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LEGISLATIVE REFORM

DEEM AND DEEMER: ERISA PREEMPTION UNDER THE DEEMER CLAUSE AS APPLIED TO EMPLOYER HEALTH CARE PLANS WITH STOP-LOSS INSURANCE

I. INTRODUCTION: ERISA PREEMPTION

A. The Preemption Clause

The federal Employee Retirement Income Security Act of 1974 (hereinafter "ERISA")¹ regulates the creation, operation, maintenance and termination of any "employee welfare benefit plan."² As such, ERISA provides sophisticated requirements and standards concerning reporting, disclosure, fiduciary responsibility, minimum employee participation, vesting and funding of employee welfare benefit plans.³ ERISA, however, does not substantially regulate the content of any such plan.⁴ For example, ERISA does not mandate the specific type or extent of coverage that an employee health care plan must provide to its members. Notwithstanding this, ERISA expressly preempts any state law from directly regulating such plan.⁵

Specifically, section 514(a) (hereinafter "preemption clause") provides that "... the provisions of this title ... shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ..."⁶ The Supreme Court has concluded that "... a law relates to an employee welfare plan if it has a 'connection with or reference to such a plan.'"⁷ Thus, the Court has applied the plain meaning of the preemption clause and afforded ERISA with broad exclusive jurisdiction.⁸

1. 29 U.S.C. § 1001-1461 (1996).

2. An employee welfare benefit plan is defined as, *inter alia*, "any plan, fund or program ... established or maintained by an employer or by an employee organization ... for the purpose of providing for its participants or beneficiaries ... medical, surgical, or hospital care or benefits ..." 29 U.S.C. § 1002(1) (1996). Thus, an employee welfare benefit plan includes certain employee health care plans.

3. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). Note that, with the exception of some requirements and standards such as fiduciary responsibility, employee participation and vesting, the internal revenue code also provides for many of the same requirements set forth in ERISA for purposes of pension taxation of qualified plans. See I.R.C. § 401-420 (1996); JOHN LANGBEIN AND BRUCE WOLK, *PENSION AND EMPLOYEE BENEFIT LAW* (2d ed., Foundation Press 1995) p. 147-605.

4. *Metropolitan Life Ins. Co.*, 471 U.S. at 732.

5. 29 U.S.C. § 1144(a) (1996). See also Daniel Fox & Daniel Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AMER. J. TAX POLICY 47 (1988) (ERISA preemption clause is unusual because it forbids the states from regulating employee benefits even when federal law is silent on an issue).

6. 29 U.S.C. § 1144(a) (1996).

7. *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983). See also *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

8. See *id.* ("The pre-emption clause is conspicuous for its breadth."); *Metropolitan Life*, 471 U.S.

B. The Insurance Savings Clause as an Exception to the Preemption Clause

ERISA provides an exception to the broad reach of the preemption clause. Section 514(b)(2)(A) (hereinafter "insurance savings clause") states that ". . . nothing in [Section 514] shall be construed to exempt or relieve any person from any law of any State which regulates insurance"⁹

In *Metropolitan Life Ins. Co. v. Massachusetts*,¹⁰ the Supreme Court examined the insurance savings clause exception to the preemption clause and found that, as with the preemption clause, the insurance savings clause must be broadly applied. In *Metropolitan Life*, a state law required insurers to provide certain health care benefits in its health insurance policies (hereinafter "mandated-benefit statute").¹¹ The state sought to enforce this mandated-benefit statute on an insurance company selling health care policies to employers and unions.¹² Specifically, the state asserted that such law, as applied to an insurer and its policies sold to employers and unions, fell within the scope of the insurance savings clause as an exception to ERISA preemption.¹³

The Court determined that, according to its plain meaning, the insurance savings clause was broad in scope.¹⁴ Accordingly, the Court found that because the mandated-benefit statute "regulates the terms of certain insurance contracts . . . [the law] . . . seems to be saved from pre-emption by the [insurance] saving[s] clause as a law 'which regulates insurance.'"¹⁵ Thus, as with the preemption clause, the insurance savings clause enjoys a sweeping reach.

C. The Deemer Clause as an Exception to the Insurance Saving Clause

1. The Deemer Clause as Applied to Self-Funded Plans

To ensure that any employer health care plan funded solely by the employer (hereinafter "self-funded plan") would not be subject to state regulation under the insurance savings clause, Congress promulgated an exception to this clause under

at 732; Leon Irish & Daniel Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J. L. REFORM 109, 110 (1985) ("The language of section 514(a) sweeps as broadly as the English language allows.").

9. 29 U.S.C. § 1144(b)(2)(A) (1996).

