

1-1986

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Recommended Citation

Richard M. Rindler and Evan Miller, Thoughts on a Faded Peacock: The Effect of ERISA's Preemption Provision on State Third Party Prescription Drug Program Statutes, 39 *Vanderbilt Law Review* 23 (1986)
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Thoughts on a Faded *Peacock*: The Effect of ERISA's Preemption Provision on State Third Party Prescription Drug Program Statutes

*Richard M. Rindler**

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I. INTRODUCTION

The preemption provision of The Employee Retirement Income Security Act of 1974 (ERISA)¹ is "virtually unique."² The

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The authors gratefully acknowledge the assistance of Angela Bottum and Mary Latimer.

1. The Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 [hereinafter cited by session law sections of ERISA and United States Code Annotated sections]. ERISA is a comprehensive regulatory statute that Congress enacted to correct abuses in the area of private employee benefit plans. See *Nachinan Corp. v. Pension*

breadth of the statute's language³ and the legislative history⁴ clearly evidence a congressional design to occupy the field of private employee benefit plan regulation.⁵ Notwithstanding this specific design, the question of whether a state law impinges on federal superintendence often is difficult to resolve. The difficulty occurs largely because employee benefit plans do not exist in a vacuum. State regulation in other fields, for example, laws respecting health care, domestic relations, employment discrimination, securities transactions, and taxation, may touch upon employee benefit plans in a variety of ways.⁶

Benefit Guar. Corp., 446 U.S. 359, 362 (1980) (Title IV of ERISA intended as a means of protecting interests of employees and their beneficiaries). The statute, *inter alia*, imposes participation, vesting, accrual, and funding requirements on pension plans. ERISA §§ 201-306, 29 U.S.C.A. §§ 1051-1086 (West 1985). It also establishes rules concerning reporting, disclosure, and fiduciary responsibility for both pension and welfare plans and provides remedies, sanctions, and access to the federal courts if a fiduciary or plan administrator breaches those rules. ERISA §§ 101-111, 401-414, 502, 29 U.S.C.A. §§ 1021-1031, 1101-1114, 1132 (West 1985). If ERISA preempts a state law, it is void under the supremacy clause. See U.S. CONST. art. VI, § 2.

2. Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 24 n.26 (1983).

3. Section 514(a) of ERISA, 29 U.S.C.A. § 1144(a) (West 1985), provides generally for the preemption of "any and all State laws" that "relate to any employee benefit plan." See *infra* text accompanying notes 29-30.

4. See S. REP. NO. 1090, 93d Cong., 2d Sess. 383 (1974) (conference report on ERISA); 120 CONG. REC. 29,197 (1974) (statement of Rep. Dent); *id.* 29,933 (statement of Sen. Williams); *id.* 29,942 (statement of Sen. Javits).

5. See *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-99 (1983); *Alessi v. Reybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981); see also *Stone & Webster Eng'g Corp. v. Ilesley*, 690 F.2d 323 (2d Cir. 1982); *Standard Oil Co. of Cal. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980); *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978); *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

Despite the perception by some commentators that Supreme Court doctrine regarding preemption is in a state of disarray, see, e.g., Note, *The Preemption Doctrine: Shifting Perspectives on Federalism and the Burger Court*, 75 COLUM. L. REV. 623 (1975); Note, *A Framework for Preemption Analysis*, 88 YALE L.J. 363 (1978), many scholars view a court's finding that federal law occupies a given field as one of the "two most commonly-used standards" to determine preemption. See Turza & Holloway, *Preemption of State Laws Under the Employee Retirement Income Security Act of 1974*, 28 CATH. U.L. REV. 163, 175 (1979); see also Hirsch, *Toward a New View of Federal Preemption*, 1972 U. ILL. L.F. 515, 526-33. See generally L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 6-23 (1978). Once courts make such a finding, they analyze preemption questions by focusing on the outer scope of the federal law and examining whether the state regulation falls within its boundaries. Turza & Holloway, *supra*, at 373. Courts generally employ this analysis to determine preemption questions under ERISA.

6. See *Alessi v. Reybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981); *Farmer v. United Brotherhood of Carpenters*, 430 U.S. 290, 298 (1977) (most difficult preemption questions arise when state and federal laws are aimed at different subject matters, but application of state law touches upon congressional desire to create uniform federal regulatory scheme). The problem is complicated by the disparity of regulation between pension and welfare

Although the Supreme Court has stated that the reach of ERISA's preemption provision is wide, it has not demarcated a clear boundary.⁷ The Court's guidelines are metaphorical rather than functional,⁸ and lower courts now are grappling with an onslaught of ERISA preemption challenges to state regulation in fields other than employee benefits. One such preemption question is the validity of state legislation regulating third party prescription drug programs.

Third party prescription drug programs, as their name indicates, involve the payment for prescription drugs by a party other than the patient-purchaser.⁹ The programs are implemented by agreements between the service provider (a pharmacy) and the third party payor.¹⁰ The extent of these programs has increased

plans. ERISA imposes minimum regulatory standards on many basic terms and conditions of pension plans, but with respect to welfare plans it imposes only reporting and disclosure obligations and rigid duties upon fiduciaries. See *supra* note 1. Thus, much of the state regulation that affects welfare plans does not impinge upon specific subject matters regulated by ERISA. See Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 IOWA L. REV. 57 (1976) (arguing that ERISA creates a vacuum with respect to regulation of welfare plans, and preemption rules should be amended to allow states to fill the vacuum).

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

8. See *id.* at 100 n.21.

9. The concept of third party prescription drug programs originated in 1967 as an outgrowth of the collective bargaining agreement reached that year between the United Auto Workers and Ford Motor Company. See *Blue Cross and Blue Shield v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258 (N.D. Ala. 1983) (discussing history of third party prescription drug programs). Ford agreed to provide prescription drug benefits to its employees and contracted with Blue Cross and Blue Shield of Michigan (Blue Cross of Michigan) to insure the cost of the benefits. *Id.* at 1262. Blue Cross of Michigan entered into agreements with various pharmacies in the state, in which the pharmacies agreed to provide prescription drugs to eligible Ford employees. Blue Cross of Michigan in return would reimburse the pharmacies based on their acquisition costs plus a dispensing fee. *Id.* Additionally, Blue Cross of Michigan contracted with local Blue Cross organizations in other states to enter into similar pharmacy agreements to provide prescription drug benefits to eligible Ford workers outside of Michigan. This arrangement continues today. *Id.*

10. In the typical case, the agreement is entered into between a pharmacist and either an insurance company or local Blue Cross/Blue Shield organization acting as the third party payor. The third party payor insures the consumer against liability for the cost of pharmaceuticals. An employer (or employee welfare plan) pays the third party the cost of insurance premiums, and the third party pays the participating pharmacists pursuant to the provider agreement. In most other instances the agreement is executed by pharmacists and a claims administrator. The claims administrator, in turn, has contracted with an employer or employee welfare plan that has itself insured the cost of pharmaceuticals for the plan's participants. The employer pays the claims administrator a service fee and the cost of claims, and the claims administrator reimburses the participating pharmacists pursuant to the agreement. See *Problems on Third Party Prepaid Prescription Programs: Hearings Before the Subcomm. on Environmental Problems Affecting Small Business of the House Select Comm. on Small Business*, 92d Cong., 1st Sess. 54-57 (1971) [hereinafter cited as

since their introduction in 1967. These agreements, however, have long been unprofitable to pharmacists, particularly to independent retail pharmacists. Typically, third party prescription drug agreements reimburse the participating pharmacist for his acquisition costs, plus a fixed dispensing fee; they do not reimburse the provider based on his usual and customary charges.¹¹ For the independent pharmacist, the fixed fee often barely covers the costs of filling a prescription.¹²

The ability of third party payors to impose uneconomical terms on independent pharmacies results from two factors: first, the economic power of the group purchasers (usually large insurance carriers), combined with their natural desire to reduce costs; and second, the weak bargaining power of independent pharmacists, who are precluded by the antitrust laws from joining together to bargain collectively.¹³ As a result, the independent pharmacist confronts the business dilemma of either acceding to an unprofitable third party agreement or losing a significant amount of new and existing patronage.

Independent pharmacists who enter third party payor agreements often attempt to negate the resulting economic loss by charging higher prices to uninsured patient-purchasers. The burden falls most heavily upon uninsured patient-purchasers who do

Hearings].

11. If, however, a pharmacist's usual and customary charge for a particular prescription is lower than the acquisition cost plus fixed dispensing fee, many programs limit the pharmacist's reimbursement to his usual and customary charge. This provision is modeled after Medicaid provisions concerning pharmaceutical reimbursement. See 42 C.F.R. § 447.331-.334 (1984). It also is not uncommon for agreements to require a fixed copayment by the consumer, for example one or two dollars per drug. The copayment, in turn, is deducted from the reimbursement fee otherwise paid by the insurer. See generally *Hearings*, *supra* note 10, at 54-57.

12. For example, a study by the Michigan Pharmacists Association (MPHA) found that in 1981 Michigan pharmacies absorbed \$21.8 million in lost profits as a consequence of insufficient third party reimbursement fees, an average of \$10,198 per pharmacy. WEEKLY PHARMACY REP., June 28, 1982, at 1, 4 (THE GREEN SHEET, published by F-D-C Reports) [hereinafter cited as THE GREEN SHEET]. The magnitude of this loss is starkly revealed by the fact that the average net profit of community pharmacies in Michigan in 1981 was \$13,973. See Eli Lilly and Company, *Lilly Digest*, at 5 Table 1 (1982). Since the advent of third party prescription drug programs, the average net profit of independent pharmacies has decreased steadily from 5.8% in 1965 to 3.2% in 1981. *Fixed Fee Pegged As Cause for Declining Profits*, NARD J., Aug. 1983, at 14.

13. See, e.g., Northern Cal. Pharmaceutical Ass'n v. United States, 306 F.2d 379 (9th Cir.) (concerted activity by pharmacists to affect prices violates prohibition against horizontal price fixing under § 1 of the Sherman Antitrust Act), *cert. denied*, 371 U.S. 862 (1962); United States v. Utah Pharmaceutical Ass'n, 201 F. Supp. 29 (D. Utah) (same), *aff'd per curiam*, 371 U.S. 24 (1962).

not have insurance coverage, including the non-Medicaid poor. Rather than reduce consumer drug prices generally, third party programs shift costs to the uninsured public.¹⁴ To the extent these programs are uneconomical to independent pharmacists, they have contributed to a reduction in the number of independent pharmacies. Because pharmacies, particularly in rural or lower income areas, often provide the only readily accessible source of health care counseling,¹⁵ this result has substantial adverse societal impacts.¹⁶

14. For example, a 1984 study in Indiana estimated that although third party payor reimbursement fees were below the average total costs per prescription for 82% of the state's pharmacies, pharmacists would continue to participate in these inequitable third party payor programs as long as reimbursement levels were sufficient to cover variable costs per prescription. To cover average total costs, therefore, they must shift a disproportionate amount of the fixed costs per prescription to their uninsured customers. Jacobs, *The Adequacy of Third-Party Payments for Prescriptions*, CURRENT CONCEPTS IN RETAIL PHARMACY MGMT., Nov.-Dec. 1984, at 8, 12-13; see also R. DeNuzzo, 29 *Alhany College of Pharmacy Prescription Survey 17* (Mar. 15, 1985) (published by MED. ADVERTISING NEWS). The Alhany College Survey of 15,416 prescriptions filled in 1984 estimated that, on the average, pharmacists charged uninsured, cash-paying customers a dispensing fee (difference between the pharmacist's acquisition costs and the consumer's price for a prescription) that is \$0.43 higher per prescription than the dispensing fees they charge for prescriptions filled under third party payor agreements. The average dispensing fee for cash-paying customers was \$3.83 while that for beneficiaries of third party payor programs was \$3.40.

