

# THE LEGALITY OF NONINSURED EMPLOYEE BENEFIT PROGRAMS

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In 1962, one of the nation's leading insurers filed for approval in Illinois a form under which its client, a major farm implement company, would itself be liable for the initial costs of its employee medical benefits program.<sup>1</sup> Under the plan, the liability of the insurance carrier was retained through a provision which obligated the carrier after claims payments by the employer reached a predetermined dollar level. The Illinois Commissioner of Insurance approved this application; but he did so only after announcing that no future approval would be forthcoming until a further study of such plans was conducted. He explained that inauguration of such a program might place a company in violation of state laws requiring the licensing of insurers. Thus was added a wholly new dimension to be considered in the debate over noninsured employee benefit plans.

## OBJECTIVE OF NONINSURED PLANS

The magnitude of employee benefit programs, especially in terms of cost and personnel relations, necessarily has made the choice of how they are to be structured one for top-level decision-making. In response to the past several years' squeeze on corporate profits, there has been a great deal of re-thinking with respect to corporate insurance programming.<sup>2</sup> Recent years have witnessed a substantial trend toward noninsured plans of varying kinds, with a number of the nation's largest enterprises having made the decision to conduct their programs on their own. The principal lure is savings—the hope that by eliminating certain of the “non-claims” costs, the total price tag on employee benefits can be reduced or contained.

Converting to noninsurance means the partial or complete elimination of the insurance carrier. The term “noninsurance” is used here in place of the more frequent characterization of “self-insurance”, which strictly speaking is incorrectly used when employed in the context of

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<sup>1</sup> Future of Private Insurance in Big Group Cases Tied to Tax Bill in Next N.Y. Legislature, *The National Underwriter*, Aug. 10, 1963, p. 1, col. 1. The *National Underwriter* news item referred to dealt with an instance where a company undertook to be responsible for the major part of its employee benefits, with the insurer assuming responsibility for what might be termed excess coverage. The legal principles discussed in this paper are equally applicable to a situation where an employer assumes total responsibility for payments under its employee benefit programs, with no part being taken by a commercial carrier.

<sup>2</sup> *Going It Alone With Self-Insurance*, *Bus. Week*, July 6, 1963, p. 94.

employee benefit programs. A company may "self-insure" its fire and liability risks, but it does not "self-insure" its employees' health and accident risks.

A decision to become noninsured on employee benefit programs is not easily made. The considerations are not always the same from company to company,<sup>1</sup> or from benefit to benefit. Size and distribution of company plants and offices, for example, are important factors. Without a sufficient number of employees among whom to spread the risk, noninsurance is often not practicable, and if the company's plants and offices are widely scattered, the problems of servicing claims may become so burdensome and expensive as to rule out the probability of any savings. Also important is the nature of the business activity, for this relates directly to the problems of adequate risk selection and control. History, too, has its influence, for certain benefits, such as medical coverages, have more traditionally been insured, whereas sick pay and pension plans, on the other hand, probably because treated as salary continuance, in many companies have never been funded through insurance.

#### POINTS TO CONSIDER

Before any company, regardless of size or activity, takes the step of becoming noninsured, an examination of how it has been spending its premium dollar should be undertaken. The principal disposition of the premium dollar is, of course, claims payment. But the pie is sliced into other pieces, too. Typically, that portion of the premium dollar not utilized for claims payment is divided among:

- (a) Commissions.
- (b) Administrative costs—overhead, actuarial, accounting, printing, etc.
- (c) Reserves, among others, to cover major catastrophies.
- (d) State premium taxes.

Dollars used to pay these costs are referred to as "retained dollars", or in the aggregate as the "retention portion" of each year's premium bill.<sup>8</sup> It is obvious that if noninsurance is to serve the objective of cost reduction, the savings must come from one or several of these groups.

The amount of each cost group will not be the same in every case, for many variables affect each company's final computation. For example, state premium taxes vary, and so do the demands which policyholders make on the administrative services of an insurer. Similarly,

<sup>8</sup> Dollars retained for reserves are, of course, recoverable in case of the occurrence of the events for which the reserves are created. In many cases, as a practical matter, the reserve amount will never be returned, and in any case the use value of the money is lost.

