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Jana K. Strain
Supreme Court of Indiana

Eleanor D. Kinney
Indiana University School of Law--Indianapolis

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The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA

Jana K. Strain, J.D.* & Eleanor D. Kinney, J.D., M.P.H.**

I. INTRODUCTION

The American health insurance market needs reform. Historically, states regulated insurance markets, yet the Employee Retirement Income Security Act of 1974 (“ERISA”) precludes the states from regulating employer-sponsored health plans covered by ERISA.¹ ERISA regulates most employee health insurance plans because most working, non-elderly people obtain health coverage through their employment.² The resulting bifurcation in the regulation of the American private health insurance market thwarts state reform of the insurance market.³

*Law Clerk to The Honorable Brent E. Dickson, Justice of the Supreme Court of Indiana. J.D., Indiana University School of Law—Indianapolis, 1997; B.A. Psychology, Indiana State University, 1986; M.S. Marriage and Family Therapy, Butler University, 1990. The authors would like to thank Phyllis Bonds, Chris Paynter and James Martin for their assistance and support in completing this project.

**J.D., Duke University, 1973; M.P.H., University of North Carolina at Chapel Hill, 1979; A.B., Duke University, 1969. Professor of Law and Co-Director, The Center for Law and Health, Indiana University School of Law—Indianapolis.

1. See 29 U.S.C.A. §§ 1001 - 1191c. (West 1999).

2. See *infra* Part II (discussing state and federal regulation of health insurance and federal preemption of state regulation on health insurance).

3. See, e.g., Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255 (1990) (concluding that federal statutory action is needed to improve health care access and that in the absence of federal action, Congress should amend ERISA to allow state regulation); Mary Ann Chirba-Martin & Troyen A. Brennan, *The Critical Role of ERISA in State Health Reform*, 13 HEALTH AFF. 142 (1994) (explaining the ERISA preemption clause and the limitations it places on the Health Security Act); Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251 (1997) (explaining the need for managed federalism in reforming health care); Lawrence O. Gostin & Alan I. Widiss, *What's Wrong with the ERISA Vacuum? Employer's Freedom to Limit Health Care Coverage Provided by Risk Retention Plans*, 269 JAMA 2527 (1993) (indicating the need to modify the ERISA preemption clause); Vicki Gottlich, *ERISA Preemption: A Stumbling Block to State Health Care Reform*, 26 CLEARINGHOUSE REV. 1469 (1993) (detailing the pervasiveness of the ERISA preemption

Thus, true reform of the U.S. health insurance market first requires reform of ERISA.

When Congress conceived and enacted ERISA in the late 1960s and early 1970s, the debate focused on the security of employee pension benefits. During that period, several factors influenced the call for regulatory oversight of employee benefits. First, private pensions grew dramatically after World War II. Between 1945 and 1984, the number of workers covered by private pension and employee benefit plans increased from 6.4 million to 65 million, and the value of these plans increased from \$5.4 billion in assets to over \$900 billion.⁴ Second, the workforce shifted from an industrialized to a post-industrialized job base,⁵ while labor unions remained concerned with protecting the benefits achieved under the industrialized system.⁶ In this climate of changing work bases, increased emphasis on governmental support in retirement, and increased health costs, Congress began to consider employee benefit regulation. The resulting text of ERISA clearly suggests that Congress' objective in creating the Act was to protect pension plans through tightly structured administrative requirements.

By the end of the 1960s, nearly all working, non-elderly Americans obtained health care coverage through employment.⁷ This increase in private, employer-based coverage, along with the inauguration of the

clause); Wendy K. Mariner, *Problems with Employer-Provided Health Insurance—The Employee Retirement Income Security Act and Health Care Reform*, 327 NEW ENG. J. MED. 1682 (1992) (explaining the need for a national system that would provide universal access to health care).

4. See Daniel W. Sherrick, *ERISA Preemption: An Introduction*, 64 MICH. B.J. 1074, 1074 (1985) (citing DANIEL M. HOLLAND, PRIVATE PENSION FUNDS: PROJECTED GROWTH 2 (1966); F.X. Lilly, Lecture at the Institute of Labor Law (October 18-19, 1984), in THE SOUTHWEST LEGAL FOUNDATION, LABOR LAW DEVELOPMENTS § 9.06 (1985)).

5. See John R. Keville, Note, *Retire At Your Own Risk: ERISA's Return on Investment?*, 68 ST. JOHN'S L. REV. 527, 531 (1994) (citing ROBERT J. LYNN, THE PENSION CRISES 26, 26-27 (1983)). The industrialized workforce was predominantly blue-collar and labor unions often protected its concerns. See *id.* at 531-32. The post-industrial workforce is characterized by a decreased emphasis on blue collar employment and substantial increases in white collar work, particularly in service areas such as health care, insurance, banking, finance, government, transportation, and hotel and restaurant work. See *id.* at 532 n.24. Between 1948 and 1974, the average number of private wage and salary workers in service areas increased 150% to 200% annually. See *id.*

6. See *id.* at 532 (citing David Langer, *Protector Becomes the Threat to Pensions*, PENSIONS & INVESTMENTS, Sept. 14, 1992, at 15). For example, in 1964, the United Auto Workers and the United Steelworkers of America, two large unions representing weakening industries and members with depleted or at-risk pension benefits, began lobbying Congress for federal pension protection. See *id.* at 532 n.26.

7. See Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990's*, 21 J. L. MED. & ETHICS 141, 148 (1993).

Medicare⁸ and Medicaid⁹ programs in the late 1960s precipitated a dramatic rise in health care expenditures.¹⁰ As a result, in order to control the rising cost of employee benefits and to escape the state mandated requirements, employers began to self-insure employee welfare benefits for health coverage.¹¹

Several reforms in health care coverage amended ERISA and improved the protections available to employee-welfare plan participants and beneficiaries. For instance, in 1985, Congress mandated extended coverage to employees and family members upon termination of employment or other threats to health coverage access.¹² More recently, health reform legislation further amended ERISA by enacting specific reforms, including health insurance portability,¹³ mandated post-natal hospital stays,¹⁴ and mandated mental health benefit limitations.¹⁵

These changes to health care coverage indicate ERISA's potential as a tool for genuine health care reform. This potential is particularly far-reaching because ERISA provides a framework in which federal authority over most health plans for the non-elderly already exists. Unfortunately, ERISA reform amendments to date have been piecemeal and characterized by consumer-driven attempts to resolve problems by attracting media attention.¹⁶ Nevertheless, ERISA's structure offers greater opportunity for more comprehensive and coordinated reform, should the political will develop to exploit this opportunity.

8. Congress enacted Medicare in 1965 as the "Health Insurance for the Aged" portion of the Social Security Act. See SOCIAL SECURITY BULLETIN, ANNUAL STATISTICAL SUPP. 75 (1993). This federal program provides hospital insurance and supplemental medical insurance for the aged and disabled who are insured under social security. See *id.*

9. Medicaid is a joint state and federal program to provide health insurance benefits to eligible persons with limited income and resources. See *id.*

10. See *id.* at 150.

11. See PATRICIA BUTLER & KARL POLZER, PRIVATE-SECTOR HEALTH COVERAGE VARIATION IN CONSUMER PROTECTIONS UNDER ERISA AND STATE LAW 6-8 (1996); Gail A. Jensen & Jon R. Gabel, *The Erosion of Purchased Health Insurance*, 25 INQUIRY 328, 329 (1988).

12. See *infra* notes 95-104 and accompanying text (discussing recent amendments to ERISA, including COBRA, and the difficulty in enforcing the statute).

13. See *infra* notes 105-12 and accompanying text (explaining how the Health Insurance Portability and Accountability Act ("HIPAA") deals with pre-existing conditions).

14. See *infra* notes 116-20 and accompanying text (explaining the Newborns' and Mothers' Health Protection Act ("NMHPA")).

15. See *infra* notes 113-15 and accompanying text (describing the Mental Health Parity Act).

16. See *infra* notes 226-30 and accompanying text (describing the limited success of health care reform proposals).

This article reviews the current regulation of private health insurance benefits at the state and federal level.¹⁷ This article then reviews the protections envisioned by Congress and the effectiveness of ERISA in providing uniformity in the insurance industry.¹⁸ Finally, this article proposes changes to improve ERISA's regulation of employer-sponsored health insurance.¹⁹ These proposed changes should provide greater uniformity and consistency for the insurance industry, while creating a uniform means of assuring that health insurance beneficiaries are provided reasonable protection of their employee benefits.

II. THE REGULATION OF HEALTH INSURANCE

Most non-elderly Americans receive insurance through their employment through so-called "employer-sponsored" plans.²⁰ In 1995, ERISA health plans covered approximately 114 million non-elderly Americans, insuring 44% of the U.S. population.²¹ State insurance codes regulate most of these employer-sponsored plans because these plans were funded through insurance plans that employers purchase from commercial insurers.²² "Self-insured" plans,²³ where the employer directly funds the plan, cover a substantial number of people—at least 40% of ERISA-covered participants or forty-four million people (seventeen percent of the population).²⁴ The number of people covered by these self-insured plans, however, appears to be increasing, especially among smaller employers.²⁵ In addition, employers increasingly

17. See *infra* Parts II.A-B.

18. See *infra* Parts II.C, III.A-B.

19. See *infra* Part IV.

20. See U.S. GEN. ACCT. OFF., EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA 2 (1995) [hereinafter U.S. GEN. ACCT. OFF., EMPLOYER-BASED HEALTH PLANS]. An estimated 76% of private full-time employees are insured through employment. See *id.* Only 60% of this group is covered by any kind of employer-funded retirement or savings plan. See *id.* Further, in 1990, medical benefits constituted an estimated 9.9% of total payroll. See *id.*

21. See *id.*

22. See *id.*

23. In a self-insured (also called a self-funded) plan, the employer absorbs some or all of the risk of paying claims submitted for health care expenses and does not purchase a commercial insurance product to protect against this risk. See Jensen & Gabel, *supra* note 11, at 328-29.

24. See U.S. GEN. ACCT. OFF., EMPLOYER-BASED HEALTH PLANS, *supra* note 20, at 2-3. But see Troy Paredes, Note, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 234 (1997) (suggesting that over 65% of employers self-insure, covering about half of the nation's workforce).

25. See U.S. GEN. ACCT. OFF., EMPLOYER-BASED HEALTH PLANS, *supra* note 20, at 3 (citing research that suggests that between 1990 and 1992 the increase in self-insuring for employers with fewer than 100 employees jumped 4%—from 28% to 32%); see also *infra* Part III.A (describing self-insured benefit plans).

purchase health coverage for their employer-sponsored plans from Health Maintenance Organizations (“HMOs”) and other Managed Care Organizations (“MCOs”). Indeed, approximately 75% of participants in employer-sponsored plans are currently enrolled in some type of managed care plan.²⁶

A. State Regulation of Insurance

Inherent police power accords states the authority to protect consumers in various ways. Included within this authority is the regulation of insurance. Historically, states have actively regulated insurance by addressing solvency and market conduct of insurance companies.²⁷ The unique state regulation of insurance evolved in from an 1868 U.S. Supreme Court decision that definitively ruled that insurance was not a transaction in interstate commerce.²⁸ In 1940, however, the New Deal Supreme Court altered this 1868 holding when the U.S. Department of Justice brought a suit against an interstate rating bureau. In this suit, the Court determined that insurance was a transaction in interstate commerce and ruled that the federal antitrust laws applied to the insurance industry.²⁹ Eager to continue the existing system for state regulations, a coalition of states, the National Association of Insurance Commissioners (“NAIC”),³⁰ and the insurance industry persuaded Congress to enact

26. See Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, 16 HEALTH AFF. 125, 125 (1997).

27. See *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724 (1985). States traditionally regulate the insurer through laws that govern solvency or the qualifications for management; laws regulating aspects of transacting business, including claims practices or rates; and laws regulating the content of group policies, such as mandated benefits, grace periods, and conversion privileges. See *id.* at 728 n.2 (citing Brummond, *Federal Preemption of State Insurance Regulation*, 62 IOWA L. REV. 57, 81-84, 101 (1976)).

28. See *Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868), *overruled in part by* *United States v. South-Eastern Underwriters Ass’n*, 322 U.S. 533 (1944); BANKS MCDOWELL, *THE CRISIS IN INSURANCE REGULATION* 39-41 (1994).