15. See, e.g., *Statement of Mr. John A. Johnson Before the U.S. Dep't of Health and Human Services Task Force on Reimbursement for Prescription Drugs*, NARD J., Oct. 1983, at 19-20 (retail pharmacists frequently represent sole source of medical advice in locales with high degree of Medicaid utilization). Independent pharmacists dispense nearly 90% of all Medicaid prescriptions, thereby evidencing the extent of their involvement in providing health services to residents of low income areas. *Medicaid Survey Results*, NARD J., Sept. 1983, at 14. Furthermore, retail pharmacies are geographically well distributed. Only 44 of the nation's 3,093 counties lack retail pharmacies. California Pharmacists Ass'n, Michigan Pharmacists Ass'n & Texas Pharmaceutical Ass'n, *Dollars and Sense of Pharmacy Services 6* (1983) [hereinafter cited as *Dollars and Sense*]. By contrast, the Department of Health and Human Services projected that in 1982, 761 rural counties would have a ratio of population to primary care physicians of greater than 3500 to 1. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *DIFFUSION AND THE CHANGING GEOGRAPHIC DISTRIBUTION OF PRIMARY CARE PHYSICIANS 51*, Table 2 (1983). The Department of Health and Human Services has designated these rural counties as "Health Care Manpower Shortage Areas." See *id.* at 17 Table 2. Furthermore, the ratio of population to primary care physicians is five times as great in counties with a population of 10,000 or less as it is in counties with a population of greater than 1,000,000. See *id.*

16. In addition to cost shifting, see *supra* note 14, inadequate third party program fixed fees may contribute to the pressure on pharmacists to reduce acquisition costs. This pressure has contributed to the existence of a drug diversion market. Drug diversion injects into the marketplace pharmaceuticals that do not comply with federal quality control standards. See STAFF OF HOUSE COMM. ON ENERGY & COMMERCE, 99TH CONG., 1ST SESS., *REPORT ON DRUG DIVERSION* (Comm. Print 1985). In a common diversion scheme drugstore chains purchase, at reduced wholesale prices, pharmaceuticals that are intended specifically for exportation and therefore are not manufactured in accordance with federal standards. See *id.* at 6-21. As a result, consumers unknowingly purchase unlabeled, misbranded, expired, or counterfeit drugs. See *id.* at 1-2.

Currently, six states have laws that seek to alleviate the adverse societal effects of third party prescription drug programs.¹⁷ Bills that are modeled after those laws also have been introduced in several other states.¹⁸ A seventh state, Alabama, enacted similar legislation in 1981,¹⁹ but the United States District Court for the Northern District of Alabama held that ERISA preempted the statute.²⁰ A challenge to the Georgia statute presently is pending in federal court.²¹

This Article analyzes the preemptive effect of ERISA on state third party prescription drug program legislation. It argues that such laws do not "relate to employee benefit plans" and that even if the courts were to view them as relating to employee benefit plans, the laws meet the statutory exception to preemption for state laws that "regulate . . . insurance."²²

17. See Third Party Prescription Programs Act, CONN. GEN. STAT. ANN. § 38-1740 (West Supp. 1985); Third Party Prescription Program Law of 1983, GA. CODE ANN. §§ 79A-1201 to -1209 (Harrison 1984); Third Party Prescription Program Act, ILL. ANN. STAT. ch. 73, §§ 1065.59-1 to .59-9 (Smith-Hurd Supp. 1985); Third Party Prescription Program Act, ME. REV. STAT. ANN. tit. 32, §§ 2931-2937 (Supp. 1985-1986); Third Party Prescription Act, OKLA. STAT. ANN. tit. 15, §§ 781-789 (West Supp. 1984-1985); Third Party Prescription Program Act, TENN. CODE ANN. §§ 63-10-301 to -309 (1982). These laws primarily regulate third party prescription drug programs in three ways. First, Georgia, Oklahoma, and Tennessee require that third party prescription drug agreements not establish reimbursement rates that are less than the prevailing rates paid by ordinary consumers for the same services. Second, they all require that every agreement include a formal payment schedule and precise rules on the cancellation of coverage to beneficiaries of the program. Third, they prohibit administrators of third party prescription drug programs to deny payment to any pharmacy for pharmaceutical services rendered because of the fraudulent use of prescription program identification cards.

18. The initial success in obtaining third party prescription drug program legislation led state pharmaceutical associations to pursue similar legislation in thirty-one states. Abood, *Litigation on Third Party Prescription Programs: An Update*, LAW, MED. & HEALTH CARE, Apr. 1985, at 75, 78. In recent years the issue has enjoyed high visibility and substantial legislative attention. Pending a decision in the challenge to Georgia's Third Party Prescription Law, see *infra* note 21, however, state pharmaceutical organizations are increasingly reluctant to lobby for such regulation due to the current uncertainty about its constitutionality. See, e.g., NATIONAL COUNCIL OF STATE PHARMACEUTICAL ASSOCIATION EXECUTIVES, NCSPAEE REPORT ON THIRD PARTY PRESCRIPTION PROGRAMS: 1984-85 UPDATE 13 (Texas Pharmaceutical Association had originally decided to pursue a third party prescription program bill in the 1984-85 legislative session but eventually changed its plans; Indiana Pharmacists Association lobbied for a 1984 bill entitled "The Third Party Pharmaceutical Goods Reimbursement Act," but this bill was tabled).

19. Third Party Prescription Program Act, ALA. CODE §§ 34-23-110 to -118 (Supp. 1985).

20. *Blue Cross and Blue Shield v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258 (N.D. Ala. 1983); see *infra* notes 128-34 and accompanying text.

21. *General Motors Corp. v. Caldwell*, No. C84-331A (N.D. Ga. filed Feb. 21, 1984).

22. Section 514(b)(2)(A) of ERISA, 29 U.S.C.A. § 1144(b)(2)(A) (West 1985), excepts from the general preemption rule any state law "which regulates insurance, banking, or se-

The Article contends that third party prescription drug program statutes represent a type of "borderline"²³ preemption problem, and it offers a functional approach to resolve the problem. If a state law affects employee benefit plans without infringing on their terms and conditions, a court should balance the state's interest in the regulation against the extent of the legislation's effect on employee benefit plans. Third party prescription drug program legislation serves important state interests in promoting the health and welfare of its citizenry and has an insignificant economic and administrative effect on employee benefit plans. Therefore, such regulation should not be preempted.

Furthermore, the Supreme Court has adopted a literal, plain meaning construction of ERISA's insurance saving clause.²⁴ As a result, to the extent third party prescription drug program legislation regulates pharmacy agreements executed by insurance companies that have assumed the risk of funding drug benefits, the insurance exception saves such laws from preemption. The Article concludes that *Blue Cross and Blue Shield v. Peacock's Apothecary, Inc.*,²⁵ the only case thus far to address this preemption issue, is plainly wrong and poorly reasoned.

The importance of the preemption issue extends beyond state efforts concerning third party prescription drug programs. The precipitous rise in health care costs during the last twenty years²⁶ has kindled the concern of state legislators.²⁷ State governments

curities." See *infra* notes 31-33 and accompanying text.

23. *Shaw v. Delta Air Lines*, 463 U.S. 85, 100 n.21 (1983).

24. *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380 (1985).

25. *Peacock's Apothecary*, 567 F. Supp. 1258 (N.D. Ala. 1983).

26. Health care expenses for the nation more than tripled from 1972 to 1983, rising from \$94 billion to \$355 billion. Connecticut Hospital Ass'n, Hospital Costs and Government Regulation: The Connecticut Experience 1 (Jan. 1985) [hereinafter cited as Connecticut Hospital Ass'n]. Between 1965 and 1983 health care expenditures as a share of the gross national product rose from 6.0% to 10.9%. HEALTH INS. ASS'N OF AM., 1982-83 SOURCE BOOK OF HEALTH INSURANCE DATA Table 5.2 (1984 update). Concomitant with this increase has been the increased role of third party payors. By 1982 private third parties paid 29% of America's total health care bill, compared with 28% by patients. Governmental programs accounted for the remaining 43%. *Health Care Spending Hits a New High*, NARD J., Sept. 1983, at 14, 98.

27. According to the National Conference of State Legislatures (NCSL), the states have responded to increased health care spending by developing 800 different cost containment regulations. See Connecticut Hospital Ass'n, *supra* note 26. One commentator predicts that states soon will enact legislation that will require health care providers to collect, report, and disclose usage and cost information. Such statutes would be designed to aid businesses and insurers in analyzing provider efficiency and in developing cost containment strategies. Pierce, *Health Insurance on the Statehouse Floor: 1985 Projections*, 59 HOSPITALS, Feb. 1, 1985, at 57, 58.

increasingly are attempting to reduce health care costs without sacrificing the quality of health care services to the public as a whole.²⁸ The consequence of this effort is an increase in regulation of the relationship between third party payors and other health care providers. The analysis and conclusions in this Article provide a framework for determining the effect of ERISA on these regulatory efforts and, more broadly, shed light on the role that ERISA leaves to the states in the health care cost area.

II. ERISA'S PREEMPTION SCHEME

Several provisions of ERISA directly address the preemption question. Section 514(a) states the general rule that ERISA "shall supersede any and all State laws[²⁹§ insofar as they may now or hereafter relate to any [covered] employee benefit plan."³⁰ Section

28. State governments face a difficult task in attempting to resolve the tension between the cost and quality of health care. One major complication is that technological advances made in health care since the mid-1960's have been responsible for both a significant improvement in the quality of health service and a rapid escalation in health care costs. New biomedical technology developed in the past 20 years includes CT scanners, surgical lasers, and auto-analyzers. New medical procedures include organ transplants and renal dialysis. Extraordinary health care costs have been incurred in operating and maintaining these diagnostic and treatment techniques. The chart below shows capital equipment expenditures of three new technologies:

CT Scanners	\$600,000 - \$800,000
Surgical Lasers	\$ 80,000 - \$100,000
Auto-analyzers	\$100,000 - \$200,000

Connecticut Hospital Ass'n, *supra* note 26, at 7.