## *NONINSURED EMPLOYEE BENEFIT PROGRAMS*

the proportionate alignment between the categories differs from case to case, as for example, in the case of a smaller company where the premium tax charge is likely to be less significant in the total cost pattern than is the administration charge. The opposite may be true for a big account.

Despite the inherent individuality of each company's needs, one thing is certain; namely, that large sums of money are involved. It is not at all unusual for the retention figure of a sizable account to run well in excess of a quarter or even a half million dollars.

A company cannot, however, in one great swoop, end all of these costs by going noninsured. A great many valuable services are purchased with these dollars, and noninsurance does not automatically dispense with the need for them. Even with a company long experienced in handling internally many of the details of administering its employee benefit programs, professional services of numerous kinds are inevitably required and must be purchased somewhere. These services fall generally into several reasonably definable groups, including:

- (a) Actuarial.
- (b) Professional administrative.
- (c) Claims control.

The value of these cannot be considered lightly. Actuarial counsel is needed, among other things, to develop the basic document or policy establishing the benefit program. Thereafter, actuaries are used to monitor the plan, particularly to spot developments affecting cost. And, if a program involves share-the-cost principles—as frequently they do—the services of actuaries are needed in determining the amount of employee contributions.

Administration is a major cost item, too. Many details may, of course, be handled by the company, even where the program is insured. But the professional services used in administering a plan are the ones that are important in terms of cost and effect upon operation. Where claims determination and administration is company-conducted, some observers feel that there is an increased possibility that subjective rather than objective standards will tend to allow such costs to rise. The development of objective claims criteria depends on the widest possible sources of information. For this reason, the more comprehensive fact-gathering machinery of an insurer or independent counsel is likely to be more effective than anything a single company is apt to develop internally.

Part of the program of claims cost control is that of maintaining a ceiling for medical fees and costs. Here the services of insurance carriers or other professional administrators will probably be very valuable, since the normal corporate posture is not designed to maximize opportunities for contact with the medical world. Large insurers, es-

pecially, are well equipped to send representatives into the field to deal properly with negotiations and even abuses in claims costs by employees, hospitals or doctors.

Closely related here is the important point that an insurer is often a very useful buffer between a company and its employees. Claims which are disputed usually appear in a conflict in which the carrier, not the employer, is on the other side. And it is doubtless a fact of employee psychology that a worker is more satisfied with the check of an insurer than with one from the boss. Some risk managers even feel that this attitude bears directly on the accident experience of their companies and that is an item of no little importance.

The above represent the traditionally significant factors to be considered in weighing the pros and cons of noninsurance. Being non-insured does not require development of internal facilities to manage the entire creation and handling of the program. Such services are available from a number of independent counsel, which, without being insurers, specialize in selling expertise of this kind. The point is that inevitably the money must be expended. The relative costs of the source—insurer or independent counsel—is a debate this writer prefers to avoid.

#### THE TAX COST

One cost which definitely can be eliminated via the noninsured route is the tax on premiums paid to the carriers. It is not unusual for a corporation spending six to eight million dollars annually in premiums on its health and accident insurance to pay out in excess of \$125,000 just to cover the premium taxes imposed on the carriers, who, in turn, pass the assessment along to their clients. This figure will go up or down, depending on many factors such as the types and extent of benefits given, the number of employees and the tax rate imposed by the state or states in which an employer has most of its personnel.<sup>4</sup> On the average, however, a company may expect that something in excess of two per cent of its premium dollar will go to pay the premium tax, and in most large employer cases, this will be the biggest single item in the retained dollar figure. As much as any other single factor, this potential saving has served to whet the appetite for noninsurance.

The American insurance industry is watching closely developments in this field. Many big group-writing carriers see as a contributing cause to the increasing use of noninsured programs not only the interest of their customers in dollar savings, but also what in the eyes

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<sup>4</sup> The rates vary from state to state, and in some instances (e.g., Arkansas and Florida) a tax is imposed on out-of-state carriers only. The general average of premium tax rates is fractionally in excess of 2%, with the highest rate being in Oklahoma, where it is 4% and applicable to out-of-state carriers only.

## NONINSURED EMPLOYEE BENEFIT PROGRAMS

of many is an inequitable and unfair treatment of the so-called commercial carriers as distinguished from the Blue Cross, Blue Shield and other "service" companies. In almost every state "the Blues" are subject either to no premium tax at all or to one which is substantially less in amount than that imposed on their competitors, the commercial carriers.<sup>5</sup> This disparity in tax treatment, it is argued, is a major factor in the competition for employee benefit coverages.