29. See *United States v. South-Eastern Underwriters*, 322 U.S. 533, 561 (1944).

30. The NAIC, a non-profit organization founded in 1871, plays an important role in supporting the work of state insurance regulators. See *The NAIC: A Tradition of Consumer Protection* (visited Feb. 1999) <<http://www.naic.org>> [hereinafter *NAIC: A Tradition of Consumer Protection*]. Comprised of state and territorial insurance commissioners, the NAIC effectively coordinates state regulation through model laws and regulations and technical assistance to state insurance departments. See NAT’L ASS’N OF INS. COMM’RS, *NAIC MODEL LAWS, REGULATIONS, AND GUIDELINES* (1998) [hereinafter *NAT’L ASS’N OF INS. COMM’RS, NAIC MODEL LAWS*]; see also *How Insurance Laws are Made: The NAIC and State Adoption of NAIC Model Laws: Hearing Before the Subcomm. on Antitrust, Monopolies and Bus. Rights of the Senate Comm. on the Judiciary*, 102d Cong. (1991). The NAIC provides regulators a common forum in which to address regulatory problems and to develop solutions. See *id.* In 1989, the NAIC accreditation program required accredited state insurance regulation programs to enact many NAIC model laws, particularly for solvency regulation. See KATHLEEN HEALD ETTLINGER ET AL., *STATE*

the McCarran-Ferguson Act, which substantially shielded the insurance industry from the federal antitrust law in states that regulated insurance.³¹

1. State Regulation of Health Insurance

States have historically regulated health insurance companies that operate within their territorial boundaries. State regulation of health insurance generally addresses solvency of the insurer and consumer protection issues in rate setting, underwriting, and market behavior.³² Importantly, the NAIC has proposed model statutes for the regulation of health insurers³³ and HMOs.³⁴ Recent state regulations of health insurance offered protection for consumers by mandating minimum benefits and controlling the practices used to select and insure participants.³⁵

a. Mandated Benefits

Many states mandate specific benefits for health insurance plans.³⁶ Specifically, sixteen states mandate over twenty kinds of benefits; eight others mandate as many as ten.³⁷ Common treatment-related benefits³⁸

INSURANCE REGULATION 161-63 (1995); see also *The NAIC: A Tradition of Consumer Protection*, *supra*. Thus, many states have similar insurance laws and regulation programs because nearly all states are accredited with the NAIC. See ETTLINGER ET AL., *supra*, at 161-63.

31. See 15 U.S.C. §§ 1011-1014 (1994). The McCarran-Ferguson Act places the power to regulate insurance clearly in the hands of the "several States." Specifically,

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

15 U.S.C. § 1011.

Further,

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

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unlike such Act specifically relates to the business of insurance.

15 U.S.C. § 1012.

32. See *supra* note 27 and accompanying text (discussing traditional areas of state regulation); see also ETTLINGER ET AL., *supra* note 30, at 161-63.

33. See NAT'L ASS'N OF INS. COMM'RS, NAIC MODEL LAWS, *supra* note 30, at Vols. I and II.

34. See *id.* at § 430-1.

35. See *infra* Parts II.A.1 (explaining state mandated health insurance benefits and the reform attempts to health insurance plans).

36. See U.S. GEN. ACCT. OFF., VARYING STATE REQUIREMENTS AFFECT COST OF INSURANCE 9 (1996).

37. See *id.*

include mammography screening,³⁹ alcoholism treatment,⁴⁰ mental illness,⁴¹ well child care,⁴² drug abuse treatment,⁴³ pap smear,⁴⁴ infertility treatment and in vitro fertilization,⁴⁵ temporomandibular joint disorders,⁴⁶ off-label drug use,⁴⁷ maternity care,⁴⁸ and post-mastectomy breast reconstruction.⁴⁹ Some states limit these mandates to particular types of health plans, such as HMOs or group insurance plans.⁵⁰ Mandated benefits, however, can make health insurance more expensive and, thus, have been an incentive for employers to self-insure in order to avoid compliance with these mandates.⁵¹

b. Small Market Reform

Beginning in the 1980s, the health insurance market became more competitive.⁵² As a result, state-regulated health insurance companies engaged in underwriting practices that threatened the availability and affordability of health insurance for both those who obtained health insurance through employment and those who purchased health insurance individually.⁵³ To address these problems, states enacted a number of

38. *See id.* app. IV, at 33 (citing NAIC, COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS: MANDATED BENEFITS (1995)).

39. *See id.* Forty-two states require insurance plans to cover these benefits, and four require insurance plans to offer these benefits. *See id.*

40. *See id.* Twenty-three states require coverage of these benefits, and sixteen require insurance plans to offer these benefits. *See id.*

41. *See id.* Fifteen states require insurance plans to cover these benefits, and sixteen require insurance plans to offer these benefits. *See id.*

42. *See id.* Twenty-one states require coverage of these benefits, and four require insurance plans to offer these benefits. *See id.*

43. *See id.* Thirteen states require coverage, and ten require insurance plans to offer these benefits. *See id.*

44. *See id.* Seventeen states require this to be covered. *See id.* None require it to be offered. *See id.*

45. *See id.* Twelve states require coverage, and two require insurance plans to offer these benefits. *See id.*

46. *See id.* Eleven states require coverage, and three require an offer of coverage. *See id.*

47. *See id.* Thirteen states require this to be covered. *See id.* None require it to be offered. *See id.*

48. *See id.* Eleven states require coverage, and two require an offer of coverage. *See id.*

49. *See id.* Nine states require coverage, and two require an offer of coverage. *See id.*

50. *See id.*

51. *See* Jon R. Gabel and Gail A. Jensen, *The Price of State Mandated Benefits*, 26 INQUIRY 419, 419 (1989); *see also* BUTLER & POLZER, *supra* note 11, at 25-36.

52. *See* Bovbjerg et al., *supra* note 7, at 153.

53. *See, e.g.,* Eleanor D. Kinney et al., *Serious Illness and Private Health Coverage: A Unique Problem Calling for Unique Solutions*, 25 J. L. MED. & ETHICS 180 (1997); Donald W. Light, *Life, Death, and the Insurance Companies*, 330 NEW ENG. J. MED. 498 (1994); Donald W. Light, *The Practice and Ethics of Risk-Related Health Insurance*, 267 JAMA 2503 (1992); Deborah A.

measures to prevent restrictive underwriting practices and to ensure both the portability of health insurance coverage and the stability of insurance costs for people with serious health conditions who were affected by these practices.⁵⁴ ERISA severely hampers these efforts because it allows employers to self-insure in order to completely avoid state insurance regulations.⁵⁵ In response to this problem, Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA"), which provides nationwide insurance market reforms.⁵⁶

2. State Efforts to Reform Managed Care

The NAIC⁵⁷ recently proposed model legislation to strengthen the state regulation of health insurance. The NAIC has also become quite active in the regulation of managed care plans, including many of the new risk-bearing entities⁵⁸ that emerged in the 1990s.⁵⁹ Specifically, the NAIC recently launched its "CLEAR" initiative⁶⁰ to reform state regulation of all managed care plans.⁶¹ The "CLEAR" initiative endeavored to "increase the use of common definitions and promote uniform regulation of health plans."⁶² The initiative included five model

Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287 (1993); Wendy Zellers et al., *Small-Business Health Insurance: Only the Healthy Need Apply*, 11 HEALTH AFF. 174 (1992).

54. See U.S. GEN. ACCT. OFF., HEALTH INSURANCE PORTABILITY: REFORM COULD ENSURE CONTINUED COVERAGE FOR UP TO 25 MILLION AMERICANS (1995); U.S. GEN. ACCT. OFF., VARIATION IN RECENT STATE SMALL EMPLOYER HEALTH INSURANCE REFORM (1995); Alpha Center, *1996 State Legislative Sessions: Insurance Market Restructuring Leads State Agendas*, 16 STATE INITIATIVES IN HEALTH CARE REFORM 1 (1996).

55. See *infra* notes 170-95 and accompanying text (describing the development of self-insured plans). These self-insurance plans do not fall within ERISA's savings clause exception and, thus, are not subject to state regulation. See *infra* Part III.A (discussing ERISA's preemption of state regulations attempting to govern self-insurance plans).

56. See *infra* notes 105-12 and accompanying text (discussing HIPAA).

57. See *supra* note 30 (discussing the role of NAIC in accrediting state insurance regulations).

58. The business of insurance is managing and spreading risk. As the Supreme Court has noted "[t]he primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." Allison Overbay & Mark Hall, *Insurance Regulation of Providers that Bear Risk*, 22 AM. J.L. & MED. 361, 369 (1996) (quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979)).

59. See *Health Care Quality and Consumer Protection: Hearings Before the Senate Comm. on Labor and Human Resources*, 105th Cong. 23 (1997) [hereinafter *Health Care Quality and Consumer Protection*] (testimony of Kathleen Sebelius, National Association of Insurance Commissioners).

60. CLEAR stands for "Consolidated Licensure for Entities Assuming Risk."

61. See *Health Care Quality and Consumer Protection*, *supra* note 59, at 24 (testimony of Kathleen Sebelius, National Association of Insurance Commissioners).

62. *Id.* at 72 (statement of Kathleen Sebelius, National Association of Insurance Commissioners).

statutes that address the following various types of health plans: Managed Care Plan Network Adequacy, Health Carrier Grievance Procedure, Utilization Review, Quality Assessment and Improvement, and Health Care Professional Credentialing Verification.⁶³ These model statutes would impose basic quality standards upon managed care health plans and sponsoring carriers to protect consumers who are either: (1) restricted as to their choice of provider; or (2) offered incentives to select a particular provider.⁶⁴

In addition to the NAIC, the states have become active in the regulation of health insurance. Specifically, states have recently begun to mandate protections for consumers in HMOs. Some states moved to enact consumer protections into state HMO statutes, including such things as stronger disclosure requirements and a less restrictive utilization review.⁶⁵ ERISA, however, may preempt these state reform laws to the extent that they impose obligations on employee welfare benefit plans.⁶⁶

B. Federal Regulation of Health Insurance

ERISA federally regulates private health insurance⁶⁷ within the following three basic categories of regulation: (1) regulation of plan administration;⁶⁸ (2) enforcement of plan requirements and remedies;⁶⁹ and (3) substantive mandates.⁷⁰ Administration provisions regulate, for example, the reporting and disclosure provisions as well as the procedures and standards of conduct for fiduciaries. Enforcement provisions establish the right to review plan decisions made on behalf of beneficiaries and participants and provide remedies for breach of the contractual relationship. Substantive mandates define required benefits or other

63. See NAT'L ASS'N OF INS. COMM'RS, NAIC MODEL LAWS, *supra* note 30.

64. See *Health Care Quality and Consumer Protection*, *supra* note 59, at 67 (testimony of Kathleen Sebelius, National Association of Insurance Commissioners).

65. See *Health Care Quality: Grievance Procedures: Hearings Before the Senate Comm. on Labor and Human Resources*, 105th Cong. 46-69 (1998); Families, USA, *The Text of Key State HMO Consumer Protection Provisions: The Best From the States* (visited March 5, 1998) <<http://familiesusa.org/hmostate.html>>; see also 1 GERALDINE DALLEK ET AL., CONSUMER PROTECTIONS IN STATE HMO LAWS (1995).

66. See *Corporate Health Ins. Inc. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597, 607 (S.D. Tex. 1998) (holding that ERISA preempts state efforts to reform managed care); see also *infra* Part II.C (discussing federal preemption of state insurance regulation).

67. See 29 U.S.C. § 1003 (1994 & Supp. 1996).

68. See *infra* Part II.B.1 (discussing ERISA's regulation of plan administration).

69. See *infra* Part II.B.2 (addressing ERISA provisions for enforcement of plan requirements and remedies).

70. See *infra* Part II.B.3 (discussing ERISA's substantive mandates).

terms of insurance contracts. Although ERISA contains extensive administrative provisions, it contains very few substantive mandates. Furthermore, the mechanisms for enforcement of these provisions are limited, although recent amendments to ERISA have added a small number of substantive provisions that mandate specified benefits.

1. Regulation of Plan Administration

The administrative provisions fall into the following two basic categories: (1) reporting and disclosure rules,⁷¹ and (2) fiduciary standards.⁷² Under the reporting and disclosure rules, plan administrators must disclose a summary plan description to participants and beneficiaries.⁷³ In addition, the administrators must disseminate plan information that is written "in a manner calculated to be understood by the average plan participant" and "sufficiently accurate and comprehensive to reasonably apprise [the] participants and beneficiaries of their rights and obligations under the plan."⁷⁴ This part of ERISA is highly detailed and provides clear guidelines to the plan administrators.⁷⁵

The rules pertaining to fiduciary standards are less detailed, but equally clear. These rules require the fiduciary to discharge his duties with respect to the plan solely in the interest of the participants and beneficiaries.⁷⁶ These rules also require fiduciaries to act exclusively

71. See 29 U.S.C.A. §§ 1021-31 (West 1999).

72. See 29 U.S.C. §§ 1101-1114 (1994 & Supp. II 1996).

73. See *id.* § 1021(a).

74. 29 U.S.C.A. § 1022(a).

75. For example, ERISA requires the administrator to prepare and provide substantial information to beneficiaries and participants upon written request. Among other things, administrators are required to disclose information such as whether a health insurance issuer is responsible for financing and administering the plan and the name and address of the issuer; the names and addresses of agents for service of legal process; a description of relevant provisions of applicable collective bargaining agreements; requirements for eligibility for participation and benefits; circumstances which may result in disqualification; and the procedures to be followed in presenting claims for benefits as well as the procedures to seek assistance or information from the Department of Labor regarding their rights under ERISA. See *id.* § 1022(b).