Of equal note, however, is the improvement in health care quality that these innovations have precipitated. Many lives have been lengthened or improved as a consequence of new medical services. In at least one state the citizens perceive the benefits of new medical treatments as outweighing the costs. The Connecticut Hospital Association in the spring of 1983 conducted a statewide survey and discovered that 60% of respondents favored the use of new technologies in hospitals; approximately the same percentage thought that the resulting increased costs should be spread among charges to all patients. *Id.*

The rise in pharmaceutical prices and the advent of third party pharmaceutical programs similarly creates a tension between cost containment efforts and the desirability of a widespread distribution of pharmacy services. State regulation of third party prescription drug programs attempts to resolve this tension in favor of an equitable pricing system that assures the balanced distribution of pharmacy services.

29. Under ERISA § 514(c)(1), 29 U.S.C.A. § 1144(c)(1) (West 1985), "[t]he term 'State law' includes all laws, decisions, rules, regulations or other State action having the effect of law." The term "State" is defined as "a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans." ERISA § 514(c)(2) 29 U.S.C.A. § 1144(c)(2) (West 1985).

30. 29 U.S.C.A. § 1144(a) (West 1985). Employee benefit plans include both welfare plans and pension plans. ERISA § 3(3), 29 U.S.C.A. § 1002(3) (West 1985). ERISA, however, does not cover employee benefit plans that are established or maintained by governmental

514(b)(2)(A),³¹ however, enumerates three exceptions to this rule. It provides that "nothing in this title shall be construed to . . . relieve any person from any law of any State which regulates insurance, banking or securities."³² But section 514(b)(2)(B) itself limits

entities or by churches; nor does it cover excess benefit plans "maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws," or plans "maintained outside of the United States primarily for the benefit of . . . nonresident aliens." ERISA § 4(b)(3)(4), 29 U.S.C.A. § 1003(b)(3)(4) (West 1985); see also *id.* § 3(32), 29 U.S.C.A. § 1002(32) (definition of governmental plans); *id.* § 3(33)(A), 29 U.S.C.A. § 1002(33)(A) (definition of church plans); *id.* § 3(36), 29 U.S.C.A. § 1002(36) (definition of excess benefit plans). Section 3(1) of ERISA defines an employee welfare plan as follows:

[A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C.A. § 1002(1) (West 1985).

If an employer or employee organization provides prescription drug benefits to employees, either in conjunction with other medical benefits, or as an independent health care benefit, that action constitutes the formation of an employee welfare plan.

31. 29 U.S.C.A. § 1144(b)(2)(A) (West 1985).

32. The exceptions for banking and securities laws clearly would not apply to third party prescription drug program legislation. ERISA also excepts from the preemption provision "any generally applicable criminal law of a State." ERISA § 514(b)(4), 29 U.S.C.A. § 1144(b)(4) (West 1985). If a third party prescription drug program statute included criminal penalties, this would not be a sufficient cause for excepting the statute from displacement by ERISA. Section 514(b)(4) was added to ERISA in conference, as a result of the conferees' decision to expand the general preemption rule to cover all state laws that "relate to" employee benefit plans. The conferees did not intend to cover merely those state laws that conflicted with the subject matters treated by ERISA, as earlier drafts of the legislation had provided. See *infra* note 41. Furthermore, the legislative history contains no discussion of what Congress meant by "generally applicable" criminal laws; this suggests that Congress intended that the term be given its commonly understood legal meaning. Accordingly, "generally applicable" criminal laws encompass criminal statutes that are addressed to the citizenry as a whole, such as laws respecting larceny or embezzlement. The term excludes laws limited to specific entities, such as criminal penalties to punish the conduct of an employee benefit plan *qua* plan, health care provider *qua* provider, or insurer *qua* insurer. Case law is consistent with this view. *Bucyrus-Erie Co. v. Department of Indus., Labor and Human Relations*, 599 F.2d 205, 208 (7th Cir. 1979), *cert. denied*, 444 U.S. 1031 (1980); *Trustees of Sheet Metal Workers Fund v. Aberdeen Blower & Sheet Metal Workers, Inc.*, 559 F. Supp. 561, 563 (E.D.N.Y. 1983).

Finally, ERISA also provides that it "shall [not] be construed to alter, amend, . . . impair, or supersede" any other federal law. ERISA § 514(d), 29 U.S.C.A. § 1144(d) (West 1985). Thus, ERISA would not preempt a federal third party prescription drug program statute.

these exceptions.³³ The statute provides that for the purpose of determining if a state law regulates insurance no benefit plan will be "deemed" to be an insurance company, insurer, or in the business of insurance.³⁴

A preemption challenge under ERISA to third party prescription drug program legislation therefore should be analyzed in three steps. First, does the law "relate to" employee benefit plans and thus fall within the preemption language of section 514(a)? Second, if so, is the law an insurance law for purposes of section 514(b)(2)(A)? Third, if the law is an insurance law, is it one that "deems" an employee benefit plan to be an insurer, insurance company, or in the business of insurance?

A. *Does State Legislation to Regulate Third Party Prescription Drug Programs "Relate to" Employee Benefit Plans?*

*Shaw v. Delta Air Lines*³⁵ is the starting point in determining whether state third party prescription drug program legislation "relate[s] to" employee benefit plans within the context of section 514(a).³⁶ In *Shaw* the Supreme Court construed the phrase in regard to two New York laws; the first law made it illegal to discriminate in employee benefit plans on the ground of pregnancy,³⁷ and

33. 29 U.S.C.A. § 1144(b)(2)(B) (West 1985).

34. Section 514(b)(2)(B) reads:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company 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.

29 U.S.C.A. § 1144(b)(2)(B) (West 1985) (emphasis added).

35. 463 U.S. 85 (1983).

36. Prior to *Shaw*, the court reviewed ERISA's preemption rules in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), but it did not construe the meaning of the phrase "relate to." *Alessi* concerned the effect of ERISA upon a New Jersey workers' compensation law that made it illegal for pension plans to offset benefits by the amount of a participant's workers' compensation award. Prior to ERISA the Internal Revenue Service (IRS) expressly had approved this offset mechanism, and the Court found that when Congress enacted ERISA's vesting rules, 29 U.S.C.A. § 1051, it "knew of the IRS rulings" and "essentially approved the[m]." *Alessi*, 451 U.S. at 519 & n.15. Thus, the New Jersey statute conflicted with congressional intent. The Court, therefore, held that the statute "related to" employee benefit plans and was preempted. It was of no moment to the Court that the intrusion emanated from a state workers' compensation statute rather than a state statute denominated as a pension regulation. The Court said that "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern." *Id.* at 525.

37. See *Brooklyn Union Gas Co. v. New York State Human Rights Appeal Bd.*, 41 N.Y.2d 84, 359 N.E.2d 393, 390 N.Y.S.2d 884 (1976) (construing N.Y. EXEC. LAW §§ 290-301 (McKinney 1982)).

the second law required employers to pay sick leave benefits to employees who were unable to work because of pregnancy.³⁸

The Court unanimously held that the bounds of section 514(a)'s preemptive reach were as broad as the normal sense of the phrase "relates to."³⁹ The Court stated that a law "relates to" an employee benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan."⁴⁰ Moreover, the Court mined the legislative history of section 514(a) and concluded that Congress specifically intended to use the words "relate to" in this broad layman's sense,⁴¹ and did not intend the section "to preempt only state laws specifically designed to affect employee benefit plans" or laws "dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like."⁴²

Once the Court established that the term "relates to" created a broad preemptive reach, it had no difficulty assessing the validity of the laws at issue. The pregnancy discrimination law, by requiring that employee benefit plans treat pregnancies similarly to other nonoccupational disabilities, and the disability law, by requiring employers (and thus the employee benefit plans that they sponsored) to provide pregnancy disability benefits, affected the struc-

38. N.Y. WORK. COMP. LAW §§ 204-205 (McKinney Supp. 1982-1983).

39. 463 U.S. at 98.

40. *Id.* at 96-97. In a footnote, the Court quoted from the definition of "relate" in BLACK'S LAW DICTIONARY 1158 (5th ed. 1979): "[t]o stand in some relation; to have bearing or concern; to pertain; refer; to bring into association . . . or connection with." 463 U.S. at 97 n.16.

41. The Court noted that earlier versions of the bill that became ERISA contained a limited preemption clause that applied only to state laws relating to the specific benefit plan areas regulated by the statute. For example, the version of ERISA that passed the House provided that the Act would have superseded state laws "relat[ing] to . . . reporting and disclosure responsibilities, and fiduciary responsibilities." H.R. 2, 93d Cong. 2d Sess. § 514(a) (1974), reprinted in 3 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 4057-58 (Comm. Print 1976) [hereinafter cited as LEGISLATIVE HISTORY]. The Senate version of ERISA spoke in more general but substantively similar terms: "[t]he provisions of this Act shall supersede any and all laws of the States . . . insofar as they may now or hereafter relate to the subject matters regulated by this Act." H.R. 2, 93d Cong., 2d Sess. § 699(a) (1974), reprinted in 3 LEGISLATIVE HISTORY, *supra*, at 3820. Yet the conference committee rejected these versions in favor of the present language, and the Court in *Shaw* viewed this rejection as an indication that "relates to" should be given its customary and thus broad interpretation. 463 U.S. at 98. Moreover, the Court noted that Senators Williams and Javits, floor managers of the Senate debate on the conference report, and Congressman Dent, floor manager of the House debate, each made a statement that "stressed the breadth of federal pre-emption." *Id.* at 99; see also 120 CONG. REC. 29,197 (1974) (remarks of Rep. Dent); *id.* at 29,933 (remarks of Sen. Williams); *id.* at 29,942 (remarks of Sen. Javits).

42. 463 U.S. at 98.

ture of benefit plans and thus clearly related to them.⁴³ Accordingly, ERISA preempted the two laws.

The Court's construction of section 514(a) and its statement that laws relate to an employee benefit plan if they are "connect[ed] with or refer to such a plan," imply that a state law that has *any* effect on an employee benefit plan "relates to" it. Yet the New York laws at issue affected employee benefit plans so directly that an analysis of how they related to such plans could shed no light on this very extreme implication. Justice Blackmun, apparently recognizing this, stopped short of embracing the implication. His opinion for a unanimous Court states:

Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan. Cf. *American Telephone and Telegraph Co. v. Merry*, 592 F.2d 118, 121 (CA2 1979) The present litigation plainly does not present a borderline question, and we express no views about where it would be appropriate to draw the line.⁴⁴

Third party prescription drug legislation does present a "borderline" question. State regulation of third party prescription drug programs may have an indirect economic effect on employee welfare plans. To the extent that a third party prescription drug program does not meet the three basic requirements of third party prescription drug program legislation discussed earlier,⁴⁵ compliance with those requirements may result in higher costs to the third party payor. If the third party payor has insured the drug benefits, it may seek to pass on the costs in higher premiums to the employers who fund the plan. If the third party payor is a claims administrator, employers will bear directly the increased cost of claims.⁴⁶

But any increased costs would be minor relative to the entire funding costs of a given employee welfare plan. Most welfare plans provide a package of health care benefits to plan participants and

43. *Id.* at 100.