As a result, commercial carriers have begun a long anticipated struggle for what they regard as equitable tax treatment. Failing a change in tax laws,<sup>6</sup> the concept of noninsured employee benefit programs offers a partial solution to the competitive handicap currently imposed on them by the tax laws. Since an increasing amount of group insurance is being written on a "cost-plus" basis, the concept of non-insured plans offers to the commercial carrier the opportunity to market its highly skilled and professional services, while writing only excess coverage or no coverage at all. By employing high deductible or excess coverage principles, a program can be formulated whereby the dollar flow from client to carrier, on which is based the premium tax, is reduced, although the profit enjoyment of the carrier and the predictable ultimate liability of the company are not affected. Any tax-caused cost discrepancy between contracts offered by "the Blues" and those of other carriers is narrowed and the long-standing complaints of the commercial carrier are minimized.

Paradoxically, such a program may only be a stopping point on the way to total noninsurance. As a cure, therefore, to the unfavorable competitive posture of group welfare carriers, it is only second best to the general tax relief being sought.

### LEGALITY OF NONINSURANCE

It was just such a program which gave rise to the Illinois Commissioner's ruling referred to at the opening of this article. Almost always, the debate over the merits of noninsurance has been waged in economic terms. The legal issue is whether a noninsured program, whether under some form of high deductible contract or on a 100% basis, constitutes insurance and therefore places a company conducting it in violation of state laws requiring the licensing of insurers.

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<sup>5</sup> Only six states levy a premium tax on Blue Cross and Blue Shield. All states impose a tax on out-of-state carriers, and about  $\frac{3}{4}$  of the states impose a tax on domestic insurers.

<sup>6</sup> During 1962, bills were introduced into the legislatures of several key states for the purpose of achieving an adjustment in tax treatment of so-called commercial carriers with "service" organizations. The bills were not all identical, but their common objective is tax relief. See New York Senate Bill No. 3495, Massachusetts House Bill No. 1588, Missouri House Bills Nos. 462, 463 and Pennsylvania House Bill No. 1315. Similar legislation was introduced and passed in Washington. Wash. Rev. Code Ann. ch. 166 (1963).

It may seem strange to state that a noninsured plan may cause a company to be in violation of insurance laws, particularly in view of the long-standing existence of noninsured programs, especially in the pension area.<sup>7</sup> The noninsured concept is not new. What is new is the recent activity of state insurance agencies indicating that they regard such plans as illegal unless brought within the range of their control through the licensing of the company carrying on the plan. As a matter of law, however, no court has ever ruled on the precise question of whether noninsured employee benefit plans are within the scope of regulatory insurance laws. In view of the urgency of the problem, a close look at the law, to the extent it exists, is merited.

#### STATE STATUTES

The very laws which require the licensing of insurers often do not themselves define the term "insurance", and therefore fail to set out a legislative yardstick by which borderline activities may be measured. All states have laws regulating insurers, but in more than half of them one will search in vain for a definition of "insurance" or "insurer." Some definitions are broad enough to include such common occurrences as guarantees or endorsements,<sup>8</sup> but nowhere is there a decision that either of these constitutes insurance. Courts, too, have long acknowledged difficulty in giving meaning to the term.

A good description of insurance, taken from statutes and judicial decisions, would include five basic ingredients. These are:<sup>9</sup>

<sup>7</sup> A Fund For The Republic study recently observed that in 1957, 13.2 million of 17.7 million employees covered by pension plans were under noninsured plans. Tilove, *Pension Funds and Economic Freedom* (1959).

<sup>8</sup> E.g., Cal. Ins. Code § 22, which reads: "Insurance is a contract whereby one undertakes to indemnify against loss, damage, or liability arising from a contingent or unknown event." See also Ky. Rev. Stat. § 304.002 (1958).