76. In *Massachusetts Mutual Life Insurance Company v. Russell*, the Supreme Court addressed fiduciary obligations under ERISA. See *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). The Court found that the civil enforcement provisions of ERISA § 409(a) did not support a private remedy for breach of fiduciary duty, but instead were intended only for protection of the whole plan and not the individuals. See *id.* at 142, 145-47. Justice Brennan's concurrence, however, applied traditional trust law to argue that equitable relief is available to beneficiaries as a remedy for ERISA violations under § 502(a)(3). See *id.* at 151-53 (Brennan, J., concurring). This concurrence paves the way for lower courts to allow individual recovery under § 502(a)(3). See Shelley L. Ward, *Enlarging an Employer's Fiduciary Hat: Varsity Corp. v. Howe Increases Employers' Exposure to Liability When They Act as ERISA Fiduciaries*, 34 HOUS. L. REV. 1195, 1205-06 (1997).

for the purpose of “providing benefits to participants and their beneficiaries” and “to defray reasonable expenses of administering the plan.”⁷⁷ The rules impose a standard of care requiring the fiduciary to act with the “care, skill, prudence, and diligence” that a prudent person in like capacity would use.⁷⁸ Additionally, ERISA outlines the fiduciary’s duties upon termination of the health care plan,⁷⁹ the insurer’s role in the fiduciary relationship, and the plan’s liability for acts of the fiduciary or the insurer.⁸⁰

2. Enforcement of Plan Requirements

ERISA is enforced through civil actions.⁸¹ Section 502(a) of ERISA contains a civil enforcement scheme.⁸² This is the exclusive remedy for improper processing of claims and preempts all state causes of action for claims within its scope.⁸³ Under Section 502(a), plan participants or beneficiaries may sue plans directly to recover benefits owed or to enforce other rights under the plan.⁸⁴ ERISA also authorizes civil actions against plan fiduciaries for breaches of ERISA requirements and to recover benefits due.⁸⁵ Courts may review plan fiduciary determinations de novo.⁸⁶ Plan participants, beneficiaries, and fiduciaries may also seek equitable relief for violations of ERISA requirements.⁸⁷

When plaintiffs bring a suit under Section 502(a), courts have discretion to award attorney’s fees to either party.⁸⁸ The Supreme Court, however, declined to extend the damages provisions to include punitive damages, noting that when a congressional enactment includes procedures for enforcement, a presumption exists that Congress intentionally omitted any remedy not specifically included in the statute.⁸⁹

77. 29 U.S.C. § 1104(a).

78. *Id.* § 1104(a)(1)(B).

79. *See id.* § 1104(d).

80. *See id.* § 1101.

81. *See* 29 U.S.C. § 1132(a) (1994); *see also* Richard Rouco, Comment, *Available Remedies Under ERISA Section 502(A)*, 45 ALA. L. REV. 631, 634 (1994) (summarizing the civil actions available under section 502(a) and their corresponding remedies).

82. Section 502(a) is codified at 29 U.S.C. § 1132(a) (1994).

83. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (holding that ERISA preempts state law claims of improper processing of a claim for benefits).

84. *See* 29 U.S.C. § 1132(a)(1).

85. *See id.* § 1132(a)(2).

86. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (holding that federal district courts have de novo review under section 503 for plan denials rather than review under an “arbitrary and capricious” standard).

87. *See* 29 U.S.C. § 1132(a)(3).

88. *See id.* § 1132(g)(1).

89. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (citing *Massachusetts Mut. Life*

Commentators argue that ERISA's remedies are deficient because of the manner in which the federal courts often apply ERISA. They argue that this application often results in the denial of full recovery of damages for plan participants.⁹⁰ Indeed, commentators suggest that the federal courts' application of ERISA contravenes the express congressional intent of the statute, which is to protect insurance beneficiaries.⁹¹ It is in the context of these judicial interpretations that ERISA's shortcomings become most apparent. For example, although plan fiduciaries must discharge their duties with the exclusive purpose of providing benefits,⁹² judicial review of a denial of benefits is often highly deferential and applies an "arbitrary and capricious" standard, under which courts accept the plan administrator's interpretation of ambiguous plan terms.⁹³ Furthermore, courts generally deny participants the opportunity to recover extra-contractual damages and rarely award legal fees.⁹⁴

Recent amendments to ERISA provide clearer guidelines for conduct when implementing eligibility requirements and employer plans. For example, plans may not discriminate against individuals due to health status,⁹⁵ nor may they deny continued access to coverage for an employer participating in a multi-employer plan without good cause, as specified in the statute.⁹⁶ Health care plans, however, may delay performance of their duties and force beneficiaries into court to receive contractual benefits. Therefore, even though Congress substantially improved ERISA by defining prohibited conduct in the context of eligibility requirements and employment plans, its failure to set appropriate penalties perpetuates the harm caused by ERISA's prior deficiencies.

Some provisions give the Secretary of Labor the authority to seek relief for failure to follow ERISA's administrative procedures (e.g., filing

Ins. Co. v. Russell, 473 U.S. 134, 147 (1985) (quoting Northwest Airlines, Inc. v. Transport Workers, 451 U.S. 77, 97 (1981)).

90. See BUTLER AND POLZER, *supra* note 11, at 47; see also *infra* notes 92-98 and accompanying text (discussing flaws in ERISA's remedies provisions).

91. See George Lee Flint, Jr., *ERISA: Reformulating the Federal Common Law for Plan Interpretation*, 32 SAN DIEGO L. REV. 955, 959-60 (1995).

92. See 29 U.S.C. § 1104(a) (1994).

93. See Flint, *supra* note 91, at 960 (citing Smith v. California Metal Trades Ass'n - Int'l Ass'n of Machinists Pension Trust, 654 F.2d 650, 655 (9th Cir. 1981); Bueneman v. Central States, S.E. & S.W. Areas Pension Fund, 572 F.2d 1208 (8th Cir. 1978)).

94. See *id.* at 961 (citing Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985) (providing dicta for the benefits due lawsuit)); see also Eaves v. Penn, 587 F.2d 453, 464-65 (10th Cir. 1978).

95. See 29 U.S.C. § 1182(a)(1)(A) (Supp. II 1996).

96. See *id.* § 1183 (setting forth various reasons for which a group health plan may keep continued access to certain coverage).

reports on time); however, the Secretary cannot seek relief if the plan fails to meet other ERISA requirements.⁹⁷ Indeed, the Secretary of Labor has no authority to enforce the new substantive provisions that mandate certain types of benefits.⁹⁸ Therefore, each harmed individual must bring an independent claim seeking only the authorized equitable relief, while the Department of Labor, vested with authority to regulate, can do nothing to enforce its own regulations to protect beneficiaries.

3. Substantive Regulation of Health Plans

Historically, ERISA only minimally regulated the terms of employer-sponsored health plans. Beginning in 1985, however, Congress imposed federal requirements on employer-sponsored health plans in order to address specific problems with the private health insurance market. This substantive regulation demonstrates ERISA's potential as a vehicle of health system reform.⁹⁹

a. Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") amended both the Internal Revenue Code of 1954 and ERISA to include continuation coverage requirements for employer-provided group health plans.¹⁰⁰ Under COBRA, group health plans must make coverage available to employees and dependents who might otherwise lose their benefits due to changes in employment or job status.¹⁰¹ Regardless of whether the plan is insured or self-insured, COBRA requires continuation of "core benefits" under any group health plan that furnishes medical care benefits for employees and their dependents unless the plan is a governmental, church or small employer plan.¹⁰² At termination of employment, employers must apprise employees of their COBRA rights and provide a specified time in which to elect continued coverage under the plan.¹⁰³ Failure to comply with

97. See 29 U.S.C.A. § 1132(b)-(c) (West 1999).

98. See *id.* § 1132(b)(2) (denying authority to sue for violations of section 515, codified at 29 U.S.C. § 1145).

99. See *infra* Part IV (discussing ERISA's potential to reform the health care system).

100. See 29 U.S.C. §§ 1161-1162 (1994 & Supp. II 1996); see also Deborah Shelby Nichols, *COBRA and Other Health Care Issues*, in ALI-ABA Course of Study Basic Law of Pensions, Welfare Plans, and Deferred Compensation 1029, 1031 (ALI-ABA pub., July 8-12, 1996) (discussing the background and requirements of COBRA).

101. See 29 U.S.C. § 1163 (1994).

102. See *id.* § 1003(b) (1994 & Supp. II 1996).

103. See *id.* § 1166.

COBRA may result in tax penalties as well as liability for payment of benefits that might not otherwise be required.¹⁰⁴

b. Health Insurance Portability and Accountability Act of 1996

HIPAA¹⁰⁵ is a notable amendment to ERISA because it provides for increased portability of insurance through limitations on pre-existing condition exclusions.¹⁰⁶ This amendment applies to limitations or exclusions of coverage based upon a condition that was present before the date of enrollment for coverage, regardless of whether any medical treatment or diagnosis occurred prior to the date of enrollment. Under HIPAA, limitations may only be imposed upon conditions for which an employee sought or received medical advice, diagnosis, care or treatment during the six months immediately preceding the enrollment date. Furthermore, the plan may only impose exclusions or limitations for twelve months¹⁰⁷ after the date of enrollment,¹⁰⁸ thereby providing employees greater flexibility to change jobs without fear of losing insurance coverage for themselves or their dependents.

Another protective provision of HIPAA prohibits eligibility decisions based upon factors such as health status, medical condition (including mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.¹⁰⁹ This provision does not require the plan to provide additional coverage nor does it prevent limitations or restrictions on amount, level, or nature of benefits or coverage, provided that such restrictions are applied in a nondiscriminatory manner.¹¹⁰ It does, however, prohibit higher premiums or contributions based on health-status factors.¹¹¹ HIPAA also limits acceptable reasons for denying an employee continued or different coverage (as defined by the contract)¹¹² and essentially precludes a

104. See 29 U.S.C.A. § 1132(c) (West 1999).

105. See *supra* text accompanying note 56 (discussing HIPAA).

106. See 29 U.S.C. § 1181 (Supp. II 1996).

107. See *id.* § 1181(a)(2). In the case of a late enrollee, exclusions or limitations may be imposed for eighteen months after the date of enrollment, if the late enrollee enrolls under a plan at some time other than during the first period in which the enrollee is eligible to enroll under the plan, or during a special enrollment period. See *id.* § 1181(a)(2), (b)(3).

108. See *id.* § 1181(a)(2). Creditable coverage means coverage of the individual under any of the types of medical coverage enumerated in the section, including group health plans, health insurance, or certain state or federal government-sponsored plans. See *id.* § 1181(c)(1).

109. See *id.* § 1182(a)(1).

110. See *id.* § 1182(a)(2).

111. See *id.* § 1182(b)(1).

112. See *id.* § 1183. Any of the following reasons may terminate coverage: nonpayment, fraud or intentional misrepresentation of material fact by the employer, noncompliance with ma-

plan from excluding coverage of certain types of claims once an employee has presented them.

c. Mandated Benefits

In 1996, two other acts amended ERISA by requiring coverage for mental health benefits and mother-child care. First, the Mental Health Parity Act of 1996¹¹³ requires that any aggregate lifetime limit within the plan language either: (1) apply without distinction as to type of benefit (e.g., medical, surgical, or mental health); or (2) apply a limit on mental health benefits that is equivalent to limits on other benefits.¹¹⁴ The same standards apply to annual limits on benefits.¹¹⁵

Second, the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA")¹¹⁶ requires coverage of hospital stays of at least forty-eight hours after a normal vaginal delivery and ninety-six hours after a cesarean section.¹¹⁷ The NMHPA prohibits denials of eligibility in order to avoid the requirements and prohibits monetary payments or rebates that encourage mothers to accept lesser protections.¹¹⁸ The NMHPA also prohibits: (1) reduction or limitation of payments to the medical providers who comply with the NMHPA;¹¹⁹ (2) monetary or other incentives to providers who do not comply with the statute; and (3) differences in benefits over the course of the stay.¹²⁰

d. Failed Reform Attempts

Congress considered, but declined to adopt, several amendments that would have rectified problems in current ERISA interpretation.¹²¹ For example, one proposed amendment would have preserved state law

terial provisions, the plan's decision to cease offering any coverage within the geographic area, the absence of any employee who lives, resides or works in the service area of the network plan, and failure to meet the terms of an applicable collective bargaining agreement. *See id.*

113. Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (1996) (codified at 29 U.S.C. § 1185a (Supp. II 1996)).

114. *See* 29 U.S.C. § 1185a(a)(1)(A)-(B) (Supp. II 1996).

115. *See id.*

116. Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (1996) (codified at 29 U.S.C. § 1185 (Supp. II 1996)).