44. *Id.* at 100 n.21.

45. See *supra* note 17.

46. Not only may costs per prescription increase, but indirect costs to administer the program may rise. For example, the typical third party prescription drug program statute requires that the third party payor provide precise rules on the cancellation of coverage to program beneficiaries, see *supra* note 17, which often means that the third party payor must notify promptly all participating pharmacies of the cancellation of a particular beneficiary's coverage. The third party payor may incur some additional expense to comply with that requirement, which it likely would pass on to employers in the form of higher premiums or administrative fees. Of course, benefit plans have an interest in making this information promptly available to avoid disputed claims.

beneficiaries. Prescription drug benefits are a small part of the benefits that are included in most plans; hospital and medical care represent the major portion of the average welfare plan dollar.⁴⁷ Thus, the additional amounts that employers will have to pay to fund a plan because of third party prescription drug program legislation will be inconsequential relative to the total funding requirements of a given plan.

Moreover, employers and employees still would be free to include in a plan any benefits they wish. The minor financial burden, if any, imposed by such statutes is unlikely to influence the choice of benefits that an employer provides. This differs from the situation in *Shaw*, in which New York required all welfare plans that provided benefits for nonoccupational disabilities to include pregnancy benefits.⁴⁸ Similarly, because the statutes do not mandate the inclusion of a particular benefit, an employer who provides health benefits to employees residing in several states, only some of which have third party prescription drug program regulation, will not be forced to establish multiple plans with different benefit packages or a single plan whose terms and conditions comport with the benefit requirements of the most restrictive state.

Thus, third party prescription drug program legislation raises the type of "borderline" question that *Shaw* did not consider. However, the *Shaw* Court's use of the words "tenuous, remote, or

47. In 1982 only 7% of the average health care dollar went to the purchase of drugs; 42% went to hospital care and 19% to physicians' services. By 1985, the figure had dropped to 5%. See HCFA Office of Research and Demonstrations, 5 HEALTH CARE FINANCING REV., Spring 1984, at 52 Table 5 [hereinafter cited as *HCFR 1984*]; *Statement of Gerald J. Mossinghoff, President, Pharmaceutical Manufacturers Association, Before the Energy and Commerce Subcomm. on Health and the Environment*, U.S. House of Representatives (July 15, 1985) [hereinafter cited as *Mossinghoff*] (on file with the *Vanderbilt Law Review*). Out of the \$84.2 billion expended by private insurance organizations for health care in 1982, only \$2.8 billion, or 3.3%, was attributable to the purchase of drugs and medical sundries. HEALTH INS. ASS'N OF AM., *supra* note 26, at 16 Table 5.5.

48. See also *Champion Int'l Corp. v. Brown*, 731 F.2d 1406 (9th Cir. 1984) (state age discrimination law that required pension plans to provide service credit after age 65 for work "relates to" employee benefit plans; it limits how plans can structure vesting rules); *Stone & Webster Eng'g Corp. v. Ilesley*, 690 F.2d 323 (2d Cir. 1982) (state law requiring provision of health insurance to employees on workers' compensation "relates to" plans; it dictates the type of benefit that a plan must provide); *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977) (state requirement that all issuers of group health insurance provide coverage for the treatment of mental illnesses "relates to" employee benefit plans; benefit plan that purchases such group insurance must accept the added coverage), *cert. denied*, 435 U.S. 980 (1978).

peripheral" in footnote 21 provides little functional guidance to resolve this question.⁴⁹

In *Rebaldo v. Cuomo*⁵⁰ the United States Court of Appeals for the Second Circuit suggested a functional rule to resolve whether third party prescription drug program legislation "relates to" an employee benefit plan. *Rebaldo* concerned a challenge to a portion of New York's Public Health Law⁵¹ that prescribed rates that hospitals could charge payors for inpatient services. The law established one rate of payment for major third party payors such as Medicare, Medicaid, and Blue Cross and a higher rate for all other payors. As a result, hospitals could not enter into provider agreements with self-insured employee benefit plans that established reimbursement rates that were lower than those prescribed by the statute.

The challenger in *Rebaldo*, a representative of a self-insured employee welfare plan, argued that to the extent this law indirectly precluded employee benefit plans from securing discount rates with hospitals, it "relate[d] to" employee benefit plans and therefore was preempted. The trial court agreed and invalidated that part of the law.⁵² The Second Circuit unanimously reversed.⁵³ As the Second Circuit construed the term "relate to," New York's Public Health Law did not "relate to" employee benefit plans and was not preempted.

The Second Circuit began its analysis by evaluating the gloss on the general preemption clause made by ERISA section 514(c).⁵⁴ Section 514(c)(2) defined the term "State," for preemption purposes, to include "a State, any political subdivisions thereof, or any agency or instrumentality . . . which purports to regulate, directly

49. See *supra* text accompanying note 44; Savings and Profit Sharing Fund of Sears Employees v. Gago, 717 F.2d 1038, 1040 (7th Cir. 1983) (same observation as in *Shaw*). Indeed, without a principled approach to determine whether a state law's effect is remote or peripheral, inconsistent results are assured. For example, in *Time Ins. Co. v. Department of Indus., Labor and Human Relations*, 16 Fair Empl. Prac. Cas. (BNA) 391 (Dane County Wis. Cir. Ct. 1978) (state law required employers to pay pregnancy disability benefits), the court upheld the same type of law that the Supreme Court later struck down in *Shaw* on the ground that the statute was "merely of peripheral concern of [sic] ERISA." *Id.* at 396 (emphasis added).

50. 749 F.2d 133 (2d Cir. 1984), cert. denied, 105 S. Ct. 2702 (1985).

51. N.Y. PUB. HEALTH LAW § 2807-(a)(1) (McKinney 1982).

52. *Rebaldo v. Cuomo*, No. 83-8707, slip op. (S.D.N.Y. Mar. 13, 1984) (available on LEXIS).

53. 749 F.2d 133. The opinion was written by Judge Ellsworth Van Graafeiland, who was joined by Judges Henry Friendly and Jon Newman.

54. Section 514(c) of ERISA, 29 U.S.C.A. § 1144(c) (West 1985), defines certain terms as they are used in § 514(a). See *supra* note 29.

or indirectly, the terms and conditions of employee benefit plans.”⁵⁵ Accordingly, the court concluded that ERISA did not preempt every state statute that merely had an effect on employee benefit plans. Only if the state law “purport[ed] to regulate . . . the terms and conditions of employee benefit plans” would it be held to “relate to” such plans and thus be preempted.⁵⁶ The court found that footnote 21 of *Shaw* supported its conclusion but also believed it to be the common sense result:

This conclusion follows as a matter of common sense from the fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514. A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.⁵⁷

Furthermore, the Second Circuit reasoned that the regulation of hospital costs was “an exercise of a State’s police powers,” which “should not be found to ‘relate’ to ‘the terms and conditions of employee benefit plans’ unless this conclusion is unavoidable.”⁵⁸ The challenger in *Rebaldo* argued that the New York statute “related to” employee benefit plans by increasing their costs of doing business, but the court found that such an effect did not “unavoidably” lead to preemption.⁵⁹

The court noted that many state laws of general application affected a plan’s cost of doing business, such as state minimum wage laws, rent control laws, and even bridge and tunnel toll restrictions. If ERISA were held to invalidate New York’s Public Health Law, then those other laws also would be invalid to the extent that the laws affected a plan. Employee benefit plans thus would be “permitted a charmed existence that never was contemplated by Congress.”⁶⁰ The court concluded that if “a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that [it] has some economic impact on the plan does not re-

55. ERISA § 514(c)(2), 29 U.S.C.A. § 1144(c)(2) (West 1985) (emphasis added); see *infra* text accompanying notes 68-70.

56. 749 F.2d at 137 (quoting ERISA § 514(c)(2), 29 U.S.C.A. § 1144(c)(2) (West 1985)).

57. *Id.* at 138.

58. *Id.* The court devoted considerable space to the genesis of the statute and clearly intimated that the regulation of hospital rates served the extremely important state interest of health cost containment. *Id.* at 135-36. The court implicitly weighed the importance of the statute in determining whether it was preempted.

59. *Id.* at 138.

60. *Id.* at 139.

quire that the statute be invalidated."⁶¹

The Second Circuit in *Rebaldo* did not examine in detail the legislative history of ERISA, nor did it extensively review Supreme Court preemption doctrine; yet the court's analysis and outcome are consistent with both. Congress chose to expand ERISA's preemption clause beyond its configuration in earlier drafts because it believed that if the states were given continued freedom to regulate private employee benefit plans employers might be dissuaded from establishing or maintaining such plans. One of Congress' overriding concerns in enacting ERISA was its desire to encourage the growth of a private pension and welfare plan system.⁶² Moreover, Congress found that benefit plans were increasingly interstate in scope and operation.⁶³ Congress recognized that some benefit

61. *Id.* When read in light of *Shaw*, the *Rebaldo* opinion indicates that a state law that simply has an incidental economic effect on employee benefit plans does not "relate to" employee benefit plans within the meaning of § 514(a). The relationship is too tenuous to violate § 514(a). See *Lane v. Goren*, 743 F.2d 1337, 1340 (9th Cir. 1984) (mere fact that state law affects benefit plans by increasing cost of doing business does not, without more, mean ERISA preempts the law).

62. Indeed, the entire regulatory framework of ERISA attempts to strike a balance between the often competing concerns of securing workers' expectations of benefits and encouraging the development of a private employee benefit system. The House Education & Labor Committee's Report on H.R. 2, the bill that became ERISA, made this point very clear:

The primary purpose of the bill is the protection of individual pension rights, but the committee has been constrained to recognize the voluntary nature of private retirement plans. The relative improvements required by this Act have been weighed against the additional burdens to be placed on the system. While modest cost increases are to be anticipated when the Act becomes effective, the adverse impact of these increases have [sic] been minimized. Additionally, all of the provisions in the Act have been analyzed on the basis of their projected costs in relation to the anticipated benefit to the employee participant.

. . . .

The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations. In adopting this approach, the Committee believes it has designed a bill, which, like the National Labor Relations Act, the wage-hour laws and other labor standards laws, brings the workers' interests up to parity with those of employers. This legislation strikes an appropriate and equitable balance between two opposing schools of thought—those who advocate complete and stringent control of private pensions and those who oppose any form of government supervisory or regulatory control.