<sup>9</sup> Cf. N.Y. Ins. Law § 41. The New York statutory definition is the most explicit and detailed among American states, and the elements set out here in the text are embodied in its provisions. Cf. also, *Commonwealth v. Vrooman*, 164 Pa. 306, 30 Atl. 217 (1894), where it is said that:

The conditions necessary to the business of insurance are: (a) The existence of a known danger to which all property owners are exposed, and against which they cannot effectually protect themselves; (b) the strong probability that loss from this danger will fall upon but few of those who are exposed to it; (c) the certainty that when the loss happens it will fall so heavily on those to whom it comes as to make pecuniary indemnity a matter of great importance; (d) some knowledge of the relative value of the property annually destroyed by fire to serve as a basis for calculating the risk assumed by the insurer, and the amount of the premium required to enable the insurer to meet losses and expenses and secure a fair return for the capital employed.

*Commonwealth v. Vrooman*, *supra* at 318, 30 Atl. at 219.

The penalties vary according to state laws. E.g., in Missouri, Mo. Rev. Stat. § 375.310, a fine of \$250 is provided for each violation. "Each violation" is not defined, but presumably could be interpreted to include each contractual commitment to each employee. N.Y. Ins. Law § 112(5) provides that any person or corporation acting for an unlicensed insurer shall forfeit \$500 for the "first offense," and an additional \$500 for each month during which such party continued to act in violation of the section.

## NONINSURED EMPLOYEE BENEFIT PROGRAMS

- (a) consideration (premium),
- (b) fortuitous event,
- (c) a group of people with identical interests more or less equally exposed to the same risks,
- (d) a shifting of that risk to the insurer and
- (e) a distribution of the risk to others similarly exposed.

If nothing more is done than to try to fit the terms of most noninsured employee benefit plans into this five-part definition, it is readily perceived that they involve engaging in insurance. This is especially true if the employees contribute to the plan. A group medical plan for which employees pay part of the cost, for example, transfers to the employer each employee's risk of loss due to certain stipulated events which are largely beyond control, and to which each employee in the group is, in general, equally exposed. In turn, the employer may be said to distribute this risk to all employees, who assume their proportionate share of the risk in the form of contributions (premiums) paid into the plan.

But does it necessarily follow that if a given program satisfies each of the conditions of a legislative or judicial description of the term, that this of itself should be decisive?

### JUDICIAL TESTS

A look at other areas in which courts have spoken demonstrates in general a negative response to the inquiry. Cases which have carefully discussed the meaning of insurance invariably proceed from the sometimes unstated inquiry, "Why is the question being asked?" The inquiry is appropriate, for the traditional apologia for insurance regulation is that the public is in need of government protection to insure performance when it is due.<sup>10</sup> As stated in one case, regulation is to protect "the public from surrendering its money in exchange for questionable or worthless pieces of paper denominated insurance policies."<sup>11</sup>

Essentially, there are two tests used by courts in assessing the validity of transactions alleged to be insurance. One, which may be

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<sup>10</sup> The security of policy holders requires, first, permanency in the custodian of the funds gathered from them, and on which their indemnity in case of loss depends; second, an honest and competent administration of these funds; third, restraint against the division of the profits of the business whenever such division would injuriously affect the security of policy holders.

*Commonwealth v. Vrooman*, *supra* note 9, at 318, 30 Atl. at 219.

<sup>11</sup> *State ex rel. Herbert v. Standard Oil Co.*, 138 Ohio St. 376, 381, 35 N.E.2d 437, 440 (1941). This case involved litigation over a warranty on the quality of tires. In discussing the *raison d'être* for government regulation of insurance, the court said: "Laws regulating and supervising those engaged in the business of insurance were enacted chiefly in the interest of the people to make it as certain as possible that the fund created by their contributions would be held, managed and disbursed in a prudent and proper manner." *State ex rel. Herbert v. Standard Oil Co.*, *supra* at 381, 35 N.E.2d at 440.

denominated the control test, focuses upon the ability of the alleged insurer effectively to regulate the happening of the insured event, thus eliminating the element of fortuity.<sup>12</sup> There is little or nothing in the body of cases applying the control test which is helpful in defending noninsured employee benefit programs against attack by state insurance commissioners. Death, illness and injury caused by accident—all traditional subjects of employee benefit plans—are by definition events of destiny and not design.

The second test, the primary purpose test, questions the need for bringing a given set of facts within the ambit of state regulation by focusing on the objectives of the challenged transaction.<sup>13</sup> As such, it moves beyond the more or less formalistic control analysis, and because of this, lacks the precision and predictability many wish to see in rules of law. Using this approach, a substantially persuasive argument can be made in favor of the validity of noninsured employee benefit programs outside the scope of state regulation.