10. *Metropolitan Life Ins. Co.*, 471 U.S. 724.

11. *Id.* at 727. The mandated-benefit statute required health insurance policies to provide a certain minimum of mental-health care. *Id.* at 730.

12. *Id.* at 734. Such employers or unions would then offer these purchased policies to employees under a health care plan. *See generally, id.* at 727.

13. *Id.* at 733.

14. *Id.* at 739-40. The Court further noted that the broad scope of the insurance savings clause preserved the federal policy permitting the states to regulate the insurance industry. *Id.* at 739-47. This federal policy is embodied in the McCarran-Ferguson Act which provides that federal law should not be construed to supersede state laws "regulating the business of insurance." 15 U.S.C. § 1012(b) (1996). *See also* LANGBEIN & WOLK, *supra* note 3, at 417.

15. *Metropolitan Life Ins. Co.*, 471 U.S. at 740. The Court also found that the mandated-benefit statute (1) regulated the spreading of the policyholder's risk of mental-health care, (2) was an integral part of the policy relationship between the insurer and the policyholder since the law required the policy to contain certain terms, and (3) only imposed requirements upon insurers. *Id.* at 743. Because these criteria were present, the Court found that the mandated-benefit statute qualified as a traditional insurance law under the McCarran-Ferguson Act. *Id.* at 742-43. This finding was persuasive as to the Court's determination that the mandated-benefit statute fell within the ambit of the insurance savings clause. *Id.*

section 514(b)(2)(B) (hereinafter the "deemer clause").¹⁶ The deemer clause provides that "... an employee benefit plan . . . shall [not] be deemed to be an insurance company or other insurer . . . in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies . . ." ¹⁷ Thus, any (1) state law purporting to regulate insurance (2) as applied to a health care plan "established or maintained by an employer"¹⁸ would fall within the scope of the deemer clause and thus be preempted by ERISA.

In *FMC Corp. v. Holliday*,¹⁹ the Supreme Court construed the deemer clause as applied to a self-funded plan. In *FMC*, Holliday was a member of her mother's self-funded plan.²⁰ After Holliday sustained injuries as a result of an automobile accident, the plan paid for a portion of her medical expenses.²¹ Holliday filed a negligence action against the other driver in the accident and subsequently settled her claim.²² The plan sought reimbursement of the medical expenses from Holliday disbursed on her behalf pursuant to the plan's subrogation clause.²³ Holliday refused to reimburse the plan and claimed that a state law prohibiting subrogation precluded the plan from recovering its medical expenses from her.²⁴

The Court held that the state antisubrogation law was subject to the broad scope of the preemption clause because the law had "a connection with or reference to such a plan."²⁵ Specifically, the state law subjected plan administrators to potentially conflicting state regulations concerning the calculation of benefit payments.²⁶ Moreover, the state law included a "reference to" benefit plans governed by ERISA because such law expressly provided that benefits payable by a hospital plan corporation were not subject to reimbursement from a claimant's tort recovery.²⁷

Further, because the state law effectively invalidated any subrogation provision contained in an insurance contract sold to any employer or union, the Court found that

16. Before Congress enacted ERISA, many state insurance departments unsuccessfully sought to regulate self-funded plans under state insurance laws in order to collect premium taxes from employers offering such plans. See, e.g., *Danna v. Commissioner of Ins.*, 228 So. 2d 708 (La. Ct. of App. 1969); *California-Western States Life Ins. Co. v. State Bd. Of Equalization*, 151 Cal. App. 2d 559 (1957); *State Tax Comm'n v. John Hancock Mutual Life Ins Co.*, 341 Mass. 555 (1960); *Williams v. Massachusetts Mutual Life Ins. Co.*, 221 Tenn. 508 (1968).

However, one case in Missouri held "self-funded medical benefit plans to be insurance companies for purposes of state regulation." LANGBEIN & WOLK, *supra* note 3, at 420-21 (*Missouri v. Monsanto Co.*, Cause No. 259774 (St. Louis Cty. Cir. Ct., Jan. 4, 1973) *rev'd* 517 S.W. 2d 129 (Mo. 1974)); See also *Bost v. Masters*, 235 Ark. 393 (1962) (union accident and death benefit plan is subject to a state insurance law regulating the service of process upon insurers).

Most authorities agree that, in response to this Missouri case, Congress enacted the deemer clause to ensure that such self-funded plans would not be excepted from ERISA preemption under the insurance savings clause. Note that when Congress enacted ERISA, *Monsanto* had not yet been reversed. LANGBEIN & WOLK, *supra* note 3, at 420-21.

17. 29 U.S.C. § 1144(b)(2)(B) (1996).