117. *See* 29 U.S.C. § 1185(a)(1)(A) (Supp. II 1996). The provision does not apply where the attending provider, in consultation with the mother, determines to discharge her from the hospital at an earlier time. *See id.*

118. *See id.* § 1185(b).

119. *See id.*

120. *See id.*

121. *See* Flint, *supra* note 91, at 964-65.

remedies against insurance companies.¹²² Another would have created federal procedures and judicial remedies for the improper handling of claims by welfare plans.¹²³ Yet another would have removed health care plans from ERISA established new procedures, administrative hearings, and judicial review for the protection of plan beneficiaries.¹²⁴

More recently, the 105th Congress considered, but did not pass, serious reform of ERISA.¹²⁵ Although tabled just before the 1998 election, all of the proposed bills addressed, in some manner, required disclosures regarding benefits and coverage, utilization review, and quality improvement.¹²⁶ The proposed bills also emphasized appeal procedures and would have imposed extensive requirements on grievance and appeal procedures, particularly in emergency situations.¹²⁷ The 106th

122. *See id.* at 965. Two bills, the Health Insurance Claims Fairness Act of 1991 and the Health Insurance Claims Fairness Act of 1993, would have exempted from preemption state laws that allowed workers to sue insurance companies for compensatory and punitive damages arising from unfair claims practices. They would not provide similar exemptions for claims against plan sponsors. *See id.* at 965 n.45.

123. *See id.* at 965. The Health Insurance Claims Fairness Act of 1993, H.R. 1881, 103d Cong. (1993) (introduced by Rep. Howard Berman), would:

- (1) add a specified time frame for processing claims, (2) permit mediation to resolve claim disputes, (3) allow federal action for actual damages, including compensatory and consequential damages, caused by violation of ERISA or the terms of an ERISA plan, (4) permit recovery of punitive damages against certain parties in case of fraud, and (5) require an award of attorney fees for prevailing plaintiffs.

Id. at 965 n.46.

124. *See id.* at 965. President Clinton's proposed Health Security Act, H.R. 3600, 103rd Cong. (1993), would:

- (1) establish time limits for claims processing and plan review procedures of denials, (2) permit aggrieved claimants to elect alternative dispute resolution, plan administration hearings, or court remedies, (3) establish the National Health Board to review plan administrative decisions with appeals to the circuit courts for amounts in excess of \$10,000, and (4) establish substantial civil penalties for wrongful denial or delay of claims.

Id. at 965 n.47.

125. The proposed reform legislation included President Clinton's Health Insurance Consumer's Bill of Rights Act of 1997, H.R. 2967, S. 1499, 105th Cong. (1998) (introduced by Rep. Charles Schumer (D-N.Y.) and Sen. Barbara Boxer (D-Cal.)). The major viable Democratic reform proposal was the Patients' Bill of Rights Act of 1998, H.R. 3605, S. 1890, 105th Cong., (1998) (introduced by Sen. Thomas A. Daschle (D-S.D.) and Rep. John H. Dingell (D-Mich.)). The major Republican bill was the Patients' Bill of Rights Act, S. 2330, 105th Cong., (1998) (introduced by Sen. Don Nickels (R-Okla.)). Other proposal reforms included: Patient Access to Responsible Care Act of 1997, H.R. 1415, S. 644, 105th Cong. (1997) (introduced by Rep. Charlie Norwood (R-Ga.) and Sen. Alphonse D'Amato (R-N.Y.)); Patient Protection Act of 1998, H.R. 4250, 105th Cong. (1998) (introduced by Rep. Newton Gingrich (R-Ga.)).

126. *See* Amy Goldstein & Helen Dewar, *Senate Kills 'Patients' Rights' Bill*, THE WASHINGTON POST, Oct. 10, 1998, at A1.

127. *See infra* notes 243-48 and accompanying text (citing the proposed reform bills that required disclosure of available grievance and appeal procedures).

Congress has fitfully begun consideration of new legislation.¹²⁸ It remains to be seen, however, whether the 106th Congress will be more successful than the 105th in reforming ERISA.

C. Federal Preemption of State Regulation

ERISA expressly preempts state law that might otherwise govern employee benefit plans; however, the preemption is not total in that it permits the states to exercise some continued regulatory power.¹²⁹ Specifically, ERISA contains three provisions which, together, preempt state law: (1) the preemption clause,¹³⁰ (2) the savings clause,¹³¹ and (3) the deemer clause.¹³² Given these three clauses, the scope of state regulatory powers might aptly be characterized as “ERISA taketh away; ERISA giveth; ERISA taketh away again.” First, the preemption clause eliminates the states’ power to regulate by preempting any state laws that “relate to” an employee benefit plan.¹³³ The savings clause, however, restores state power to regulate if the state law “regulates insurance, banking, or securities.”¹³⁴ Finally, the deemer clause limits this restored state power by prohibiting states from bringing an employee benefit plan within the scope of regulation by calling it an “insurance

128. See, e.g., Frank Bruni, *Curbs on Managed Care Still Divide Two Parties*, N.Y. TIMES, Mar. 17, 1999, at A18 (noting that unresolved issues that divided the two parties in the past threaten to inhibit any new attempts at legislation); James Jeffords, *Three Goals for Health Care Reform in 1999*, THE HILL, Jan. 20, 1999, at 30 (highlighting health care issues on the agenda of the Senate Committee on Health, Education, Labor and Pensions, and indicating a need for solutions instead of finger-pointing).

129. See, e.g., Bobinski, *supra* note 3; Farrell, *supra* note 3; Karen A. Jordan, *ERISA Preemption: Integrating Fabe Into the Savings Clause Analysis*, 27 RUTGERS L.J. 273 (1996); Karen A. Jordan, *The Shifting Preemption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149 (1998); Larry J. Pittman, *ERISA’s Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355 (1994); Lawrence Allen Vranka, Jr., Note, *Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern*, 42 VAND. L. REV. 607 (1989).

130. The preemption clause states, “Except as provided in [the savings clause] . . . [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” 29 U.S.C. § 1144(a) (1994).

131. The savings clause provides, “[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” 29 U.S.C. § 1144(b)(2)(A).

132. The deemer clause provides, “Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts” 29 U.S.C. § 1144(b)(2)(B).

133. See *id.* § 1144(a).

134. *Id.* § 1144(b)(2)(A).

company or other insurer.”¹³⁵ Despite the limited exemptions of the savings clause, the sweeping language of ERISA preempts most state laws that “relate to” employee benefit plans.¹³⁶ Thus, ERISA generally provides the exclusive remedy when a claim is presented under an employee benefit plan.¹³⁷

Although the ERISA preemption is sweeping, the savings clause creates a loophole that allows states to protect their citizens’ interests through regulation of health plans.¹³⁸ For example, the Supreme Court held that ERISA did not preempt a state law that required a minimum level of mental health benefits.¹³⁹ The law in question clearly “related to” welfare benefit plans under the Court’s broad common-sense approach to its meaning. The Court, however, found that the statute was not preempted because it regulated insurance under the savings clause’s exception for the “business of insurance.”¹⁴⁰

1. Legislative History

The corresponding legislative history, or lack thereof, of ERISA’s preemption clause is astounding. As one participant noted retrospectively, the resulting regulatory vacuum was not deeply considered during the years of planning, negotiating, and drafting the bill.¹⁴¹ The ERISA bills initially contained language that merely prevented the states from enacting legislation concerning subject matters regulated by ERISA;¹⁴² thus, the bills prohibited only direct conflicts in the law. The Conference Committee scrapped this more limited preemption clause and adopted the present, broader language, just before ERISA’s enactment.¹⁴³ The language added during the final negotiations, and dis-

135. *Id.* § 1144(b)(2)(B). For example, an employer who establishes a trust fund to pay its employees’ medical claims (a self-insured plan) cannot be deemed an insurer for purposes of state regulation. *See FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

136. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (stating that “the express pre-emption provisions of ERISA are deliberately expansive”); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983) (stating that “[t]he breadth of [the clause’s] preemptive reach is apparent . . .”).

137. *See* JAIME RUTH EBENSTEIN & MARK E. SCHMIDTKE, *ERISA LITIGATION PRIMER* 9 (1992).

138. *See* 29 U.S.C. § 1144(b)(2)(A).

139. *See Metropolitan Life Ins., Co. v. Massachusetts*, 471 U.S. 724, 758 (1985).

140. *See id.* at 742-44.

141. *See* Daniel M. Fox & Daniel C. Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. HEALTH POL. POL’Y, & L. 239, 248 (1989).

142. *See id.* at 241 (citing H.R. 2, 93d Cong., § 699(a) (1974) (as amended by Senate)).

143. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) (referencing H.R. CONF. REP. No. 93-1280, at 383 (1974); S. CONF. REP. No. 93-1090, at 383 (1974))).

closed only ten days before Congress' final action, was the result of strong opinions of House conferees who spoke on behalf of powerful interest groups.¹⁴⁴ The new language preempted state law relating to "any employee benefit plan," even if the plan was not regulated by the Act.¹⁴⁵ The ERISA Committee Conference Report, however, is silent with respect to these provisions,¹⁴⁶ thus, aside from the text of the statute itself, it is difficult to ascertain Congress' precise intent regarding the scope and significance of the preemption clause.

Some legislators viewed the preemption clause as a means of creating a more uniform governance of benefits law.¹⁴⁷ Others viewed it as a "starting point" in regulating insurance.¹⁴⁸ For example, in delivering the Conference Committee Report, Senator Javits indicated the statute's defined protection would only be successful if the federal courts developed a body of federal common law rights and obligations under employee benefit plans.¹⁴⁹

144. The NAIC was a major party to the change in the preemption language, specifically championing protection for "any law of any State which regulates insurance," consistent with the traditional arrangement in insurance regulation as expressed in the McCarran-Ferguson Act, 29 U.S.C. § 1144(b)(2)(A). Fox & Schaffer, *supra* note 141, at 242. Organized labor pushed for preemption of state regulations in order to protect its members from non-uniform regulation, such as state-mandated benefits, and to prevent interference with national collective bargaining agreements. *See id.* at 243. Finally, the insurance industry, which clearly would be affected by ERISA, was, as a whole, ambivalent to the process. *See id.* For it, preemption of state law avoided mandates and would make it easier to offer uniform policies to national employers, but on the other hand, the industry was well-established in the state insurance system. *See id.* However, smaller insurers, who preferred state regulation, were concerned about competition with self-insured plans within regional and state markets. *See id.*

145. *Shaw*, 463 U.S. at 98.

146. *See Congressional Committee of Conference on ERISA Joint Explanatory Statement of the Committee of Conference on ERISA*, in ERISA SELECTED LEGISLATIVE HISTORY 1974-1991, 1, 107 (1992).

147. Indeed, Representative John Dent (R-N.Y.), a sponsor of the bill, referred to the preemption clause as the "crowning achievement of this legislation" because it eliminated the "threat of conflicting and inconsistent State and local regulation." 120 CONG. REC. 29,197 (1974) (statement of Rep. Dent); *see also* Fox & Schaffer, *supra* note 141, at 241 (citing Rep. Dent's debate in the CONGRESSIONAL RECORD).

148. Further, Senator Jacob Javits (R-N.Y.), a sponsor of the bill, looked forward to future refining of the clause, saying that the "desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention . . ." 120 CONG. REC. 29,942 (1974) (statement of Sen. Javits); *see also* Fox & Schaffer, *supra* note 141, at 241-42 (citing Sen. Javits's debate in the CONGRESSIONAL RECORD).

149. *See* 120 CONG. REC. 29,942 (1974) (statement of Sen. Javits); *see also* William K. Carr & Robert L. Liebross, *Wrongs Without Rights: The Need for a Strong Federal Common Law of ERISA*, 4 STAN. L. & POL'Y REV. 221, 224 (1992/1993) (referencing Congress' mandate that the federal courts apply common law principles to ERISA cases).

2. Judicial Interpretation

Due to the dearth of preemption clause legislative history, the Supreme Court has concluded that Congress intended to give the preemption clause a scope as broad as its language.¹⁵⁰ Congress' failure to revise ERISA in light of this interpretation has effectively ratified the Court's holding. In arriving at its expansive reading of these provisions, however, the Court ignored the statements of ERISA's sponsors. These statements reflect an intent to "round out the protection afforded participants by eliminating the threat of *conflicting and inconsistent* State and local regulation."¹⁵¹ Indeed, one sponsor stated that "with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans."¹⁵²

Notwithstanding these statements, the Court, in reaching its conclusions, did not consider whether an actual conflict of laws or inconsistency exists. Clearly, no conflict or inconsistency exists when federal law does not address an issue. Nevertheless, the Supreme Court consistently allows the preemption clause to foreclose state laws that "relate to" an employee benefit plan, even when the federal law provides no direct regulation. In so doing, the Court reasoned that preemption is "compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose."¹⁵³ Thus, the Court has held that ERISA preemption sweeps aside much of the states' power to regulate health plans.