First, of course, is the proposition that programs of this kind are nothing more than incidents of the employment contract by which an employer hopes to get better services from its employees.<sup>14</sup> They are a form of compensation. As one court has said of a company-operated contributory retirement plan, it was merely "one aspect of the company's employer-employee relations, a method by which it assumes an expense to facilitate its business and compensates its employees for services. . . ."<sup>15</sup> If such be the attitude of a court as to pension plans which are noninsured, no sound reason appears for distinguishing medical, accident or any other benefit program.

Performance of the employer's obligations depends upon its solvency, just as does its ability to pay wages which have been earned. No legislation has ever been proposed that would subject the business

<sup>12</sup> It has been used most frequently in deciding cases involving sales promotional schemes, such as warranties to replace damaged or lost goods. *State ex rel. Herbert v. Standard Oil Co.*, *supra* note 11. Cf. *State ex rel. Duffy v. Western Auto Supply Co.*, 134 Ohio St. 163, 16 N.E.2d 256 (1938).

<sup>13</sup> In the leading group health case, the court said:

That an incidental element of risk distribution or assumption may be present should not outweigh all other factors. If attention is focused only on that feature, the line between insurance or indemnity and other types of legal arrangement and economic function becomes faint, if not extinct . . . . The question turns, not on whether risk is involved or assumed, but on whether that or something else to which it is related in the particular plan is its principal object and purpose.

*Jordan v. Group Health Ass'n*, 107 F.2d 239, 247-48 (D.C. Cir. 1939).

<sup>14</sup> E.g., *California-Western States Life Ins. Co. v. State Bd. of Equalization*, 151 Cal. App. 2d 559, 312 P.2d 19 (1957), wherein the court commented that a retirement plan to which employees contributed was neither insurance nor an annuity, but rather a program for improvement of employee services and relations.

<sup>15</sup> *State Tax Comm'n v. John Hancock Mut. Life Ins. Co.*, 341 Mass. 555, 563, 170 N.E.2d 711, 716 (1960).

## NONINSURED EMPLOYEE BENEFIT PROGRAMS

community in general to the detailed and intense regulation familiar in insurance in order to assure employees the payment of their wages, so it would seem to follow that a mere incident of the employment contract is not as a matter of public policy in need of strict state supervision. The fact that some employers will miscalculate their financial depth is not itself a reason to bring this area of their activity within insurance regulation. Insurers, too, have been known to fail.

Marketing practices are a second major distinction. They are substantially different from those normally used in selling insurance, and these dissimilarities serve to minimize the need for state regulation.

Two characteristics of the programs stand out. Protection available through employee benefit plans is neither offered to the public generally nor marketed for profit. While probably these points alone would be insufficient to save an otherwise susceptible transaction from coming within the insurance laws, they do have a cumulative impact, and have been the subject of judicial comment in decisions sustaining the validity of cognate programs unsuccessfully contested as insurance. Only recently, the Court of Appeals for the District of Columbia had occasion to consider a death benefit program available only to members of the municipal police force. In approving the noninsured plan, it was emphasized that the association conducting it did not solicit public membership, and that its ranks were limited.<sup>16</sup> The relevance of both points to the present discussion is self-evident.

As to the absence of a profit objective, there is strong judicial language to the effect that this will save a noninsured program from coming within regulatory insurance laws. Perhaps the strongest statement is found in a provocative, but well-reasoned, California case in which an insurance company sought to recover premium taxes paid on contributions received from its employees to the company retirement plan. Without equivocation, it wrote:

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<sup>16</sup> *Metropolitan Police Retirement Ass'n v. Tobriner*, 306 F.2d 775 (D.C. Cir. 1962). The court stated:

They [the statutes] assume a separateness of identity, diversity of ownership, public solicitation of business, and probable conflict of interest between insurer and insured, necessitating regulation for the latter's protection. When the purposes for which these regulations were enacted have no significance in a particular situation this serves as a guide in determining whether a particular activity is not within the regulations. The Association does not solicit public membership, its ranks are limited, and its investments are controlled by the membership. The bylaws provide that investments of funds shall not only be approved by a majority of the Board of Directors, but also by a majority vote of the membership in regular session. The absence of a profit motive and the facts that the Association possesses a representative government and engages in no solicitation of the public, add some though not controlling support to the view that its activities are not within the scope of a statute primarily designed to protect the insured *vis-à-vis* the insurer.

