans should not be regarded as a law that “purport[ed] to regulate insurance companies [or] insurance contracts” or that “deemed” such plans to be “insurers” or “engaged in the business of insurance.” In other words, the same arguments that counseled against considering noninsured plans to be “insurance” also implied that laws narrowly targeting noninsured plans should not fall within the scope of the deemer clause. So while the deemer clause might quash judicial decisions or legislation that regulated noninsured plans in the guise of regulating “insurance,” it is less clear what effect the deemer clause would have had on state laws that regulated noninsured plans in the guise of “non-insured employee welfare benefit plans” (as NAIC’s model bills labeled them). [1964 *Proc. Nat’l Ass’n Ins. Comm’rs*, vol. I, 59-60 (Draft Bill A § 2(5)); see also the discussion of the deemer clause in Pfennigstorf and Kimball, 1976 *Am. B. Found. Res. J.* at 825-827.] (It should be noted that some provisions of NAIC’s Draft Bill A likely would have been preempted by the subject-matter preemption language in H.R. 2.)

Moreover, even if courts did interpret the deemer clause to preempt legislation that adopted the approach in NAIC’s model bills for noninsured plans, the broad scope of state regulatory powers meant that states possessed myriad ways to regulate noninsured welfare plans without running afoul of the subject-matter preemption language and deemer clause in the June 1974 version of the preemption provision. A recent amendment to the American Bar Association’s (ABA) model rules of professional conduct for attorneys presented just such a threat.

As will be discussed more fully in the next installment in this series, unions and other proponents of prepaid legal services plans were not only at odds with NAIC. They were also involved in a conflict

with elements within the legal community over how legal services plans ought to be structured. Some collectively bargained legal services plans were "closed-panel" plans in which a participant was limited to a panel of lawyers selected by the plan. Many lawyers and bar organizations were hostile to such plans, instead favoring "open-panel" plans, in which a participant would be allowed to select an attorney of her own choosing. [See Wooten, *ERISA: A Political History*, 235-236.] At its midyear meeting in February 1974, the ABA amended its Model Code of Professional Responsibility in a manner that, in the words of an ABA representative on NAIC's advisory committee on legal services plans, would, "in effect, prohibit an individual lawyer participating in a 'closed panel' Prepaid Legal Service plan." [1974 *Proc. Nat'l Ass'n Ins. Comm'rs*, vol. II, 646; see also Jay Conison, "ERISA and the Language of Preemption," 72 *Wash. U.L.Q.* 619, 649 n. 116.] The ABA's Model Code did not have legal effect, but many states relied on it in drafting their rules of professional conduct for attorneys. [Pfennigstorf and Kimball, 1976 *Am. B. Found. Res. J.* at 798 and n. 61] If states adopted the new rules the ABA had approved in February 1974, those rules would have legal effect, and it is hard to imagine an interpretation that would bring state rules of professional conduct for attorneys within the scope of the subject-matter preemption language or deemer clause in the June 1974 version of the preemption provision.

To sum up, then, although NAIC President Fletcher Bell warned that the deemer clause in the House version of H.R. 2 would create a "regulatory vacuum" and Mike Gordon spoke of the clause as "preempting the states from regulating non-insured welfare plans," a closer look reveals that the subject-matter preemption language and deemer clause in the June 1974 version of the preemption provision would have provided less freedom from state regulation than Bell and Gordon suggested. If the conferees wished, in Gordon's words, to "preempt in the field of welfare plans" (or pension plans, for that matter), the June 1974 version of the preemption provision was unlikely to do the job. Union representatives had reached a similar conclusion shortly after the House passed H.R. 2. In comments submitted to the conferees in March 1974 on behalf of the AFL-CIO's Building and Construction Trades Department, the Segal Company warned that, if Congress passed a "law which preempts only particular aspects" of employee benefit plans, "(1) states will seek out for legislation aspects not specifically preempted, and (2) endless litigation will emerge from disputes over whether a particular aspect has, or has not, been preempted." To avoid this danger, Segal urged the conferees to apply the "broadest possible preemption of state law." [Quoted in Wooten, *ERISA: A Legislative History*, 265.] On July 31, 1974, the conferees did just that by adopting the sweeping preemption language in ERISA Section 514(a). That decision will be the subject of the next installment in this series. ■