Despite stated concerns about ERISA's language, the Supreme Court has also concluded that it is bound by the plain meaning of the statute, which invokes a broad reading of the preemption clause. Accordingly, the Supreme Court has determined that a "state law 'relates to' . . . [a] benefit plan . . . if it has a connection with or reference to such a plan."¹⁵⁴ Since this decision, the Supreme Court has identified four categories of state laws with sufficient relation to ERISA plans to justify

150. See *Shaw*, 463 U.S. at 98.

151. 120 CONG. REC. 29,197 (1974) (statement of Rep. Dent) (emphasis added).

152. *Id.* at 29,933 (1974) (statement of Sen. Williams), *quoted in* *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

153. *Shaw*, 463 U.S. at 95 (quoting *Fidelity Fed. Sav. & Loan Assn. v. De la Cuesta*, 458 U.S. 141, 152-53 (1982); *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977)); *see also* *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court . . . must give effect to the unambiguously expressed intent of Congress.").

154. *Shaw*, 463 U.S. at 96-97.

preemption: “laws that specifically apply to ERISA plans; laws that impose a duty on ERISA plans by referencing ERISA plans; laws that mandate specific benefit structures or prohibit a method of determining the level of benefits; or common law actions that are within the scope of ERISA’s civil enforcement provisions.”¹⁵⁵

Any state law that applies solely to ERISA plans “relates to” ERISA plans and is preempted.¹⁵⁶ ERISA, however, does not preempt a state law when it “relates to” employee benefits, but not to a plan. For example, the Supreme Court upheld a state law requiring a one-time severance payment to displaced workers because the law, which affected an employee benefit, did not relate to a plan.¹⁵⁷ In reaching this conclusion, the Court reviewed the plain language of the preemption provision, the purpose of the provision, and the overall objectives of ERISA.¹⁵⁸ The Court found that the words “benefit” and “plan” had distinct uses and, therefore, they could not be treated as synonyms.¹⁵⁹

Even when a law relates to a plan, the Court must consider whether the law “regulate[s] insurance,” within the scope of the savings clause before concluding that ERISA preempts the law. To regulate insurance, the law must “not just have an impact on the insurance industry, but must be specifically directed toward that industry.”¹⁶⁰ Moreover, it must regulate “the business of insurance” as that phrase is specified in the McCarran-Ferguson Act.¹⁶¹ A law regulates the “business of insurance,” as contemplated by the McCarran-Ferguson Act, when it meets these criteria: “*first*, whether the practice has the effect of transferring or

155. Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255, 263-64 (1996); see, e.g., *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 126-27 (1992) (preempting a workers’ compensation provision that was related to ERISA plans); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829-30 (1988) (preempting a Georgia statute because it specifically referenced ERISA); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (preempting state common law contract claims seeking relief from ERISA’s civil enforcement provision); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (preempting state law that mandated specific benefit structures).

156. See *Greater Washington Bd. of Trade*, 506 U.S. at 129-31. For instance, a state statute applies solely to ERISA plans if it bars the garnishment of ERISA plan funds and benefits or workers’ compensation provisions. See *id.* at 126-27.

157. See *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 7-8 (1987). A Maine statute, which required employers to provide a one-time severance payment to employees in the event of a plant closing, was not preempted by ERISA despite the fact that ERISA does cover severance benefits. See *id.* at 23.

158. See *id.* at 7.

159. See *id.* at 7-8.

160. *Pilot Life*, 481 U.S. at 50.

161. 15 U.S.C. §§ 1011-1014 (1994).

spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry."¹⁶² A state law must meet all three of these criteria to fall within the scope of the savings clause and thus avoid preemption by ERISA. Even if a state law is "saved" by virtue of this analysis, however, it will still be preempted if it attempts to deem an employee benefit plan to be insurance for purposes of the law.¹⁶³ Thus, self-insured plans are not subject to state law as a result of the deemer clause.¹⁶⁴

III. PROBLEMS IN COORDINATING STATE AND FEDERAL INSURANCE REGULATION

The problems with the current statutory structure are myriad. One commentator, summarizing the literature on protection of beneficiaries, observed that "[e]mployees frequently are cheated out of employer-provided pension, health insurance, and severance pay benefits. The reason is simple: the courts do not construe the law to protect them."¹⁶⁵ From the state regulators' (and perhaps the beneficiaries') perspective, the problem with ERISA is not only that it preempts state insurance regulation, but that it provides no clear alternative to protect consumers. Indeed, ERISA not only makes federal law primary, it also precludes state regulation even where federal law is silent.¹⁶⁶ ERISA explicitly prohibits all state regulation of health insurance, but in its original form provides no regulation of this employee benefit whatsoever.¹⁶⁷ The resulting "regulatory vacuum" has gone unremedied—both legislatively and judicially—in the ensuing decades, leaving states powerless to protect their citizens from harm. In many cases, an employee benefit plan controls who receives treatment and the type of treatment available, and the regulatory vacuum provides no recourse to citizens who are denied coverage that results in physical detriment or death to the participant.¹⁶⁸

162. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

163. *See* 29 U.S.C. § 1144(b)(2)(B) (1994).

164. *See id.*; *infra* Part III.A (discussing self-insured benefit plans).

165. Carr & Liebross, *supra* note 149, at 221, *quoted in* Paul O'Neil, *Protecting ERISA Health Care Claimants: Practical Assessment of a Neglected Issue in Health Care Reform*, 55 OHIO ST. L. J. 723, 724 n.5 (1994).

166. Fox & Schaffer, *supra* note 141, at 240; *see also supra* notes 129-49 and accompanying text (discussing ERISA preemption of state insurance law).

167. Recent amendments have addressed some substantive benefits. *See supra* Part II.B.3 (discussing congressionally imposed mandates on employer-sponsored health plans).

168. *See, e.g., Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (holding that employee's state tort claims are preempted by ERISA and that extra-contractual damages are not recoverable under ERISA section 502(a)(3)).

In its current form, ERISA meets none of the stated legislative goals. It does not protect beneficiaries because it does not regulate benefits or guide courts in doing so. Instead of the envisioned uniform national standards, ERISA indirectly creates inconsistent standards for insurance companies because judicial interpretations of ERISA have carved out an assortment of seemingly unrelated pockets of state regulation.¹⁶⁹

A. *Self-Insured Benefit Plans*

A self-insured benefit plan is any plan not funded by an insurance policy.¹⁷⁰ Self-insured plans fall into two categories, depending upon the extent of risk borne by the employer. First, when an employer assumes all of the risk, the plan is totally self-insured. Second, “[u]nder a minimum-premium plan, the employer bears the risk up to some stop-loss threshold, after which an insurer bears or shares the risk for additional claims.”¹⁷¹ In order to be self-insured, the day-to-day administration of the plan must be “the responsibility of the employer, an insurance carrier, a third-party administrator (“TPA”), or a combination of these.”¹⁷² In 1984, for example, employers administered twenty-three percent of self-insured plans, thereby accounting for sixteen percent of all employees covered by self-insured plans.¹⁷³

States cannot regulate anything that is not within the scope of the

169. Many of the significant Supreme Court cases themselves define exceptions in which states may regulate. For example, the Supreme Court found that a state law that required a one-time severance payment to employees in the event of a plant closing was not a “plan” under ERISA and therefore was not preempted. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). The Court has also determined that a statute mandating certain health benefits in all insurance plans was saved from preemption, applying the McCarran-Ferguson definition of business of insurance. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). Creating another loophole in *Shaw v. Delta Air Lines Inc.*, the Supreme Court held that state laws are only preempted insofar as they prohibit practices that are otherwise lawful under federal law. *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85, 102-03 (1983). Thus, a state law designed to assist in enforcement of federal Title VII rights was not preempted given the importance of state fair employment laws in the Title VII scheme. *See id.* Similarly, the inconsistency between the circuits regarding the manner in which partially self-insured plans (those using stop-loss coverage to protect against catastrophic loss) has created opportunities for some states to regulate while others are preempted. *See supra* Part II.B (discussing regulatory framework for employer-sponsored health insurance under ERISA).

170. *See Jensen & Gabel, supra* note 11, at 328.

171. *Id.* at 329.

172. *Id.*

173. *See id.* (citing a national survey conducted by the Health Care Financing Administration and described in Patricia McDonell et al., *Self-Insured Health Plans*, 8 HEALTH CARE FINANCING REVIEW 2 (1986) and Mandex, Inc., *Survey of Employer-Sponsored Health Plans: Benchmark Report* (1987) (prepared for Dep’t of Health & Human Services, Health Care Financing Administration)).

“business of insurance,” nor can they regulate anything that is not insurance.¹⁷⁴ Due to the deemer clause, states may not characterize an employer funded benefits plan as insurance.¹⁷⁵ Likewise, stop-loss coverage, which is not a commercial health insurance plan, is generally not subject to state regulation under recent court decisions.¹⁷⁶ Accordingly, self-insured plans that do not purchase traditional commercial insurance cannot be regulated.

In *FMC Corporation v. Holliday*,¹⁷⁷ the Supreme Court read the deemer clause to exempt self-insured ERISA plans from state laws that regulate insurance within the meaning of the savings clause. The Court noted that “if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts; if the plan is uninsured, the State may not regulate it.”¹⁷⁸ Therefore, the Court reasoned that any power to regulate arises from the contractual nature of the “business of insurance.” Where the plan is self-insured, no third party contract is in place and, thus, no “business” to regulate exists.

In his dissent to *FMC*, Justice Stevens noted that “[t]he Court’s construction of the statute draws a broad and illogical distinction between benefit plans that are funded by the employer (self-insured plans) and those that are insured by regulated insurance companies (insured plans).”¹⁷⁹ Lower courts, following *FMC*, have found that fully self-insured plans are beyond the states’ power to regulate pursuant to the deemer clause.¹⁸⁰ The Court’s interpretation of ERISA thus indirectly encourages employers to become self-insured in order to remove themselves from the jurisdiction of state laws that might otherwise regulate their insurance contracts.

Self-insuring is most prevalent among larger employers, but is present in nearly identical percentages across broad occupational categories

174. See *supra* notes 133-34 and accompanying text (discussing the savings clause).

175. See *supra* note 135 and accompanying text (discussing the deemer clause).

176. See *infra* notes 196-204 and accompanying text (discussing preemption of state laws regulating stop-loss coverage as insurance).

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

178. *Id.* at 64.

179. *Id.* at 65 (Stevens, J., dissenting).

180. See, e.g., *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977); *Raimondo v. United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund*, 1987 WL 7033 (E.D. La. 1987); *Kilmer v. Central Counties Bank*, 623 F. Supp. 994 (W.D. Pa. 1985); *Wheeler v. Furr’s Inc.*, 7 EBC 2102 (N.M. 1986); *Dillard v. Teamsters Council 83 Health & Welfare Fund*, 6 EBC 2558 (W.D. Va. 1985); *Provience v. Valley Clerks Trust Fund*, 209 Cal. Rptr. 276 (Cal. App. 3d 1984); *Russo v. Boland*, 431 N.E.2d 1294 (Ill. App. Ct. 1982); *State Farm Mut. Auto. Ins. Co. v. C. A. Muer Corp.*, 397 N.W.2d 299 (Mich. Ct. App. 1986); *Hunt v. Sherman*, 345 N.W.2d 750 (Minn. 1984).

such as professional and administrative workers, technical and clerical workers, and production workers.¹⁸¹ Recent accounting suggests that only eleven percent of employees in small firms (100 or fewer employees) were covered by self-insured plans, while thirty-four percent of employees in moderate-size firms (101 to 500 employees) and sixty-three percent in large firms (over 500 employees) were covered by self-insured plans.¹⁸² In fact, enrollment in self-insured plans among medium and large private sector employers nearly doubled between 1981 and 1985.¹⁸³ Even among small firms, however, self-insuring for employers with fewer than 100 employees increased by four percent between 1990 and 1992.¹⁸⁴ Many state regulators fear that ready availability will lead to the purchase of stop-loss insurance which assumes most of the risk. They argue that this stop-loss insurance should therefore be subject to state health insurance laws.¹⁸⁵

The well-publicized case of *McGann v. H. & H. Music Co.*¹⁸⁶ illustrated the potential effect of this trend toward self-insuring.¹⁸⁷ In *McGann*, an employer dramatically reduced lifetime benefits for employees with AIDS-related illnesses after discovering an employee had AIDS.¹⁸⁸ The employer eluded liability for the benefits reduction even though the employer admitted that its knowledge of the employee's illness prompted the reduction.¹⁸⁹ Because the original contract allowed termination or amendment of the plan by the sponsor,¹⁹⁰ the employer avoided liability by simply changing from an insured health plan to a self-insured plan, which took the plan outside the scope of the savings

181. See Jensen & Gabel, *supra* note 11, at 331.

182. See U.S. GEN. ACCT. OFF., VARYING STATE REQUIREMENTS AFFECT COST OF INSURANCE, *supra* note 36, at 4.

183. See Jensen & Gabel, *supra* note 11, at 331.

184. See U.S. GEN. ACCT. OFF., EMPLOYER-BASED HEALTH PLANS, *supra* note 20, at 3.

185. See U.S. GEN. ACCT. OFF., VARYING STATE REQUIREMENTS AFFECT COST OF INSURANCE, *supra* note 36, at 4. Maryland and Missouri enacted regulations embodying the National Association of Insurance Commissioners (NAIC) stop-loss model act which defines the levels of risk that a stop-loss carrier may assume. See *id.* at 4 n.7. Lower courts found that ERISA preempted both of these state regulations. See *American Med. Sec. Act, Inc. v. Bartlett*, 915 F. Supp. 740, 746 (D. Md. 1996); *Associated Indus. of Missouri v. Angoff*, 937 S.W.2d 277 (Mo. Ct. App. 1996).