*Metropolitan Police Retirement Ass'n v. Tobriner*, *supra* at 778.

Regardless of the noted similarities in so many of the provisions contained in the plan to those found in annuity policies regularly sold by insurers, the great dissimilarity which inheres in the total absence of profit motive—never ignored by successful insurers—compels a conclusion that the establishment and maintenance of respondent's employees' retirement plan cannot be classified as insurance business done by it in this state. Such was not its purpose and such was not its nature.<sup>17</sup>

To this reasoning of the California court, there is the rebuttal that the presence or absence of profit is irrelevant to the purpose of government regulation. There is some inconsistency in arguing that regulation may be avoided by conceiving a plan in which funds received are designedly inadequate to provide a profit.<sup>18</sup> Mutual companies, which theoretically by-pass the profit objective, are nonetheless subject to regulation. Perhaps what the court was impressed with was the noncommercial nature of the plan, the absence of a profit objective being but one of several attributes so distinguishing the plan as to insulate it from state regulation.

Noninsured employee benefit programs may be further distinguished from insurance by the inadequacy or total absence of an employee contribution. In very few instances is the entire cost of an employee plan carried by employee contributions, although it is probably more common than not for them to make some payment. The absence of a contribution tends to strengthen the arguments for the legality of the plan, because it makes available the contention that one of the essential elements of insurance—a premium—is lacking. Providing for contributions does not necessarily impair the plan, for contributions "markedly lower" than premiums for commercially available coverage have been the basis for saving plans from regulation.<sup>19</sup>

<sup>17</sup> *California-Western States Life Ins. Co. v. State Bd. of Equalization*, supra note 14, at 561, 312 P.2d at 20.

<sup>18</sup> Cf. N.Y. Ins. Law § 41(4) which provides that the absence of profit shall not conclusively establish that a transaction is not insurance.

<sup>19</sup> *California-Western States Life Ins. Co. v. State Bd. of Equalization*, supra note 14, where the court observed that the employee contributions

were markedly lower than amounts which would have to be paid under formal group annuity policies to a company issuing the same, whether paid wholly or partly by employer and employee and that, viewed in this way, employee contributions were not calculated by actuarial methods used in the insurance world. Thus it was shown that where actuaries calculating the premiums on insurance contracts, whether of the life or of the annuity type, consider three elements, namely, the rate of mortality, the rate of interest and the rate of expense, the amount of contributions by respondent's employees were arrived at by non-actuarial methods. For instance, employee contributions varied according to amount of salary or wages earned and to that extent were arbitrary rather than actuarial, and the gap between the cost of the plan and the employee's [sic]

One weakness of this contention lies in the fact that an employee's services may be regarded as a "payment". Money is not the only thing of value, nor the only recognized form of premium.<sup>20</sup> This very point was forcefully made by the country's highest court in *Haynes v. United States*,<sup>21</sup> a case in which, ironically, the government lawyers had to argue that a noninsured sick pay plan was not insurance. The Supreme Court said that payment of premiums in a fixed amount at regular intervals is not a necessary element of insurance, and added that the employment itself was sufficient to satisfy the formal requisite of consideration to make the agreement binding.<sup>22</sup> However, it is one thing to construe "insurance" for purposes of the tax laws, and quite another to do it so as to permit state regulation of a private corporate activity. The fact remains that courts have indicated that dollar premiums and the creation of investment income are essential characteristics of the business of insurance.<sup>23</sup>

The preceding judicial evaluations distinguishing noninsured employee benefit plans from insurance appear to state that from a public policy perspective, the need for government regulation must be proved. There is a difference between an enterprise whose main purpose is to assume and distribute risks and one engaged in the risk-shifting and risk-distribution activities as a mere incident of its main business purpose. There are good reasons for this disposition. An insurer's primary source of income, and therefore the economic fountain of its financial solvency, is premiums. Employees, on the other hand, even where they may contribute to their benefit plan, are not their employer's principal source of economic stability. It is, rather, the employer's business prosperity which is important, and no amount of insurance regulation is either intended or competent to influence this.