H.R. REP. NO. 533, 93d Cong., 2d Sess. 1, 9 (1974), reprinted in 2 LEGISLATIVE HISTORY, *supra* note 41, at 2348, 2356; see also *Michigan United Food and Commercial Workers Unions v. Baerwaldt*, 572 F. Supp. 943, 949 (E.D. Mich. 1983) ("ERISA was carefully devised to insure that the regulations it imposed . . . would not strangle the growth of [employee benefit] plans."), *rev'd on other grounds*, 767 F.2d 308 (6th Cir. 1985).

63. ERISA § 2(a), 29 U.S.C.A. § 1001(a) (West 1985) ("Findings and Declaration of

plan regulation in addition to the federally imposed scheme might be beneficial. However, if the states remained free to regulate in the benefit plan area outside of specific subject matters regulated by ERISA, a patchwork of multiple and conflicting state laws could emerge that would impose substantial additional costs and administrative burdens on benefit plan sponsors.⁶⁴ This patchwork scheme, when added to ERISA's complicated federal regulatory scheme, might create a potentially formidable disincentive to employers to establish or maintain plans. Congress decided that this possibility outweighed the potential benefits of state regulation and, accordingly, imposed broad preemption to eliminate the potential disincentive. Senator Javits revealed this legislative exercise during the Senate debate on ERISA's conference report:

Both House and Senate bills provided for preemption of State law, but—with one major exception appearing in the House bill—defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme.

Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.⁶⁵

As discussed earlier, ERISA section 514(c)(1) defines the term "State" for preemption purposes.⁶⁶ Both section 514(c) and the expanded preemption rule were added to ERISA when the bill went to conference. These additions are not surprising because the portion of the definition of "State" that the *Rebaldo* court emphasized—"which purports to regulate, directly or indirectly, the

Policy").

64. See 120 CONG. REC. 29,197 (1974) (remarks of Rep. Dent); *id.* at 29,933 (remarks of Sen. Williams); *id.* at 29,942 (remarks of Sen. Javits).

65. *Id.* at 29,942. A second impetus behind Congress' expansion of the preemption clause centered on prepaid legal service plans. In response to the concerns of organized labor, Congress sought to preempt state action with respect to mandated open panels in prepaid legal service plans. However, the subject matters substantively regulated by the statute did not address the open-panel issue; thus, under the earlier drafted preemption language the states were free to regulate on this subject. Congress intended to take away that power by enlarging the preemptive reach of the statute with the language "relate to," thereby precluding direct regulation of the terms and conditions of legal service plans. See *id.* at 29,933 (remarks of Sen. Williams); Turza & Halloway, *supra* note 5, at 365.

66. See *supra* note 29.

terms and conditions of employee benefit plans' ”⁶⁷—would have been unnecessary if section 514(a) had preempted only the more narrow set of regulations relating to the specific matters addressed by ERISA. Accordingly, given that Congress added section 514(c)(1) to ERISA as part of its decision to expand ERISA’s preemption clause, it is entirely appropriate to view this provision as reflecting, as the Second Circuit noted, the breadth of state regulation that Congress sought to preempt: regulation, either direct or indirect, of the “terms and conditions” of employee benefit plans.⁶⁸

Congress recognized that the form of regulation that created the most powerful disincentive to the establishment or maintenance of an employee welfare plan was regulation of its terms and conditions. This type of state governmental imposition is exactly what Congress sought to avoid. Nothing in the legislative history of ERISA indicates that Congress ever considered exempting employee benefit plans from state regulation of commonplace commercial transactions in which employee benefit plans and other business entities might engage. Nor is there evidence that Congress considered preempting state laws that regulated the conduct of parties who were neither sponsors nor participants in employee benefit plans merely because the statute had the effect of increasing the cost to operate such plans.⁶⁹ These laws do not affect the terms and conditions of employee benefit plans. The Court in *Rebaldo* therefore was correct in asserting that “if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress.”⁷⁰

Furthermore, by integrating New York’s strong interest in containing health care costs into its preemption calculus, the *Rebaldo* court adhered to traditional preemption doctrine. Pre-

67. 749 F.2d at 137.

68. Unfortunately, ERISA’s legislative history does not shed light on what Congress meant by the phrase “terms and conditions.” However, one may set out a practical definition by focusing on the following three basic questions an employer assuredly would ask in deciding whether to establish an employee benefit plan: (1) What benefits should be provided? (2) Who should receive the benefits? and (3) How should the benefits be funded? Thus, a plan’s rules regarding what benefits are available, how they are paid, how they accrue, how they are funded, and how a person may qualify to participate in the benefit program constitute the basic terms and conditions of employee benefit plans. See *infra* note 134 and accompanying text.

69. See generally Kilberg & Heron, *The Preemption of State Law Under ERISA*, 1979 DUKE L.J. 383, 391; Turza & Hallway, *supra* note 5, at 365 (discussion of congressional intent regarding scope of preemption).

70. 749 F.2d at 138-39.

emption theory recognizes that a state's interest justifying a regulation often determines whether federal law preempts that regulation. If the state regulation constitutes an exercise of the historical police power of the states, courts should be circumspect before finding it preempted. Federal law should not displace the regulation unless Congress "unambiguously" manifested that intent.⁷¹ As the Court stated in *Farmer v. United Brotherhood of Carpenters*,⁷² "inflexible application of the [preemption] doctrine is to be avoided, especially where the State has a substantial interest in regulation of the conduct at issue and the State's interest is one that does not threaten undue interference with the federal regulatory scheme."⁷³

These doctrinal precepts originated in the seminal construction of the supremacy clause in *Gibbons v. Ogden*,⁷⁴ in which the Court found that the supremacy clause invalidated only those laws that "interfere[d]" with or were "contrary" to congressional statutes.⁷⁵ Notions of federal-state comity and the tenth amendment⁷⁶ did not allow the judiciary to "withdraw from the States . . . the 'power to regulate where the activity regulated [is] a merely peripheral concern' of federal law."⁷⁷

The *Rebaldo* decision suggests a functional approach to deter-

71. *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218 (1947); accord *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977); *De Canas v. Bica*, 424 U.S. 351, 356-57 (1976); *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 141 (1963); *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 243-44 (1959); *Mintz v. Baldwin*, 289 U.S. 346, 350 (1933). As these cases indicate, the view that state interests are relevant in federal preemption analysis is not simply a phenomenon of the Burger Court. The present Court, however, has strongly supported this concept. See *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380, 2389 (1985) ("We . . . must presume that Congress did not intend to pre-empt areas of traditional state regulation.").

72. 430 U.S. 290 (1977).

73. *Id.* at 302.

74. 22 U.S. (9 Wheat) 1 (1824).

75. *Id.* at 211; see *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981) (noting that *Gibbons* provides "the underlying rationale of the preemption doctrine"). If, however, Congress has chosen to preempt a field of regulation, that choice itself is a congressional objective. Thus, even state laws that supplement federal regulation within the subject areas addressed by Congress interfere with and are contrary to Congress' intent. See, e.g., *City of Burbank v. Lockheed Air Terminal*, 411 U.S. 624 (1973); *Campbell v. Hussey*, 368 U.S. 297 (1961); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218 (1947); *Transit Comm'n v. United States*, 289 U.S. 121 (1933).

76. The tenth amendment states: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST. amend. X.

77. *Chicago & N.W. Transp. Co.*, 450 U.S. at 317 (quoting *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 243 (1959)).

mine borderline preemption problems that is consistent with the Supreme Court's prior statements on preemption generally. If a state law affects the terms and conditions of employee benefit plans, it "relates to" such plans and should be preempted unless it meets one of the exceptions articulated in ERISA section 514(b)(2)(A).⁷⁸ Congress indicated its intent that with regard to laws that affect the terms and conditions of employee benefit plans, ERISA's goal of promoting the growth of employee benefit plans should override state interests. One could even say that those laws do not present borderline questions.

But if a state law affects employee benefit plans without infringing upon their terms and conditions,⁷⁹ a court should balance the state's interest in the regulation against the statute's effect on employee benefit plans. If the regulation serves an important state interest and the economic and administrative effect on employee benefit plans is insignificant, ERISA should not displace the regulation. If the equities are weighted toward a significant economic effect, preemption is required.⁸⁰ The balancing of interests is nec-

78. See *supra* note 22.

79. The predominant example is a state law that marginally increases the economic costs to operate the plan. See *supra* text accompanying notes 45-49.

80. This analysis is consistent with the approach followed in *AT&T v. Merry*, 592 F.2d 118 (2d Cir. 1979), of which the Supreme Court apparently approved in footnote 21 of *Shaw*, see *supra* text accompanying note 44, and *Gilbert v. Burlington Indus.*, 765 F.2d 320 (2d Cir. 1985). *Merry* was one of a series of cases in which federal courts considered the interplay between ERISA and the power of state courts to regulate domestic relations. In *Merry* the Second Circuit held that ERISA did not preempt state garnishment of a spouse's pension income to enforce alimony and support orders. See also *Savings and Profit Sharing Fund of Sears Employees v. Gago*, 717 F.2d 1038 (7th Cir. 1983); *Operating Engineers' Local 428 Pension Trust Fund v. Zamborsky*, 650 F.2d 196 (9th Cir. 1981) (same facts and holding as *Merry*); *Stone v. Stone*, 632 F.2d 740 (9th Cir. 1980) (upholding state court award to spouse as community property 40% interest in husband's pension payments, and ordering pension fund to make payments directly to spouse). In *Merry* the support payments ordered by the state court "result[ed] in unanticipated increases in pension plan administration costs." 592 F.2d at 125. But the attendant higher administrative costs did not affect the terms and conditions of the pension plan. The Second Circuit held that this effect was remote and peripheral and that Congress did not intend to preempt such state action. The *Merry* court did not weigh the effect of the state action in a vacuum. Instead, it examined that effect in light of a state's strong public policy interest in having spouses fulfill their family obligations. The Second Circuit concluded that the increased pension plan administration costs were inconsequential when balanced against the state's overriding interest in enforcing domestic relations laws. *Id.*

In *Gilbert* participants in a severance benefits plan covered by ERISA sought severance pay, in part based on state wage collection statutes. The Second Circuit conceded that such laws were an important exercise of traditional police powers, but declined to let it mandate the preemption analysis. 765 F.2d at 327. The state statute determined the conditions under which severance benefits would be paid, clearly a term or condition of the plan. The court recognized that such a law did not present a borderline preemption problem; therefore it

essary because even borderline legislation may be a disincentive to the establishment and maintenance of welfare plans. But to preempt any state regulation because it may be a disincentive to the growth of employee welfare plans accords unwarranted deference to a congressional objective. Weighing the state's interest provides a principled method for courts to accommodate statutory objectives without treading on state laws that Congress never intended to preempt.⁸¹

When this analysis is applied to state third party prescription drug program legislation, the conclusion reached is that such legislation should not be displaced. Indeed, these laws present a much easier case than the laws at issue in *Rebaldo*. Unlike the New York Public Health Law, third party prescription drug program regulation does not establish different reimbursement rates for different payors. Private insurance carriers, Blue Cross organizations, and claims administrators that act for self-insured plans all pay the same rate. Thus, the laws do not affect how a welfare plan chooses to fund drug benefits.