186. *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991).

187. See *id.*

188. See *id.* at 403.

189. See *id.* at 404. There was no allegation "that the reduction of AIDS benefits was intended to deny benefits to McGann for any reason which would not be applicable to other beneficiaries who might then or thereafter have AIDS . . ." *Id.*

190. See *id.* at 405.

clause and brought it within the scope of ERISA's preemptory power.¹⁹¹

In contrast to *McGann*, however, the Sixth Circuit held that totally self-insured plans were not entirely immune from traditional state insurance regulation by operation of the deemer clause.¹⁹² Rather, the Sixth Circuit held that some federal interest in the uniformity of administration must outweigh the expressed federal interest in the states' regulation of insurance under the McCarran-Ferguson Act in order for the deemer clause to override the savings clause, otherwise affording exemption for state insurance laws.¹⁹³ The court stated that this approach allowed a reconciliation of the competing federal policies of the McCarran-Ferguson Act and ERISA and was not inconsistent with the Supreme Court's dicta in *Metropolitan Life Insurance Co. v. Massachusetts*.¹⁹⁴ Thus, according to the Sixth Circuit, the deemer clause does not bar operation of the state law when there is "no demonstrated interest in national uniformity and preemption of the state law would substantially disrupt a state regulatory scheme generally applicable to both insured and self-insured ERISA plans"¹⁹⁵

B. *Stop-Loss Coverage of Self-Insured Plans*

Currently, the federal circuits are split regarding the extent of permissible state regulation regarding stop-loss coverage of self-insurance plans. The ambiguous nature of these plans drives part of the confusion behind this split. Self-insured plans may be fully funded by the employer so that all risk is borne by the employer without recourse to an outside insurance policy. State regulation of these plans is preempted by ERISA.¹⁹⁶ More commonly, however, the self-insuring employer seeks stop-loss coverage to limit the risk of catastrophic loss.¹⁹⁷ When a self-insuring employer uses stop-loss coverage, the employer pays all claims up to a certain limit or trigger-point. Above the trigger-point, a

191. The court does not discuss what, if any, claims would have been available to *McGann* under state tort law. See generally *McGann*, 946 F.2d 401. *McGann*, however, alleged discriminatory motive in the amendment of the plan. See *id.* at 404. Under state tort law, this might have been characterized as bad faith and a non-ERISA plan might be found liable. See, e.g., *Cathey v. Metropolitan Life Ins. Co.*, 805 S.W.2d 387, 391-93 (Tex. 1991).

192. See *Northern Group Serv., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 95 (6th Cir. 1987).

193. See *id.*

194. See *id.* at 94; see also *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-41, 747 (1985).

195. *Northern Group*, 833 F.2d at 95.

196. See *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

197. See Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 249 (1997).

commercial insurance company assumes the risk of paying claims.¹⁹⁸ When a self-insured employer uses this stop-loss coverage to control its risk, the courts must determine whether laws governing these otherwise self-insured plans are preempted because of the deemer clause or saved because the stop-loss coverage causes the plan to revert to insurance.¹⁹⁹

The Supreme Court has yet to address the question of stop-loss coverage in partially self-insured plans. The courts that have addressed the issue have reached no clear consensus. Some courts take a purely textual approach when interpreting these contracts and find them to be free from state regulation by the action of the deemer clause.²⁰⁰ Other courts take a more functional view, considering the process and effect of the stop-loss insurance rather than the name the insurer uses to describe the plan.²⁰¹

The disparate means of analyzing stop-loss plans leads to inconsistent results, depending upon the district in which the claim is brought. Some courts, notably the Sixth Circuit, have not found that ERISA preempts state laws purporting to regulate stop-loss coverage as insurance.²⁰² Other courts have found state law to be preempted.²⁰³ The net effect of this circuit split is to create a national inconsistency in the regulation of employee benefits plans that are partially self-insured.²⁰⁴

198. See Jeffrey G. Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX REV. 615, 626 (1995).

199. See Edward Albuo Morrissey, *Deem and Deemer: ERISA Preemption under the Deemer Clause as Applied to Employer Health Care Plans with Stop-Loss Insurance*, 23 J. LEGIS. 307, 312-13 (1997).

200. *But see* Michigan United Food & Commercial Workers Unions v. Baerwaldt, 767 F.2d 308 (6th Cir. 1985) (holding that as long as the plan purchases insurance from an insurer offering health insurance, it is subject to state regulation of insurance).

201. See, e.g., Thompson v. Talquin Building Prod. Co., 928 F.2d 649 (4th Cir. 1991) (finding that stop-loss insurance is designed to protect the employer from catastrophic losses, not to provide health or accident insurance to the participant); United Food & Commercial Workers Trust v. Pacyga, 801 F.2d 1157 (9th Cir. 1986) (noting that stop-loss provider did not pay benefits to participant or take over administration of the plan, thus, the plan should properly be considered a self-insured plan despite using a commercial insurer).

202. See *Baerwaldt*, 767 F.2d 308; see also Northern Group Serv., Inc. v. Auto Owners Ins. Co., 833 F.2d 85 (6th Cir. 1987) (holding that state law requiring insurers to offer coordination of benefits provisions was not preempted by ERISA).

203. See *Pacyga*, 801 F.2d 1157 (holding that a self-insured plan that purchases stop-loss coverage is not insurance for the purpose of saving it from preemption); Moore v. Provident Life & Accident Ins. Co., 786 F.2d 922 (9th Cir. 1986) (finding that because the "trigger point" was never reached, there was no insurance contract eligible for regulation involved in the plaintiff's claim and it was preempted); St. Paul Elec. Workers Welfare Fund v. Markman, 490 F. Supp. 931, 933-34 (D. Minn. 1980).

204. See, e.g., *Northern Group*, 833 F.2d at 90-91 (preempting state law regulating insurance when plan is insured by an outside carrier only for stop-loss); Bone v. Association Management Serv., Inc., 632 F. Supp. 493, 495 (S.D. Miss. 1986) (holding that characterization of a plan as

C. Preclusion of State Common Law Claims

State tort law has developed to protect citizens from encroachment by other citizens and commercial enterprises through compensation and, in some cases, punishment. Arguably, the congressional intent of the savings clause was to achieve the purpose of "saving *all* state law regulating insurance, including state decisional law."²⁰⁵ If this were Congress' intent, the Supreme Court's decision in *Pilot Life Insurance Co. v. Dedeaux*²⁰⁶ clearly frustrated it.

In *Pilot Life*, the Court held that state common law does not fall within the savings clause.²⁰⁷ The Court reasoned that in order to regulate insurance within the requirements of the clause, the law must not only have an impact on insurance, but must also be specifically directed toward insurance.²⁰⁸ The Court pointed out that bad faith claims derive from general principles of state tort and contract law and any bad faith breach of contract may create liability, not just a breach of an insurance contract.²⁰⁹ Thus, the Court held that bad faith law does not affect spreading of policyholder risk, has only tenuous effects on the relationship between the insured and the insurer, is not limited to the insurance industry in its impact,²¹⁰ and does not meet the criteria of "the business of insurance" set forth in the McCarran-Ferguson Act.²¹¹ Moreover, the Court concluded that all suits brought asserting improper processing of claims under ERISA-regulated plans are subject to ERISA's enumer-

"partially insured" was not appropriate because the stop-loss policy insured only the plan and not the individual beneficiary); *Hutchinson v. Benton Casing Serv., Inc.*, 619 F. Supp. 831, 838-39 (S.D. Miss. 1985) (holding there was no cause of action for wrongful termination of medical benefits provided through a stop-loss trust that could not be deemed insurance); *Cuttle v. Federal Employees Metal Trades Council*, 623 F. Supp. 1154, 1157 (D. Me. 1985) (holding that stop-loss insurance is not group health insurance but is insurance obtained by self-insuring entity to cover risks beyond its premiums; application of state law would have been proper except for deemer clause); *Dawson v. Whaland*, 529 F. Supp. 626, 632 (D. N.H. 1982) (preempting state law from covering stop-loss insurance on grounds that plan's benefit provisions were negotiated through a collective bargaining agreement); *General Split Corp. v. Mitchell*, 523 F. Supp. 427, 430 (E.D. Wis. 1981) (holding that the deemer clause preempted a state statute mandating certain conversion benefits and establishing risk-sharing plan for residents unable to secure coverage); *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931, 933-34 (D. Minn. 1980) (holding that the deemer clause preempted a state statute that required self-insurers to be members of a mandatory state-sponsored association to provide reinsurance, even though the statute applied only some regulations to the group of reinsurers).

205. O'Neil, *supra* note 165, at 728.

206. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987).

207. *See id.*

208. *See id.* at 50.

209. *See id.*

210. *See id.* at 50-51.

211. *Id.* at 51.

ated remedies.²¹² As a result, even when a participant or beneficiary raises issues of bad faith in the claims process, there is no cause of action for punitive damages.²¹³ Thus, ERISA provides little incentive for insurance companies to quickly address problems in claims processing to avoid potential negative consequences.²¹⁴

ERISA's preemption of state common law claims, compounded by the failure to provide similar federal causes of action, creates the obvious inequity of leaving an injured party with no remedy. This is due to the fact that "[e]arly pension and health insurance cases under ERISA were often brought in state courts alleging state causes of action."²¹⁵ After removal to federal court, courts have generally dismissed these early pension and health insurance cases because ERISA preempted state law. Yet ERISA itself provides no remedy for the claims presented.²¹⁶ If state constitutional law governed the issue, it might be found unconstitutional under an "open courts" clause.²¹⁷ The United States Constitution, however, does not provide the same remedial protections.²¹⁸ This ultimately results in ERISA's failure to meet one of its express policies: "[t]o protect . . . the interests of participants in

212. See *id.* at 56.

213. See 29 U.S.C. § 1132(a) (1994 & Supp. II 1996).

214. As a Congressional Report noted:

[L]ittle financial downside exists for an insurance company that routinely delays payment or refuses to pay large claims [E]ven if a suit is brought and the court finds that the insurance company has behaved in the most egregious and outrageous way, the worst that could happen to the insurance company is that it would be forced to pay the claim it should have paid in the first place.

H.R. REP. NO. 102-1023, at 23-24 (1992).

215. Carr & Liebross, *supra* note 149, at 225.

216. See *id.*

217. Thirty-nine state constitutions include clauses, commonly called "open courts" clauses, that establish the citizens' rights to a remedy for injury. See Mark Thompson, *Letting the Air Out of Tort Reform*, 83-May A.B.A. J. 64, 68 (1997). For instance, the Indiana Constitution provides: "All courts shall be open; and every person, for injury done to him in his person, property, or reputation, shall have remedy by due course of law. Justice shall be administered freely, and without purchase; completely, and without denial; speedily, and without delay." IND. CONST. art. I, § 12 (emphasis added). The Oregon Constitution provides: "No court shall be secret, but justice shall be administered, openly and without purchase, completely and without delay, and every man shall have remedy by due course of law for injury done him in his person, property, or reputation." OR. CONST. art. I, § 10 (emphasis added). The Texas Constitution provides: "All courts shall be open, and every person for an injury done him, in his lands, goods, person, or reputation shall have remedy by due course of law." TEX. CONST. art. I, § 13 (emphasis added).