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contributions was thus arbitrarily assumed by respondent as its contribution. *California-Western States Life Ins. Co. v. State Bd. of Equalization*, supra at 560-61, 312 P.2d at 20. See also, *Colaizzi v. Pennsylvania R.R. Co.*, 208 N.Y. 275, 101 N.E. 859 (1913).

<sup>20</sup> Numerous statutes, e.g., N.Y. Ins. Law § 41, Neb. Rev. Stat. § 44-102 (1960), require that there be a conferring of a benefit of pecuniary value, or of money or its equivalent. There are some decisions, however, where the payment of money has seemed to be regarded as essential for a contract of insurance. *Denton v. Ware*, 228 S.W.2d 867 (Tex. Civ. App. 1950).

<sup>21</sup> 353 U.S. 81 (1957).

<sup>22</sup> The payment of premiums in a fixed amount at regular intervals is not a necessary element of insurance. Similarly there is no necessity for a definite fund set aside to meet the insurer's obligations. And the fact that the amount and duration of benefits increased with the length of time that an employee worked . . . reflected the added value to the company of extra years of experience and service.

*Haynes v. United States*, supra note 21, at 84.

<sup>23</sup> *Bowers v. Lawyers Mortgage Co.*, 285 U.S. 182 (1932). "Premiums" are characteristic of the business of insurance, and the creation of 'investment income' is generally, if not necessarily, essential to it." *Id.* at 189.

## ATTORNEYS GENERAL RULINGS

Besides those courts which have had occasion to examine non-insured employee benefit plans, attorneys general in three states—New York,<sup>24</sup> California<sup>25</sup> and Florida<sup>26</sup>—have written opinions excluding them from insurance regulation. As might be expected, the reasons given vary. The New York ruling is not particularly relevant to the precise question at hand, since it was predicated upon an express provision of the insurance law exempting labor unions.<sup>27</sup> The California attorney general gave the most comprehensive study to the issue, and while several reasons were assigned for excluding these plans from regulation, the thrust of the opinion lay in the assessment that such programs are an incident of employment, or of union membership where carried on solely by a union.<sup>28</sup>

## OTHER SUGGESTIONS

The broadest assault on behalf of the exclusion of these plans from state supervision under insurance laws is undoubtedly found in the "main purpose" argument outlined above, for it clashes with the threshold question of the need for government regulation. Prevail here, and any traditional form of employee benefit plan almost certainly will successfully avoid the grip of state-control. Failure, however, does not mean that all routes are closed, save those of submission to regulation or funding through a duly licensed insurer. Cases dealing with a definition of insurance suggest the following considerations:

1. Recite in the plan that no enforceable rights in favor of employees are being created, or that whatever obligation does exist, it is limited to the availability of funds as they accumulate under the plan. This was the basis of the Florida attorney general ruling, and apparently is based upon the elimination of any misplaced reliance by the employee on the presumed financial soundness of the source of his protection.

2. Construct a plan which is purely voluntary, to which no employee contributions are made, and which by express provision may be modified or terminated at the sole discretion of the employer. Courts agree that no contractual relations with employees arise under these

<sup>24</sup> Ops. N.Y. Att'y Gen., Nov. 21, 1956.

<sup>25</sup> Ops. Cal. Att'y Gen., No. 57/158, Dec. 8, 1958. "[T]he prevailing judicial climate does not indicate that the California courts would interpret such direct payment to employees or their beneficiaries . . . as constituting the fund or employer or labor union an insurance company or as constituting a violation of the provisions of the Insurance Code. The tendency of the decisions has been the other way."

<sup>26</sup> Ops. Fla. Att'y Gen., No. 057-360 (1957).

<sup>27</sup> N.Y. Ins. Law § 466.

<sup>28</sup> See note 25 *supra*.

terms, and without a contract there can be no insurance.<sup>20</sup> The obvious practical limitation is that most employee benefit plans are, either as a result of a collective bargaining agreement or other term of employment, designed to confer enforceable rights.