Moreover, the increased cost that would be passed on to wel-

was unnecessary to consider the state interest that the statute served. *Id.* Only if the statute affected the plan in "too tenuous or remote . . . a manner," *i.e.*, the statute did not affect plan terms or conditions, would the court consider the importance of the state's interest. *Id.*

81. Antitrust doctrine supports the principle that state action inconsistent with the objectives of federal law may be immune from displacement if Congress never *clearly* intended such action to be preempted. Antitrust laws play an indispensable role in the maintenance of a free economy. *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 348 (1963). Their objective, of course, is to prevent activity that displaces competition. Given the immense importance of the statute, implied immunities are disfavored, and courts have construed exemptions strictly. *E.g.*, *National Gerimedical Hosp. and Gerontology Center v. Blue Cross*, 452 U.S. 378, 388 (1981) (implied immunities); *Abbott Laboratories v. Portland Retail Druggists Ass'n*, 425 U.S. 1, 11 (1976) (exemptions). Nonetheless, the Supreme Court has implied an immunity from antitrust laws for state action, *see Parker v. Brown*, 317 U.S. 341, 350-51 (1943), and has construed the state action immunity broadly. The Court has granted immunity to private parties who are restrained from competitive conduct by state regulation. *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). Moreover, state regulation need not *compel* the anticompetitive conduct; private actions may be protected from the antitrust laws even if the state merely authorized them. *Southern Motor Carriers Rate Conference, Inc. v. United States*, 105 S. Ct. 1721 (1985). Despite the acknowledged importance of antitrust laws in commercial regulation, courts uphold these competitive restraints because federalism principles require antitrust goals to give way to state action if Congress has not indicated unambiguously a contrary result. *Id.* at 1729-30. Similarly, although Congress expressly stated in ERISA that all laws relating to employee benefit plans should be preempted, *see supra* text accompanying notes 29-30, it did not indicate unambiguously that state laws which do not regulate the terms and conditions of plans be preempted. Thus, even if those laws are contrary to ERISA's objectives, federalism principles require that courts weigh the state's interest in deciding whether to displace them.

fare plan sponsors as a result of compliance with third party prescription drug program legislation is insignificant relative to the total annual cost to operate those plans.⁸² Therefore, it is highly unlikely that the economic effect would dissuade sponsors from providing drug benefits or would cause them to cut back on other benefits. The decisions respecting choice of benefits are unaffected. Finally, such legislation affects neither the process by which prescription benefits are provided to plan participants nor rules respecting eligibility. For example, the legislation does not require indemnification of consumers rather than direct payment to the pharmacist. The legislation regulates the relationship between the third party payor and the pharmacist but not the relationship between the third party payor and the consumer-participant.⁸³

Third party prescription drug program legislation serves a compelling state interest. Pharmacists provide essential health care services to the community by filling prescriptions, maintaining patient profiles, and offering drug counseling. They often review the propriety of a prescription before dispensing it to a customer. They also advise customers respecting drug utilization procedures and offer counseling on the interaction between the prescribed drug and other prescription medications, as well as the interaction between prescription medications and over-the-counter medications and foods.⁸⁴ These practices are a cost effective form of health care

82. See *supra* notes 45-48.

83. See *Deiches v. Carpenters' Health & Welfare Fund*, 572 F. Supp. 766, 770 (D.N.J. 1983) (state preferential transfer statute did not affect terms and conditions of plan even though it resulted in plan returning contributions). If a state third party prescription drug program statute contained requirements beyond those generalized in this article, see *supra* note 17, the conclusions expressed above would not change. For example, a statute might require that the third party payor provide program enrollees with detailed information concerning the extent of their coverage under the program. See Third Party Prescription Program Act, New Jersey Senate Committee Substitute for Senate Nos. 793, 1029, 1157 (proposed Jan. 31, 1983) (on file with the *Vanderbilt Law Review*). This requirement would constitute a reporting and disclosure regulation and would add to the reporting and disclosure obligations already imposed by ERISA. But in such instances a court simply should find that this requirement alone "relates to" employee benefit plans and is preempted. The court should enforce the remainder of the statute. The three primary requirements of third party prescription drug program legislation, see *supra* note 17, do not depend on any secondary requirements that a particular legislature may see fit to add to achieve the statute's purpose. Cf. *INS v. Chadha*, 462 U.S. 919, 931-32 (1983) (valid portions of a statute are to be preserved unless it is evident legislature would not have enacted valid provisions independently of the invalid ones). Obviously, there might be additional permissible requirements as well.

84. See generally Godfrey, *What's Ahead for OTC's? Weigh These 5 Predictions*, AM DRUGGIST, Apr. 1982, at 94 ("Second only to safe and effective health products, consumer information is the most important commodity in which [pharmacists] deal."); Dollars and Sense, *supra* note 15, at 13-15.

and frequently reduce the need for more costly physician and hospital visits.⁸⁵

The Supreme Court has recognized that "[s]tates have a compelling interest in the practice of professions within their boundaries."⁸⁶ Implicit in this statement is a recognition that professional services are essential to the public welfare. Because the practice of pharmacy is an integral and cost effective component of the public health care delivery system, it is a calling similar to medicine or dentistry, in which states have a compelling interest.

This compelling interest raises two regulatory concerns: first, that citizens receive quality pharmacy services, and second, that all citizens have access to pharmacy services. In certain rural communities and inner city areas, the only readily accessible outlet for health counseling of any sort is the independent pharmacist.⁸⁷ If third party prescription drug programs continue to go unregulated, the financial solvency of many independent drugstores might be jeopardized. As a result, it might be difficult to obtain needed medication and prescription counseling in many rural and inner city areas.⁸⁸

Furthermore, independent pharmacists are forced to compensate for the losses from third party prescription drug programs by charging higher prices to patient-purchasers not enrolled in the programs.⁸⁹ This cost shifting approach directly affects those patient-purchasers who lack alternative forms of drug insurance coverage. These patient-purchasers tend to be part-time service or retail trade personnel and the non-Medicaid poor.⁹⁰ As a result, these two groups may be priced out of the prescription drug market.

Legislation regulating third party prescription drug programs therefore constitutes state action tailored to meet the important

85. A 1982 Ohio State University study demonstrated that counseling by pharmacists to ensure patient compliance with drug regimens resulted in an acute reduction in further hospital and medical care. The 33 month study revealed an average savings per person of \$2,856 as a result of regular drug counseling. Cable & Schneider, *Experiences with the Compliance Clinic: Assessment of the Effect*, CONTEMP. PHARMACY PRACTICE, Winter 1982, at 34-44; see also *Mossinghoff*, *supra* note 47, at 3. As previously indicated, pharmacy services are also available to a much broader extent than physician services. See *supra* note 15.

86. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 792 (1975).

87. See *supra* note 15.

88. See *Fear and Loathing in Coal Country*, NARD J., Jan. 1985, at 57.

89. See *supra* note 14.

90. Medicaid program enrollees are protected from cost shifting because the government, as payor, sets the pharmacists' compensation levels. See 42 U.S.C.A. §§ 1395u(b)(3), 1395x(v) (West 1983 & Supp. 1985).

state interest of insuring access to health care counseling and prescription drugs for all citizens. It also ensures the continued existence of a very cost effective form of health care delivery.

The economic effect of state regulation of third party prescription drug programs clearly is not sufficiently significant to dictate the terms and conditions of employee welfare plans. Moreover, when viewed in light of the compelling state interest in such regulation, that effect is *de minimis*. Accordingly, courts should find that such legislation falls outside the preemptive reach of section 514(a).

B. Does State Legislation Regulating Third Party Prescription Drug Programs Constitute a Law That Regulates Insurance?

Even if third party prescription drug program legislation were found to "relate to" employee benefit plans, the question still would remain whether the legislation "regulates insurance" and thus falls within the exception of section 514(b)(2)(A).⁹¹ The Supreme Court decision in *Group Life & Health Insurance Co. v. Royal Drug Co.*,⁹² in which the Court examined the relationship of third party prescription drug program agreements to the insurance industry generally, provides a guideline for the analysis.

The Court in *Royal Drug* ruled that third party prescription drug programs were not the "business of insurance" for the purpose of determining whether the programs were exempt from the antitrust laws under the McCarran-Ferguson Act. The McCarran-Ferguson Act exempts the "business of insurance" from the anti-trust laws "to the extent such business is . . . regulated by State law."⁹³ The Court stated that third party prescription drug program agreements were not the "business of insurance" because that term contemplated an arrangement that involved the underwriting and spreading of risk.⁹⁴ Prescription program agreements between pharmacies and insurance companies do not transfer and spread risk but merely are business arrangements undertaken by insurance companies to reduce their costs.⁹⁵

91. Certain of the third party prescription drug program statutes and proposed legislation extend beyond the three areas of regulation discussed earlier. See *supra* note 17. Arguably, these provisions relate to employee benefit plans. See *supra* note 83. If, however, these statutes "regulate insurance," they are exempt from preemption in their entirety.

92. 440 U.S. 205 (1979).

93. 15 U.S.C.A. § 1012(b) (West 1976).

94. 440 U.S. at 211-12.

95. *Id.* at 214.

At first glance, it might appear to be an easy leap from the *Royal Drug* analysis to the conclusion that because third party prescription drug agreements are not the business of insurance for McCarran-Ferguson Act purposes, state regulation of such agreements would not constitute a "State [law] which regulates insurance"⁹⁶ under the language of section 514(b)(2)(A). But upon closer scrutiny such a leap becomes precarious.

First, section 514(b)(2)(A) does not speak of state laws regulating the "business of insurance," but rather, of "any law of any State which regulates insurance." Congress' use of different language in section 514(b)(2)(A) suggests that it contemplated that the phrase "any law of any State which regulates insurance" had a different meaning than state regulation of "the business of insurance."

Moreover, in *Royal Drug* the Supreme Court defined the term "business of insurance" narrowly.⁹⁷ Only transactions containing the traditional elements of an insurance arrangement—risk transferal and spreading—were considered the "business of insurance." It is reasonable to conclude that Congress, in choosing to use different language in section 514(b)(2)(A), intended that the exemption provision apply not only to laws that regulate traditional insurance transactions but also to laws that regulate arrangements that insurance companies regularly enter into when they sell and service an insurance policy. These laws include fee standards for sales agents and brokers⁹⁸ and standards of conduct for advertising.⁹⁹ Third party prescription drug program agreements fit this category because they are a common practice by which health ser-

96. 29 U.S.C.A. § 1144(b)(2)(A) (West 1985).