218. The federal counterpart is found in the Fourteenth Amendment, which provides that no state "shall . . . deprive any person of life, liberty, or property, without due process of law . . ." U.S. CONST. amend. XIV, § 1.

employee benefit plans . . . by providing for appropriate remedies, sanctions, and ready access to the Federal courts.”²¹⁹

IV. ERISA’S POTENTIAL TO REFORM HEALTH INSURANCE

ERISA contains a framework of federal authority to regulate employee benefits, including health insurance. The bare bones framework, however, waits to be beefed up. Its intent was to create uniformity of administration in order to protect both insurers and beneficiaries from the pitfalls of multiple standards depending on which state is involved. Indeed, the Supreme Court acknowledged “[t]he most efficient way to meet [the responsibilities of employers’ administration of employee benefits] is to establish a uniform administrative scheme, which provides a set of standard procedures”²²⁰

The Congressional Record suggests that “Congress wanted the federal common law to be modeled upon the law of collective bargaining agreements under section 301 of the Labor Management Relations Act of 1947 (“LMRA”).”²²¹ Interpreting the LMRA mandate, the Supreme Court found it appropriate to look to legislative policy and compatible state law in order to find the rule most likely to effectuate federal policy.²²² Like the LMRA, ERISA does not provide all of the information necessary to implement the statute’s objectives. Guidance for resolving ERISA cases can be obtained from the logical implications of ERISA’s express statutory language, its policy and legislative history, and relevant principles of state law.²²³ Unfortunately, the Department of Labor, which is charged with protecting employee rights, believes that it has

219. 29 U.S.C. § 1001(b) (1994).

220. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1986). The Court noted that the statements of the sponsors of ERISA reflected an awareness of the realities of employee benefits administration and sought a uniform set of procedures that would guide the processing of claims and disbursement of benefits. *See id.*

221. *Carr & Liebross*, *supra* note 149, at 225.

222. *See id.* (citing *Textile Workers of America v. Lincoln Mills of Alaska*, 353 U.S. 448, 456-57 (1957)). *Textile Workers* held that the Taft-Hartley Act subsection “gives federal District Courts jurisdiction in controversies that involve labor contracts in industries affecting commerce, without regard to diversity of citizenship or amount in controversy.” *Textile Workers*, 353 U.S. at 450. Additionally, the Taft-Hartley Act authorizes federal courts to fashion a body of federal law for enforcement of those collective bargaining agreements, which includes specific performance of promises to arbitrate grievances under collective bargaining agreements. *See id.* at 451.

223. *See Carr & Liebross*, *supra* note 149, at 225.

“no obligation to help people.”²²⁴ Based upon specific statutory provisions,²²⁵ it appears the agency is right.

Congress has enacted some reform measures as amendments to ERISA; however, most amendments to ERISA have been in the area of pension plan administration. As has become evident to those involved in or following the debates on health care reform, something must be done to address problems in health care access in the United States. Change can only be achieved through amending ERISA. Unfortunately, the greatest barrier in this process may be the process itself. For example, polls indicated that a substantial majority of Americans supported health care reform in 1993,²²⁶ but it was a dead issue politically by summer of 1994.²²⁷ Although some have suggested possible reasons the public lost interest,²²⁸ only the result is clear. After months of debate, despite continued evidence that the public was still concerned about the health care system, the American public simply lost interest.²²⁹ Clearly, effective lobbying and media attention affect the passage of some bills, such as the mother-child hospital stay legislation, which received considerable national attention. Although such provisions are extremely important to individuals and to society as a whole, debating each provision separately in a national forum is not the most efficient way to reform health care and health insurance in America. On the constantly changing landscape of health care in modern society, there is a vast array of health care programs and services, and the list changes almost daily. National debate on coverage of each program or

224. Alan D. Lebowitz, the highest career official at the Pension and Welfare Benefit Administration of the U.S. Department of Labor, stated that it has “no legal obligation to help people, to put it crudely.” Carr & Liebross, *supra* note 149, at 221. A subsequent internal agency order (No. 1-92), issued on June 3, 1992, announced a limited assistance program which included an agency willingness to “intervene on behalf of individuals when there is reason to believe that they are entitled to benefits, but such intervention will be informal and will not include litigation on behalf of any individual.” *Id.* at 229 n.2 (citing 19 Pens. Rptr. No. 27 (BNA) 1170 (July 6, 1992)).

225. See, e.g., 29 U.S.C. § 1132(b)(2) (1994) (preventing the Secretary of Labor from pursuing claims on behalf of beneficiaries and participants).

226. See Mollyann Brodie, *Americans' Political Participation in the 1993-94 National Health Care Reform Debate*, 21 J. HEALTH POL. POL'Y & L. 99, 100 (1996).

227. See *id.*

228. See *id.* (suggesting that those with the greatest concerns for health care reform were less likely to be politically involved); Philip Heymann & Jody Heymann, *The Fate of Public Debate in the United States*, 33 HARV. J. ON LEGIS. 511, 519 (1996) (suggesting that the American public does not trust government to tell the truth and became tired of the debate); Mark A. Peterson, *The Limits of Social Learning: Translating Analysis Into Action*, 22 J. HEALTH POL. POL'Y & L. 1077 (1997) (suggesting that social learning is often a decidedly political struggle over ideas and information, advanced by lessons designed to serve specific interests).

229. See Brodie, *supra* note 226, at 100.

service would significantly impair the resources, both in time and money, that the political process could invest in other issues of public concern and jeopardize public involvement in the debate.

More significantly, the politicization of health care appears to make it more difficult to enact reforms. During 1994, millions of dollars were spent on advertising to influence the national debate on health care reform, reaching levels in excess of the spending by both sides for a presidential election.²³⁰ Perhaps legislation affecting the relationship between members of Congress and their constituencies and fundraisers, such as term limits and limits on campaign contributions, may be ultimately more effective in resolving health insurance crises than any other legislation because it may assure that all of the interested voices have a greater opportunity to be heard by Congress. In the short term, however, such changes to the political process do not appear forthcoming, and the crisis in health insurance will not improve or disappear on its own. Therefore, there must be some effort to amend ERISA on a small but continuing basis to address some of these problems.

A. *Improved Department of Labor Enforcement of Current Law*

ERISA authorizes the Secretary of the Department of Labor to act in a number of areas in pension plan administration and employee benefits.²³¹ If the Secretary had more general authority to fully enforce ERISA welfare benefits regulations, then the problems presented by state law preemption might have less impact. This does not remove the public from the process, but it does change the allocation of resources. Where authority is given to regulate, authority should be given to enforce the regulations. Amending ERISA to provide "mandated benefits" without giving the Secretary of Labor the authority to enforce these provisions gives only an illusory benefit to the beneficiaries and participants.

Furthermore, eliminating the duty of each beneficiary to act as a private attorney general would allow efficient resolution by the Depart-

230. See Heymann & Heymann, *supra* note 228, at 516. The advertising was predominantly funded only on the side opposing reform, possibly limiting a true public dialogue when the voices of those in need of health care reform could not compete with for-profit organizations or other monied interests. See *id.* at 516-17.

231. For example, when an administrator refuses to supply information requested in accordance with ERISA, the Secretary of Labor is authorized to assess a civil penalty up to \$1,000 per day from the date of refusal until the report is filed with the Secretary. See 29 U.S.C. § 1132(c)(2) (1994). The Secretary is explicitly prohibited from exercising his authority to enforce violations under other parts of the same enforcement scheme, however, unless action is requested by the Secretary of the Treasury and participants, beneficiaries, or fiduciaries. See *id.* § 1132(b).

ment of Labor through one action against an insurer and would thereby relieve the courts of a potentially debilitating flood of duplicative cases against the same defendant. Surely a Congress that has considered tort reform as a means of controlling access to the courts did not intend to create a law that would potentially force hundreds into the legal system.²³² The reduction in duplicative litigation would also level the playing field between insurers who voluntarily comply with federal regulation and those who maintain "illegal" policies with only minimal penalties. Although the current overall policy clearly flies in the face of the stated purpose of ERISA of protecting beneficiaries, authorizing an administrative exercise of power could remedy this problem.

B. *Establish a Higher Standard of Judicial Review*

ERISA contains no express standard of review for decisions made by plan administrators.²³³ The Supreme Court determined that trust law guides the appropriate standard of review because ERISA is filled with principles appropriated from the law of trusts.²³⁴ Therefore, decisions made by a plan administrator with discretionary authority to determine eligibility for benefits or to construe terms of the contract are to be reviewed with a deferential standard.²³⁵ A large number of plans provide for administrative discretion in benefit determinations, thus, courts are often limited to review plan decisions for an abuse of discretion.²³⁶ Where terms are disputed or doubtful, the administrator may exercise reasonable discretion in interpreting terms without fear of reversal.²³⁷ Where the administrator does not clearly have discretionary authority

232. At least since 1983, Congress has considered questions of tort reform. See Andrew F. Popper, *A One-Term Tort Reform Tale: Victimizing the Vulnerable*, 35 HARV. J. ON LEGIS., 123, 123 n.2 (1998) (noting that the first generic tort reform bill of consequence was S. 44, 98th Cong. (1983), which would have rewritten the field in all areas, particularly punitive damages). Since that time, Congress has addressed numerous other proposals. See *id.* Despite the ongoing concern about tort reform, a recent study suggested that only four percent of all civil actions arise in tort. See Thompson, *supra* note 217, at 68 (citing a study by the Rand Institute for Civil Justice in Santa Monica, California).

233. With no guidance from the statute, courts reviewing early plan decisions applied a highly deferential "arbitrary and capricious" standard to review denial of benefits. See Jonathan P. Heyl, *Bedrick v. Travelers Insurance Co.: The Fourth Circuit's Continued Attempt to Work with the "Doctrinal Hash" of the Standard of Review in ERISA Benefit-Denial Cases*, 75 N.C. L. REV. 2382, 2382 (1997).

234. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989).

235. See *id.* at 111.

236. See Heyl, *supra* note 233, at 2382.

237. See *Firestone*, 489 U.S. at 111.

and the dispute turns on interpretation of terms in a plan, the court reviews de novo.²³⁸

Giving deferential review to a plan administrator's decisions essentially gives control of the henhouse to the fox because the plan administrator has a clear mandate to act as a fiduciary whose primary purpose is *to protect the interests of the beneficiary*.²³⁹ Deferential review is only appropriate when the decision-maker, a trial court or some other impartial tribunal, such as an arbitration panel, lacks bias and, therefore, can be presumed to apply the rules even-handedly.

In contrast, the plan administrator being accorded this deference is an employee of the party who has allegedly violated the law and, in some cases, may be the actor who caused the violation. The potential for conflict arises when an employee makes a decision that either costs or saves his employer money.²⁴⁰ The potential for bias in this case is not likely to occur in other situations when the courts use deferential review. Any decision made that is not clearly in the best interest of the beneficiary is against the explicit statutory duty of the plan administrator and should be subject to significant judicial scrutiny.

C. Strengthen Consumer Protections in ERISA Plans

ERISA could also be amended to impose specific consumer protections on employer-sponsored health plans. The 105th Congress considered several major bills from both sides of the aisle to reform managed care and impose consumer protections on managed care plans through consumer mandates.²⁴¹ The President also convened a high level task

238. See *id.* at 115.

239. 29 U.S.C. § 1104 (1994) provides: "(a) Prudent man standard of care. (1) [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (I) providing benefits to participants and their beneficiaries . . ." *Id.* § 1104(a).

240. One unfortunately common example of the conflict that an administrator may face is the cost-containment process that determines whether to provide coverage in the managed care context. In *Corcoran v. United Healthcare, Inc.*, would-be parents sued their managed care organization alleging that the utilization review services were negligently provided and, as a result, were responsible for the wrongful death of their unborn child. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324 (5th Cir. 1992). The court found their claim preempted by ERISA. See *id.* at 1334; see also Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251 (1997).

241. The major republican bills were the Patients' Bill of Rights Act, S. 2330, 105th Cong. (1998) (introduced by Sen. Don Nickles (R-Okla.)); the Patient Access to Responsible Care Act of 1997, H.R. 1415, S. 644, 105th Cong. (1997) (introduced by Rep. Charlie Norwood (R-Ga.) and Sen. Alphonse D'Amato (R-N.Y.)); and the Patient Protection Act of 1998, H.R. 4250, 105th Cong. (1998) (introduced by Rep. Newton Gingrich (R-Ga.)).

President Clinton's bill was the Health Insurance Consumer's Bill of Rights Act of 1997,

force to investigate how to improve consumer protections in health plans. This task force developed recommendations that formed the basis of a democratic consumer protection bill. Several bills before the 106th Congress call for the same type of consumer protections.²⁴² Yet Congress has taken little action thus far in pushing these bills to passage.

The consumer protection provisions contained in the bills before the 105th Congress were comprehensive.²⁴³ Specifically, as amendments to ERISA, these bills required disclosure of extensive information about plan coverage and benefits as well as available grievance and appeal procedures.²⁴⁴ The bills also regulated utilization review and included use of appropriately trained reviewers, timely review and other protections.²⁴⁵ Most of the consumer protection provisions required plans to advise consumers of the medical rationale for decisions.²⁴⁶ All bills generally required that medical review criteria, including medical practice guidelines, be based on sound scientific principles and the most recent medical evidence.²⁴⁷ Finally, most bills also addressed plan quality improvement programs.²⁴⁸

H.R. 2967, S. 1499, 105th Cong. (1998) (introduced by Rep. Charles Schumer (D-N.Y.) and Sen. Barbara Boxer (D-Cal.)). The major Democratic bill was the Patients' Bill of Rights Act of 1998, H.R. 3605, S. 1890, 105th Cong. (1998) (introduced by Sen. Thomas A. Daschle (D-S.D.) and Rep. John H. Dingell (D-Mich.)).