18. 29 U.S.C. § 1002(1) (1996).

19. *FMC Corp.*, 498 U.S. 52.

20. *Id.* at 54.

21. *Id.* at 55.

22. *Id.*

23. *Id.* This clause required any plan member to reimburse the plan upon any recovery in a liability action against a third party. *Id.*

24. *Id.*

25. *Id.* at 58 (citations omitted).

26. *Id.* at 59. The Court noted that such conflicting state regulations have provided the basis for ERISA preemption in previous cases. *Id.* See also *Shaw*, 463 U.S. at 93-100.

27. *FMC Corp.*, 498 U.S. at 59-60.

the law "directly controls the terms of insurance contracts."²⁸ Accordingly, the Court held that the state antisubrogation law fell within the scope of the insurance savings clause as an exception to ERISA preemption.²⁹

However, the Court found that the state antisubrogation law, as applied to a self-funded plan, fell within the deemer clause as an exception to the insurance savings clause.³⁰ In its reasoning, the Court viewed "the language of the deemer clause . . . to be either coextensive with *or broader*, not narrower, than that of the [insurance] saving[s] clause."³¹ Thus, the Court found that, at bottom, the scope of the deemer clause was as broad as that of the insurance savings clause.

The Court also recognized that, given *Metropolitan Life* and *FMC*, ERISA preemption of certain state insurance laws depends upon the status of any employer health care plan subject to such law. Specifically, if such plan is self-funded, the deemer clause applies as an exception to the insurance savings clause.³² As a result, such law, as applied to a self-funded plan, is subject to preemption by ERISA. Alternatively, if an employer wholly purchases an insurance policy from an insurance company and offers such policy under an employer health care plan, such law does not fall within the scope of the deemer clause.³³ Accordingly, such law, as applied to such plan, is not subject to ERISA preemption by virtue of the insurance savings clause.³⁴

2. Problem: The Deemer Clause as Applied to Partially Funded Plans

At least three methods exist by which an employer can fund a health care plan:

- (1) the employer purchases a group insurance policy from a commercial insurance company (hereinafter "unfunded plan"), or
- (2) the employer absorbs the entire risk of loss, thereby becoming a self-insurer (a self-funded plan), or
- (3) the employer self-insures to a certain monetary amount and purchases from an insurance company a so-called "stop-loss" policy to cover any claim over that amount (hereinafter "partially funded plan").³⁵

Where an employer elects to provide an unfunded plan, *Metropolitan Life* holds that any state law having a "connection with" or "reference to" that plan falls within the insurance savings clause.³⁶ As a result, such plan would not be preempted by ERISA. Alternatively, where an employer elects to provide a self-funded plan, *FMC* holds that any state law having a "connection with" or "reference to" that plan is excepted from the insurance savings clause under the deemer clause.³⁷ Accordingly, ERISA would preempt such law.

28. *Id.* at 61.

29. *Id.*

30. *Id.*

31. *Id.* (emphasis added).

32. *Id.* at 61.

33. *Id.*

34. *Id.* "[The Court's decisions result] in a distinction between insured and uninsured [or self-funded] plans, leaving the former open to indirect regulation while the latter is not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Id.* (citing *Metropolitan Life Ins. Co.*, 471 U.S. at 747).

35. *Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311, 1313 (5th Cir. 1985).

36. *Metropolitan Life Ins. Co.*, 471 U.S. at 740.

37. *FMC Corp.*, 498 U.S. at 61.

However, where a state law applies to a partially funded plan, ERISA preemption of such law remains an open question. Specifically, the question of whether a partially funded plan qualifies as a "self-funded" plan subject to the deemer clause has not produced a uniform answer. For example, assume that two employers each establish an employer health care plan. Employer A purchases stop-loss insurance requiring an insurer to cover any individual claim in excess of \$2,500. Employer B purchases stop-loss insurance requiring an insurer to cover any individual claim beyond \$1,000,000. Because A's insurer would be liable for a larger portion of any potential claim than B's insurer, the relationship between A's insurer and its plan participants would be similar to that of an insurance company providing a health care policy to an individual, exclusive of any employer health care plan. Whether or not such plan and its insurer are immune from certain state insurance laws under the deemer clause has not yet been addressed by Congress under ERISA or by the Supreme Court.³⁸ However, a number of circuit courts have wrestled with this issue.