97. 440 U.S. at 231-33; *see Anglin v. Blue Shield*, 693 F.2d 315, 317 (4th Cir. 1982).

98. *See American Progressive Life & Health Ins. Co. v. Corcoran*, 715 F.2d 784 (2d Cir. 1983) (state insurance regulation that established maximum commissions for life insurance salesmen on sales to union-management pension funds was an insurance law within the meaning of § 514(b)(2)(A)).

99. Courts also have recognized that laws establishing financial and certification requirements for insurance companies, minimum capital and surplus requirements, investment standards, and character standards for management also are laws that regulate insurance within the meaning of ERISA § 514(b)(2)(A). *See Wayne Chem., Inc. v. Columbus Agency Serv. Corp.*, 567 F.2d 692 (7th Cir. 1977); *Bell v. Employee Sec. Benefit Ass'n*, 437 F. Supp. 382, 391-92 (D. Kan. 1977). These laws do not even regulate transactions, let alone transactions involving risk transfer and spreading. Additionally, as with third party prescription drug program legislation, it is doubtful whether these laws even "relate to" employee benefit plans. *See Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380, 2390 (1985).

vice benefits insurers meet their service obligations to covered employees.¹⁰⁰

Royal Drug actually offers a persuasive argument that state regulation of third party prescription drug programs does constitute state regulation of insurance. In *Royal Drug* the Supreme Court focused on what it termed "the secondary purpose" of McCarran-Ferguson: the exemption from antitrust regulation that Congress gave to state regulation of the "business of insurance."¹⁰¹ The Court stated in dicta that "[t]he primary purpose of the McCarran-Ferguson Act was to preserve state regulation of the activities of insurance companies" from constitutional attack under the commerce clause.¹⁰² Moreover, the Court acknowledged that the activities of insurance companies were broader than merely the business of insurance.¹⁰³ Thus, states are constitutionally free to regulate the activities of insurance companies, and the scope of this freedom is broader than merely regulation of traditional insurance transactions; states may regulate all activities in which insurance companies regularly engage. Third party prescription drug program agreements are one such activity.

"[I]nsurance is an evolving institution."¹⁰⁴ The regular practices and activities of insurance companies often change. It is not unlikely that when Congress used the language "state regulation of insurance" in ERISA's exceptions clause, rather than "regulation of the business of insurance," Congress intended the scope of the exception to track the scope of a state's constitutional freedom to regulate the typical activities undertaken by insurance companies in their capacity as insurers. Congress did not seek to freeze the concept of insurance regulation into the mold it cast when it carved out the antitrust exemption with the McCarran-Ferguson Act.¹⁰⁵

100. *Royal Drug*, 440 U.S. at 246 (Brennan, J., dissenting). It is wrong to argue that third party prescription drug program statutes are not laws regulating insurance but laws regulating pharmacies. Although the beneficiaries of such laws are pharmacists, the laws regulate the conduct of insurance companies, not the conduct of pharmacists. See *Metropolitan*, 105 S. Ct. at 2389-93; see also *infra* text accompanying notes 115-21.

101. 440 U.S. at 218 n.18. This exemption is found in § 2(b) of the McCarran-Ferguson Act. 15 U.S.C. § 1012(b) (1982); see *supra* text accompanying note 93.

102. 440 U.S. at 218 n.18 (emphasis added). This primary purpose is reflected in the language of §§ 1 and 2(a) of the Act. 15 U.S.C. §§ 1011, 1012(a) (1982).

103. 440 U.S. at 218 n.18.

104. SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65, 71 (1959); see also Denenberg, *The Legal Definition of Insurance: Insurance Principles in Practice*, 30 J. INS. 319, 322 & n.15, 327 & n.38, 342 (1963).

105. Although several courts have construed ERISA § 514(b)(2)(A) and § 2(b) of Mc-

The few rays of light that ERISA's legislative history sheds on the insurance exception are consistent with this interpretation. Unlike the general preemption rule, the language of the insurance exception remained constant throughout the consideration of ERISA and was included among the earliest of the many bills that led to the passage of ERISA.¹⁰⁶

The so-called "deemer" clause,¹⁰⁷ which limits the insurance exception, states that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts."¹⁰⁸ This language contemplates that a business concern can act as an insurance company or insurer without being in the business of insurance. Any other interpretation would deprive the words of the subsection of independent meaning.¹⁰⁹ Consequently, in order for the "deemer" clause to limit the insurance exception, that exception should be read to include not only traditional insurance transactions, that is, the business of insurance, but also state regulation of common business practices of insurance companies.

The deemer clause appeared much later in the legislative process, as part of the version of ERISA that went to conference after House approval.¹¹⁰ In conference there was a disagreement among congressional staff members over whether to retain the provi-

Carran-Ferguson *in pari materia*, see *Rebaldo v. Cuomo*, No. 83-8707, slip op. at 18 (S.D.N.Y. Mar. 13, 1984) (available on LEXIS), *rev'd on other grounds*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 105 S.Ct. 2702 (1985); *McLaughlin v. Connecticut Gen. Life Ins. Co.*, 565 F. Supp. 434, 445 (N.D. Cal. 1983); *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162, 1168 (C.D. Cal. 1980), these holdings are suspect. The *McLaughlin* court did so without analysis. The courts in *Rebaldo* and *Eversole* based their rulings on the view that both provisions served the same policy: state primacy in the regulation of insurance. But the provision of *McCarran-Ferguson* at issue in *Royal Drug*, § 2(b), was not the one that reaffirmed that primacy. Section 1 reaffirms that primacy, and as Justice Stewart noted in footnote 18 of his majority opinion, § 1 embraces more activities than the term "business of insurance" as it is used in § 2(b).

106. For example, the insurance clause appeared in its current form in the following early pension and welfare reform bills: S. 4, 93d Cong., 1st Sess. § 609(a)(2) (1973); H.R. 2, 93d Cong., 1st Sess. § 114 (1973); S. 2, 92d Cong., 1st Sess. § 507 (1971); H.R. 1269, 92d Cong., 1st Sess. § 114 (1971); S. 3589, 91st Cong., 2d Sess. § 14 (1970); H.R. 16462, 91st Cong., 2d Sess. § 18 (1970).

107. See *supra* note 34.

108. ERISA § 514(b)(2)(B), 29 U.S.C.A. § 1144(b)(2)(B) (West 1985); see *supra* note 34.

109. See *United States v. Menasche*, 348 U.S. 528, 538-39 (1955) (quoting *Montclair v. Ramsdell*, 107 U.S. 147, 152 (1882) (a statute should be construed "to give effect . . . to every clause and word")).

110. The Senate bill that went to conference had no comparable provision.

sion.¹¹¹ As a result of the conferees' decision to expand the scope of the general preemption rule, Congress retained the deemer clause. The rationale was that the clause would prevent states from regulating the terms and conditions of employee benefit plans simply by denominating the plans as insurers, insurance companies, or banks or trust companies.¹¹² This fear would not have been legitimate had the intended scope of the insurance exception been limited to the narrow McCarran-Ferguson antitrust concept of regulation of the business of insurance.

This view of the insurance saving clause is consistent with the Supreme Court's recent construction of the clause in *Metropolitan Life Insurance Co. v. Massachusetts*.¹¹³ *Metropolitan* was the Court's first attempt to construe section 514(b)(2)(A). The issue in *Metropolitan* was the propriety of mandated-benefit laws, state laws that required insurance companies to provide certain types of benefits in insurance policies.¹¹⁴

The appellant in *Metropolitan* advocated a narrow interpretation of the clause. *Metropolitan* argued that because the intent of the law at issue was to expand the availability of mental health care in Massachusetts, it was not an insurance regulation but "in

111. See SUMMARY OF DIFFERENCES BETWEEN THE SENATE VERSION AND THE HOUSE VERSION OF H.R. 2 TO PROVIDE FOR PENSION REFORM pt. 3, at 32 (Comm. Print 1974).

112. See ACTIVITY REPORT OF THE COMM. ON EDUCATION AND LABOR, H.R. REP. NO. 1785, 94th Cong., 2d Sess. 47 (1977) (post legislative history); Comment, *ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws*, 78 COLUM. L. REV. 1536, 1540 (1978) ("deemer" clause "aimed solely at preventing states from regulating employee welfare plans by calling them insurers and taking advantage of the [insurance] exemption").

113. 105 S. Ct. 2380 (1985).

114. The specific law under consideration was a Massachusetts statute that required mental health care benefits to be provided to each Massachusetts resident insured under a general health insurance policy. The Commonwealth of Massachusetts conceded that its law "related to" employee benefit plans within the meaning of § 514(a) because it dictated to those welfare plans that funded benefits through insurance policies what forms of coverage they could provide. The Commonwealth, however, argued that the law was not preempted because it was a law "which regulates insurance." In 1982 the Massachusetts Supreme Judicial Court upheld the law against an ERISA preemption challenge, *Attorney Gen. v. The Travelers Ins. Co.*, 385 Mass. 598, 433 N.E.2d 1223 (1982), but the Supreme Court vacated that decision and remanded for further consideration in light of *Shaw v. Delta Air Lines*. See *Metropolitan Life Ins. Co. v. Massachusetts*, 103 S. Ct. 3563 (1983). On remand, the Massachusetts Supreme Judicial Court affirmed its earlier ruling. The court interpreted the purpose of the insurance exception as saving from preemption those insurance laws that did not conflict with the substantive regulatory provisions of ERISA. Because ERISA's substantive regulation of welfare plans was limited to reporting, disclosure, and fiduciary conduct, and did not prescribe the "substantive contents" of plans, the court concluded that the mandated-benefits law was not preempted. 391 Mass. 730, 463 N.E.2d 548 (1984), *aff'd on other grounds*, 105 S. Ct. 2380 (1985).

reality a health law that merely operate[d] on insurance contracts to accomplish its end."¹¹⁵ Metropolitan sought to limit the insurance exception to "state laws designed to protect the insurance purchaser from improper or imprudent conduct by the insurance company."¹¹⁶

The Supreme Court rejected this view. As it had in *Shaw*, the Court adopted a literalistic interpretation, using common sense perceptions about the scope of the statutory language. The simple and general nature of that language required a broad construction.¹¹⁷ The Court noted that the Massachusetts law regulated the terms of certain insurance policies and that everyday "common-sense" dictated that a law that regulated insurance policies was a law "which regulates insurance."¹¹⁸ Accordingly, the law fell within the exception.¹¹⁹

Furthermore, the Court found that mandated-benefit statutes regulated the "business of insurance" as that term was used in section 2(b) of the McCarran-Ferguson Act and that ERISA's insurance saving clause clearly embraced such laws. Importantly, the Court also observed that ERISA's insurance saving clause was *in pari materia* with the broad "primary concern" of the McCarran-Ferguson Act as expressed in that Act's sections 1 and 2(a), which provided states with broad "free[dom] to regulate [the activities of] insurance companies without fear of Commerce Clause attack."¹²⁰ This freedom embraces state regulation of third party prescription drug program agreements. The Court in *Metropolitan* noted that ERISA's "saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to

115. Brief for Appellant at 34-35, *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380 (1985); Reply Brief for Appellant at 3.