3. Design a plan offering benefits in the form of services rather than the payment of money. This distinction, though subject to criticism, is well established in the annals of insurance litigation, and is the basis of many cases holding that hospital and medical service organizations are not engaged in the insurance business.<sup>30</sup>

4. Consider the feasibility of some form of statutorily exempt plan, either under state or federal law. Statutory exemptions differ from state to state, but the principal arguments here are derived from the disclosure laws of some states and of the federal Taft-Hartley ouster of state jurisdiction to regulate Taft-Hartley funds under section 302(c).<sup>31</sup> The rationale under state disclosure laws is that such statutes impliedly exempt employee welfare and pension plans from supervision under insurance laws because of the alternate route of disclosure.<sup>32</sup>

5. Consider the feasibility of establishing a trustee-administered plan, under which the obligations of the employer run to the trust, of which the employees are beneficiaries. Taft-Hartley section 302(c) funds are of this kind. This form allows for the technical contention that the employees, being beneficiaries of a trust, are not in a contractual relation with their employer, and therefore no insurance contract exists. The reasoning is not altogether persuasive, and the very practical limitation is that the final responsibility for administration is taken out of the hands of the employer and transferred to the trustees, who, at least in the case of the Taft-Hartley trust, included an equal number of union representatives.

#### CONCLUSION

The future of noninsured employee benefit plans lies in very muddled waters. Since important interests of several major groups

<sup>20</sup> *Hughes v. Encyclopaedia Britannica, Inc.*, 1 Ill. App. 2d 514, 117 N.E.2d 880 (1954).

<sup>30</sup> E.g., *Michigan Hospital Serv. v. Sharpe*, 339 Mich. 357, 63 N.W.2d 638 (1954). For criticisms of the distinction between service and insurance in the context of these hospital or medical service cases, see Notes, 55 Colum. L. Rev. 109 (1955), 53 Mich. L. Rev. 484 (1955), 39 Minn. L. Rev. 218 (1955), all dealing with *Michigan Hospital Serv. v. Sharpe*.

<sup>31</sup> E.g., Cal. Ins. Code § 699 exempts, "Trustees of a fund established by one employer, or by one or more employers in the same industry, or by one or more labor unions, or by one or more employers and one or more labor unions, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions." See also, Cal. Ins. Code §§ 10505, 10494.5-7.

<sup>32</sup> E.g., *Ops. N.Y. Att'y Gen.*, Nov. 21, 1956. Cf. N.Y. Ins. Law § 370.

are in competition one with the other, it is a likelihood that before long these plans will soon be before the courts for identification as insurance or not insurance.

So long as the business community sees in these plans an opportunity to earn money by saving it, so long will the urge to noninsure continue. The situation currently existing in Illinois, where one or two plans have been approved, but future approvals have been at least temporarily foreclosed, obviously cannot persist. Too much money is involved for the precluded competitor to remain silent.

The route of state-by-state legislation to remove "existing inequities in regulation, taxation or otherwise" is at best slow and spotty. The insurance industry would like to take this road, and a major start has been made with legislation having been introduced in the 1963 legislative sessions of California, Connecticut, Massachusetts, Missouri, Pennsylvania and the key state of New York.<sup>33</sup> While pushing the cause on the legislative front, insurers must continue to be responsive to the pressures of their clients. Therefore, it may be expected that more and more carriers and an increasing number of companies will work out employee benefit programs involving noninsurance concepts.

The National Association of Insurance Commissioners, in the meantime, has made known its dislike of the trend to noninsurance in the employee benefit area.<sup>34</sup> The move it feels has two possible consequences for state commissioners. One, if it is successful, control over a major area of regulation will be lost, and two, if it is lost on the local level, there arises the head of the specter of federal intervention, such as through disclosure laws. This latter is especially distasteful to state supervisors and to the insurance industry in general, both of which for over a century have learned to live in relative harmony, almost completely free from higher powers in Washington.

The preceding discussion has been designed primarily to point out the many problems encountered when considering whether to institute a noninsurance program and particularly to focus on the newly risen, inherent issue of their legality. The debate, just getting underway, surely will increase, and in the years just ahead it must be resolved in either the courts, legislatures or both.

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<sup>33</sup> *Supra*, note 6.

<sup>34</sup> Resolution, Uninsured and Partially Uninsured Non-Regulated Employee Welfare and Pension Plans, National Association of Insurance Commissioners, Annual Meeting, December 1962. "Any existing inequities in regulation, taxation or otherwise, which would induce the adoption of noninsured plans in the employee benefit field" should be supported for removal. See also, *Future of Private Insurance in Big Group Cases Tied to Tax Bill in Next N.Y. Legislature*, *The National Underwriter*, Aug. 10, 1963, p. 1, col. 1.