All of the bills would impose protections on employer-sponsored plans regulated under ERISA. *See* S. 2330 §101(a); H.R. 3605, S. 1890 §301; *see also* H.R. 1415, S. 644 §3(a); H.R. 2967, S. 1499 §202(a); H.R. 4250, §§1001-1307. Some bills would extend protections to state regulated plans. *See* S. 2330 §303; H.R. 3605, S. 1890 §§201-202; *see also* H.R. 1415, S. 644 §2(a)(2); H.R. 2967, S. 1499 §201(a); H.R. 4250 §§2001-2301. President Clinton's bill would extend these protections to managed care plans that serve Medicare and Medicaid beneficiaries. *See* H.R. 2967, S. 1499 § 204.

242. Comparable bills before the 106th Congress include the Children's Health Insurance Accountability Act of 1999, H.R. 1661, 106th Cong. (1999); the Comprehensive Managed Health Care Reform Act of 1999, H.R. 1133, 106th Cong. (1999); the Affordable Health Care Act of 1999, H.R. 1136, 106th Cong. (1999); the Managed Care Reform Act of 1999, H.R. 719, 106th Cong. (1999); and the Patient Protection Act of 1999, H.R. 448, 106th Cong. (1999).

243. *See supra* Part II.B.3.d (outlining proposed amendments to ERISA).

244. *See* S. 2330 §111; H.R. 3605, S. 1890 §121; *see also* H.R. 1415, S. 644 §2(a)(2); H.R. 2967, S. 1499 §101; H.R. 4250 §§1101, 2101, 3101.

245. *See* S. 2330 §121; H.R. 3605, S. 1890 §115; *see also* H.R. 1415, S. 644 §2(a)(2); H.R. 2967, S. 1499 §101(2); H.R. 4250 §1201.

246. *See* H.R. 3605, S. 1890 §115(e); *see also* H.R. 1415, S. 644 §2; H.R. 2967, S. 1499 §101; H.R. 4250 §1101. The major Republican bill, S. 2330, provides only for disclosure of a summary of utilization review procedures. *See* S. 2330 §111.

247. *See* S. 2330 §121; H.R. 3605, S. 1890 §111(b); *see also* H.R. 1415, S. 644 §2(a)(2); H.R. 2967, S. 1499 §101(2).

248. *See* H.R. 3605, S. 1890 §111; *see also* H.R. 1415, S. 644 §2; H.R. 2967, S. 1499 §101.

D. Clarification of Tort Liability for Plan Conduct

ERISA largely fails to provide a sufficient remedy to an injured party. Moreover, ERISA effectively eliminates many claims because the out-of-pocket expense in obtaining legal assistance to reinstate benefits is often not very cost effective, either for the beneficiary or for the attorney. Although ERISA specifically allows for the award of attorney fees to the prevailing party, prevailing defendants are almost uniformly unsuccessful in receiving a fee.²⁴⁹ When plaintiffs prevail, most circuits use a five-part test to determine whether attorneys' fees should be awarded.²⁵⁰ As a result, the outcome of a claim for attorney's fees is highly unpredictable.²⁵¹ However, once a court makes a decision on attorney's fees, it is reviewable only for abuse of discretion.²⁵²

Furthermore, the list of available claims does not necessarily reflect the types of claims that might have been available in the pre-ERISA era.²⁵³ Congress designed ERISA to eliminate the abuses of the employee pension process, yet ERISA has effectively created the potential to perpetuate the same kinds of abuse in employee benefit plans that existed before ERISA's enactment. The failure to create real deterrent effects for abuses does little to promote the intent of the Act. Thus, Congress should amend ERISA to address at least three issues: (1) judicial interpretation of preemption provisions,²⁵⁴ (2) guidelines for federal

249. See *ERISA Attorneys' Fees; Part II: Discretion Continued*, 4 No. 6 ERISA LITIG. REP. 22, 23 (1996).

250. See *id.* at 22. The five-factor test was adopted by the Tenth Circuit in *Eaves v. Penn* and has since been applied to varying degrees in other jurisdictions. *Eaves v. Penn*, 587 F.2d 453, 453 (10th Cir. 1978). Under this test, attorney's fees are only awarded after weighing:

(1) the degree of the offending party's culpability or bad faith; (2) the ability of the offending party to satisfy an award of attorneys' fees; (3) whether an award of attorneys' fees would deter other persons in similar circumstances; (4) the benefit conferred by the action on other participants or a plan as a whole; and (5) the relative merits of the parties' positions.

Id.

251. See *id.*

252. See *id.*

253. Prior to the adoption of ERISA, a claim against an insurance provider for denial of benefits was usually brought under state contract law, and to a lesser extent, under state trust law. See George Lee Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611, 611 (1994). None of these common law claims is available to injured beneficiaries and participants as a result of the Supreme Court's determination that Congress did not intend to save the common law under ERISA's savings clause. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987).

254. See *infra* Part IV.D.1 (providing guidance to the judiciary in interpreting the preemption provisions).

common law relating to ERISA;²⁵⁵ and (3) specific mandatory remedies for failing to fulfill ERISA mandates.²⁵⁶

1. Guidance to the Judiciary in Interpreting the Preemption Provisions

Despite the Supreme Court's determination that section 502(a) provides the exclusive source for civil enforcement, preempting state common law actions that do not regulate the "business of insurance,"²⁵⁷ ERISA's text clearly suggests that state decisional law was intended to be within the scope of state law that might be "saved" from preemption.²⁵⁸ The Supreme Court noted in a footnote that: "[d]ecisional law that 'regulates insurance' may fall under the saving clause For purposes of § 514, '[t]he term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State."²⁵⁹ The effect of this interpretation would be to recognize state common law that "relates to" employee benefit plans just as the Court recognizes state statutory law that "relates to" employee benefit plans. If Congress takes this approach, courts can better protect individuals because most states have lengthy histories leading to the adoption of specific rules. The difficulty in recognizing any state law (statutory or common) is that it re-creates the diversity of standards that insurers must meet when they offer insurance in different states. The diversity of standards already exists, however, because of the saving of statutory law.²⁶⁰ Thus, recognition of state common law should not make this diversity any more deplorable from a legal perspective.

2. Guidance for Developing a Federal Common Law Furthering the Purposes of ERISA

Courts generally restrict federal common law development to areas that are either consistent with a federal statute or that fill the gaps, oversights, ambiguities or neglected procedural questions of the statute. As one court explained:

A federal court may create federal common law based on a federal statute's preemption of an area only where the federal statute does not

255. See *infra* Part IV.D.2 (offering guidance for developing a federal common law furthering the purposes of ERISA).

256. See *infra* Part IV.D.3 (outlining specific remedies for failing to fulfill ERISA mandates).

257. See *Pilot Life*, 481 U.S. at 41.

258. See 29 U.S.C. §§ 1144(c)(1), (2) (1994) (defining "state law" as including every law, decision, rule, regulation, and all other state actions that affect the law).

259. *Pilot Life*, 481 U.S. at 48 n.1 (quoting 29 U.S.C. §§ 1144 (c)(1), (2)).

260. See *supra* notes 134, 136, 138-40 and accompanying text (discussing the savings clause as it relates to preemption).

expressly address the issue before the court Furthermore, even when it is appropriate for a federal court to create federal common law, it may use state common law as the basis of the federal common law only if the state law is consistent with the policies underlying the federal statute in question.²⁶¹

One of the policies underlying ERISA is to protect beneficiaries from the failure of the plan to provide contractual benefits. If this policy statement is insufficient to guide courts in determining which state common law may be consistent with the federal policies, then it is essential that Congress speak to the courts as to its intent for the interpretation of ERISA. At this point, there are substantial gaps between the pure text of ERISA and the purpose statements both within its text and in its legislative history; thus, it is vital that Congress provide clarification so courts may implement the will of Congress. Congress can approach this task in several ways. First, although unlikely and unwieldy, Congress could directly specify the rules it wished courts to follow by incorporating more concrete language into ERISA itself. For example, Congress could specify when to apply state common law, or Congress could adopt statements by specific recommending committees, such as the Restatements of the Law or Model Codes.

Second, and more appropriately, Congress could directly address the standards and duties to be imposed upon the parties involved. Specifically, Congress should impose duties of good faith and fair dealing and other common duties from state agency, contract, and tort law in order to meet the expectations of participants in employee benefit plans. Instead, if Congress chooses to maintain a fiduciary standard as the guide for plan administrators, then it must directly address the conflict of interests inherent in the role as well as identify clear and reasonable penalties for violation of the fiduciary duty.

In addition, the rapid growth of self-insured plans, managed care plans that utilize "mixed" provider-insurer structures, and other innovative health provider networks has created concerns regarding quality of care. Where these plans fall within the scope of ERISA preemption, Congress must provide guidance as to the applicable standards. Although states address these issues in a variety of ways, some generally applicable rules, which would not change the requirements most insurers must meet when their plans fall within the state's control, are available. The common law has a long history of protecting beneficiaries and this excellent resource should not be dismissed. Again, Congress

261. *Nachwalter v. Christie*, 805 F.2d 956, 957-58 (11th Cir. 1986).

could give tremendous guidance to the judiciary simply by adopting existing sources as a standard for decision-making.

3. Specific Remedies for Failure to Meet ERISA or Plan Provisions

Penalizing an insurer that discriminates only by requiring the inclusion of the person on the plan is insufficient. This scheme does not encourage compliance, but obstructs the participant or beneficiary who must often expend considerable resources to compel the insurer to act. Although ERISA does allow attorney fees for either party, the award of fees is at the judge's discretion and is inconsistently available.²⁶² If the only remedy available will be injunctive relief, Congress must mandate payment of attorney fees when an insurer is in violation of ERISA. The use of a private enforcement scheme is not effective unless the private individual is protected in the process and has some legitimate expectation that a valid complaint will not cost more than the cost of purchasing alternative coverage.

The alternative, of course, would be to give the Secretary of Labor the authority to prosecute these claims on behalf of the beneficiary or participant. Although this may be a tremendous burden on the agency, it could effectively serve the purpose of protecting the participants' and beneficiaries' interests. Along with this transfer of authority, there should be an opportunity for the Secretary of Labor to seek penalties commensurate with the harm done. For example, if the Secretary of Labor discovers a pattern of consistently refusing the same services, a greater penalty should be imposed, such as a fine for violations, in addition to costs. The Secretary of Labor currently has authority to impose fines for behavior that violates certain provisions of ERISA. Allowing fines for violations of beneficiaries' rights would simply make the Secretary of Labor's existing powers consistent throughout ERISA.

E. Regulation of Stop-Loss Insurance

The exclusion of self-insured plans from state regulation has increased the gap in which no regulation exists. This results in many employers avoiding state regulation by becoming self-insured; however, they obtain stop-loss coverage to lessen the risk of a catastrophic claim. Although the stop-loss is ostensibly designed to control the employer's risk, it is often really the primary means of health insurance because the employer sets a very low threshold. The stop-loss carrier may (and often does) function more as a health insurer than a casualty insurer, be-

262. See *supra* notes 94, 249-52 and accompanying text (discussing the rarity of attorney fees awards by judges).

cause stop-loss coverage is not subject to a mandated minimum level. Courts have not consistently recognized this distinction.²⁶³ Instead, courts often take a “form over function” approach, placing these plans beyond the scope of state regulation.

In order to provide the protection of beneficiaries—an explicit purpose of ERISA—Congress must consider the effect of this gap in the current regulation. It may either: (1) expressly provide for state regulation of the business of insurance based upon the actual function of an insurance contract; or (2) set minimum thresholds for stop-loss coverage based upon the size of the employer. In either instance, it appears this requires an amendment to the deemer clause to redefine the types of arrangements that may not be deemed insurance.

V. CONCLUSION

Congress enacted ERISA to protect workers and their dependents from the loss of pensions and other employment benefits. Although ERISA has in some ways protected workers from harms such as pension plan insolvency, courts have given it an effect that has perpetuated the loss of workers’ other benefits. In the case of health insurance, Congress has failed to meet its own purpose of providing protection for participants and beneficiaries and must act to remedy this dreadful state. The courts, ruling within the scope of ERISA, have also failed to protect these two-fold victims (victimized first by their plan’s administration and second by Congress). In order to meet the stated legislative purpose of ERISA, Congress must either remedy its textual inconsistencies or add express protections. If Congress fails to do so, the courts must work to develop a common law consistent with the policies of ERISA, as expressed in the purpose statement, in order to protect beneficiaries. As the law currently stands, no one is acting to assure the protection of the beneficiaries. Thus, the protections afforded by ERISA remain merely illusory.

263. *See supra* Parts III.A-B (defining self-insured benefit plans and explaining stop-loss coverage of self-insured benefit plans).