116. Brief for Appellant at 34. These buyer protection laws, which the appellant dubbed the "traditional area . . . of state insurance regulation," included minimum capital and surplus restrictions, investment standard restrictions, and character standards for insurance company management. *Id.* at 34-35.

117. The Court found nothing in the scant legislative history of the insurance saving clause to require anything other than a construction based on plain meaning. *Metropolitan*, 105 S. Ct. at 2392.

118. *Id.* at 2388-89.

119. The Court held that the language of the "deemer" clause supported this plain meaning construction. The Court reasoned that "[u]nless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans." *Metropolitan*, 105 S. Ct. at 2390.

120. *Royal Drug*, 440 U.S. at 217-18 & n.18; see also *supra* text accompanying notes 101-05.

define what is left to the States."¹²¹

Thus, for purposes of ERISA section 514(b)(2)(A), insurance regulation neither excludes nor is limited to state regulation of the business of insurance as defined for purposes of the antitrust exemption. If a state law regulates the conduct of insurance companies with respect to activities they perform in their capacity as insurers, the law should be considered one "which regulates insurance."¹²² This statement is the plain meaning rule that emerges from *Metropolitan*. To otherwise narrow the insurance saving clause would be contrary to a common sense view of the meaning of the statutory language.¹²³ State third party prescription drug program legislation regulates activities typically and primarily undertaken by insurance companies as part of servicing an assumed risk. Accordingly, common sense indicates that such legislation "regulates insurance."

State laws that regulate prescription drug programs serving participants of self-insured welfare plans, however, are *not* laws that "regulate insurance." Although third party prescription drug programs may be a necessary insurance practice when an insurance company or Blue Cross organization executes a policy to an employee welfare plan and assumes the risk of the cost to provide drug benefits,¹²⁴ not all welfare plans are funded through insurance. Welfare plans are also self-insured. Typically, in such situations an insurance company nonetheless will contract with pharmacists, not to meet the obligations it has insured but to fulfill its duties as an administrator hired by the plan to operate the plan's drug benefits program. The insurance company is not acting to cut its risks but functions strictly as a claims processor. Moreover, a

121. 105 S. Ct. at 2392 n.21. The Supreme Court further implied that ERISA § 514(d) would be contravened if ERISA's insurance saving clause were not read consistently with the broad power reserved to the states in *McCarran-Ferguson*. See *id.* That section, 29 U.S.C.A. § 1144(d), provides in pertinent part that ERISA "shall [not] be construed to alter, amend, . . . impair, or supersede any law of the United States." A narrow reading of the insurance saving clause would reduce the states' power to regulate insurance companies expressly granted under federal law and therefore would alter or amend that law.

122. See *Dedeaux v. Pilot Life Ins. Co.*, 6 Empl. Ben. Cas. (BNA) 2345 (5th Cir. Sept. 16, 1985) (finding insurance exception saves state law causes of action for nonpayment of insurance benefits).

123. On the other hand, regulation of activities in which insurance companies and other entities regularly engage should not be construed as insurance regulation. Insurance companies often pay rent for office space, but it would be illogical to conclude that state rental laws regulate insurance, because the vast majority of entities embraced by the scope of such laws are not insurance companies.

124. See *supra* text accompanying notes 97-100.

self-insured welfare plan itself may administer the drug program or employ a company that does not sell insurance to do so. Indeed, a third party program administrator may engage exclusively in claims processing. Claims processing perhaps is an activity endemic to the field of insurance even when the processor has not insured the risk. But when a party executes a prescription drug program agreement on that basis, he is not protecting an assumed risk and therefore is not functioning as an "insurance company or other insurer."¹²⁵ State laws that regulate these forms of third party programs do not regulate the activities of insurance companies and are not "insurance regulation." Accordingly, the insurance saving clause of ERISA does not necessarily reach all parties regulated by third party prescription drug program statutes.¹²⁶

C. Does the "Deemer" Clause Apply?

If third party prescription drug program legislation does constitute an insurance law for ERISA purposes, the remaining question is whether the "deemer" clause applies. If a state law that "relates to" employee benefit plans regulates insurance within the meaning of section 514(b)(2)(A) of ERISA, it is exempted from preemption. If that state law, however, is so constructed that it treats an employee benefit plan as, or "deems" it to be, an insurance company, or insurer, or in the business of insurance, then the insurance law exception does not apply and the law is preempted.

This issue is not complicated. Third party prescription drug program statutes regulate the activity of the party that contracts with the pharmacist-provider. Such statutes fall within the insurance saving clause to the extent they apply to programs executed by insurance companies or Blue Cross organizations in conjunction with an assumption of risk. Thus, with respect to such programs the statutes regulate the activity of insurance companies. Employee welfare plans are not parties to such programs, nor are they third party beneficiaries. They are affected indirectly and insubstantially by such programs. Since such legislation does not regu-

125. ERISA § 514(b)(2)(B), 29 U.S.C.A. § 1144(b)(2)(B) (West 1985) (the "deemer" clause).

126. Nevertheless, as argued earlier, a court need not even reach the question whether third party prescription drug program statutes constitute insurance laws, because they do not "relate to" employee benefit plans within the meaning of § 514(a). See *supra* text accompanying notes 35-90.

late employee welfare plans directly, the "deemer" clause should not apply.¹²⁷

D. Blue Cross and Blue Shield v. Peacock's Apothecary, Inc.

*Blue Cross and Blue Shield v. Peacock's Apothecary, Inc.*¹²⁸ is the only reported case to address whether ERISA preempts third party prescription drug program statutes. The court found that ERISA preempted Alabama's Third Party Prescription Program Act.¹²⁹ But the decision was poorly reasoned and was wrongly decided.

Blue Cross and Blue Shield of Alabama (Blue Cross) had entered into third party prescription drug programs with numerous Alabama pharmacies to provide prescription drug benefits to the participants and beneficiaries of fifty-one employee welfare plans.¹³⁰ The court found that the Blue Cross provider agreements themselves "clearly [were] part and parcel of ERISA 'employee benefit plans.'"¹³¹ This finding easily led to the conclusion that the agreements "related to" employee benefit plans.

The Pharmacy Act precludes employers and employees from structuring employee benefit plans that include third party prescription programs which call for reimbursement rates that "are less than the usual and customary rates paid by consumers not covered by a third party plan." Although the Act directly regulates the agreements and relationships between insurers and pharmacies, it effectively regulates what employers and employees can and cannot include in employee benefit plans. . . . Accordingly, the Act "relate[s] to" these plans and the Act is due to be preempted unless the Act fits within one of the exemptions listed in § 514.¹³²

127. See *Wayne Chem., Inc. v. Columbus Agency Serv. Corp.*, 567 F.2d 692, 699-700 (7th Cir. 1977); *Wadsworth v. Whaland*, 562 F.2d 70, 77-78 (1st Cir. 1977) (insurance laws—laws directed toward insurance companies—that also indirectly affect employee welfare plans do not violate "deemer" clause), *cert. denied*, 435 U.S. 980 (1978); *Employees Ass'n of New Jersey v. New Jersey*, 601 F. Supp. 232, 240 (D.N.J. 1985) (law that by its terms regulates insurers and has "at most indirect effects on the cost of insurance charged to employers purchasing benefits for employees" does not violate "deemer" clause).

128. 567 F. Supp. 1258 (N.D. Ala. 1983).

129. ALA. CODE §§ 34-23-110 to -118 (Supp. 1982). The Act contained the three primary features of prescription drug program legislation defined *supra* note 17.

130. *Peacock's Apothecary*, 567 F. Supp. at 1261-63. Although the opinion is unclear, apparently Blue Cross did not insure those benefits, but acted only as a claims processor, thereby suggesting that the plans were self-insured. *Id.* at 1261. Perhaps this is why the statute's proponents apparently did not argue that the Alabama Act was an insurance law.

131. *Id.* at 1267.

132. *Id.* at 1276 (citation omitted). The defendants did argue that the statute satisfied the criminal law exception of ERISA § 514(b)(4), 29 U.S.C.A. § 1144(b)(4) (West 1985). The Alabama statute established criminal penalties for violation of its provisions, but the court properly ruled that the penalty provision did not render the Act a "generally applicable criminal law." 567 F. Supp. at 1276. As a result, ERISA's preemption exceptions did not

The court's underlying premise concerning third party prescription drug programs was wrong. To view third party programs as part of employee welfare benefit plans misconstrues ERISA's definition of a welfare plan.¹³³ That definition focuses on two groups, employers or employee organizations and employees and their beneficiaries, and their relationship with respect to the provision of certain specified benefits. "[T]he intended benefits, [the particular] class of beneficiaries, the source of financing, and [the] procedures for receiving benefits" constitute the elements of an employee welfare plan.¹³⁴ If two outside parties execute a contract that effectuates the agreed-upon or offered benefits of a welfare plan, yet does not set forth any plan elements, the contract is separate from the plan. It is not a part of the plan's terms and conditions. This conclusion remains unchanged even if an agreement between an employer and its employees that does detail plan elements were to refer to such a contract or incorporate it by reference.

Thus, the court in *Peacock's Apothecary, Inc.* was wrong to hold that Blue Cross' provider agreements were part of the fifty-one benefit plans Blue Cross served. The conclusions that emanate from the court's decision are wrong. The *Peacock* decision predates *Metropolitan* and *Rebaldo* and fails to address the true issues involved in the question of the application of ERISA to state laws regulating third party prescription drug programs.

III. CONCLUSION

After *Shaw*, it is apparent that not necessarily every law that has an effect on employee benefit plans "relates to" them and is generally preempted by ERISA. Third party prescription drug program statutes present what *Shaw* termed a borderline preemption question. The guidelines suggested in this Article to resolve these questions demonstrate that such legislation does not violate the general preemption rule of ERISA section 514(a). Furthermore, based on *Metropolitan*, state regulation of third party prescription drug programs, to the extent they apply to agreements executed by insurance companies that have assumed an obligation to fund drug

apply and the statute was displaced. See *supra* note 32.

133. ERISA § 3(1), 29 U.S.C.A. § 1002(1); see *supra* note 30 (reproducing language of § 3(1)).

134. *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1983). In turn, the specific details concerning these elements constitute the terms and conditions of the plan. See *supra* note 68.

benefits, also should be upheld on the independent ground that such laws regulate insurance. The field of insurance is broad, and the intent of section 514(b)(2), as expressed by its language, was to preserve the sovereignty of the states to legislate anywhere within the parameters of that field.

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