II. THE PREEMPTION OF STATE LAWS AFFECTING PARTIALLY FUNDED PLANS

The Ninth Circuit, in *United Food & Commercial Workers Trust v. Pacyga*,³⁹ considered the effect of ERISA preemption upon a state antisubrogation law as applied to a partially-funded plan. Similar to the facts in *FMC*, a plan member collected medical benefits from her plan as a result of injuries she suffered from an automobile collision.⁴⁰ In order to collect these benefits, the plan required her to agree to reimburse the plan if she collected damages from any third party liable for the accident.⁴¹ However, Arizona common law prohibited such assignment of third party claims.⁴² In contrast to *FMC*, the plan maintained stop-loss insurance, which reimbursed the plan up to \$1.5 million "... in the event that [the plan] must pay out more than a certain amount in claims in a given year."⁴³

After concluding that the antsubrogation law was subject to the preemption clause,⁴⁴ the court found that the insurance savings clause applied to the law as an exception to ERISA preemption.⁴⁵ Further, the court examined the relationship between the insurer and the plan members within the context of the stop-loss insurance coverage provided for the plan. The court noted that "... stop-loss insurance does not pay benefits directly to participants, nor does the insurance company take over administration of the plan at the point when the aggregate amount is reached."⁴⁶ Thus, the court concluded that "... no insurance is provided to the participants and the [p]lan should properly be termed a self-insured [or self-funded] plan, protected by the deemer clause and preemptive of the Arizona antsubrogation law."⁴⁷ Accordingly, such law,

38. Conversely, B would generally serve as the "insurer" for its plan participants and cover the cost of most claims. B's insurer would only be liable, as an insurer, in isolated cases. In this case, the question remains of whether B, as the "general insurer," is immune to certain state insurance regulations under ERISA.

39. *United Food & Commercial Workers Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986).

40. *Id.* at 1158.

41. *Id.*

42. *Id.*

43. *Id.* at 1161.

44. *Id.* at 1160.

45. *Id.* at 1161.

46. *Id.*

47. *Id.* at 1161-62. The court also held that "[t]he fact that the [p]lan also provides [accidental

as applied to a partially funded plan, was not subject to the insurance savings clause.

Similarly, in *Thompson v. Talquin Building Prod. Co.*,⁴⁸ the Fourth Circuit held that, as applied to a partially funded plan, a state mandated-benefit statute requiring certain health insurers to provide medical coverage from motor vehicle accidents fell within the scope of the deemer clause. In *Thompson*, a dependent of a plan member sought to collect medical benefits for injuries suffered as a result of an auto collision.⁴⁹ However, the plan expressly excluded coverage for medical expenses resulting from motor vehicle accidents.⁵⁰ The dependent contended that state law prohibited such exclusion.⁵¹

Citing *United Food* at length, the court examined the purpose and effect of the plan's stop-loss coverage and noted that:

[e]ven with the stop-loss coverage, [the] [p]lan is directly liable to [the] employees for any amount of benefits owed to them under the plan's provisions. The purpose of stop-loss insurance is to protect [the employer] from catastrophic losses, it is not accident and health insurance for employees. Instead of covering employees directly, the stop-loss insurance covers the [p]lan itself. Thus, for purposes of ERISA, the [p]lan remains self-funded even with the stop-loss insurance.⁵²

Thus, both the Ninth Circuit and the Fourth Circuit have concluded that a partially funded plan does not constitute a self-funded plan subject to the deemer clause.

III. NO PREEMPTION OF STATE LAWS AFFECTING PARTIALLY FUNDED PLANS

In contrast to the Ninth Circuit and the Fourth Circuit, the Sixth Circuit, in *Michigan United Food and Commercial Workers Unions v. Baerwaldt*,⁵³ held that a state

death and dismemberment] benefits partly paid by an insurance policy" did not effect the plan's status as self-funded since these benefits "are not amenable to the assignment requirements for payment of health benefits." *Id.* at 1162.

48. *Thompson v. Talquin Bldg. Prod. Co.*, 928 F.2d 649 (4th Cir. 1991).

49. *Id.* at 651-52.

50. *Id.* at 652.

51. *Id.*

52. *Id.* at 653. *Accord Moore v. Provident Life and Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986) (state law claims against health plan administrators and trustees, as applied to a partially funded plan, was subject to the deemer clause and preemption by ERISA); *Hutchinson v. Benton Casting Service Inc.*, 619 F.Supp. 831 (S.D. Miss. 1985) (state law permitting claim for extracontractual damages against plan fiduciary, as applied to a partially funded plan, was subject to the deemer clause and preemption by ERISA); *General Split Corp. v. Mitchell*, 523 F.Supp. 427 (E.D. Wis. 1981) (state mandated-statute requiring certain conversion benefits and health insurance risk sharing scheme for health plans, as applied to a partially funded plan, was subject to the deemer clause and preemption by ERISA); *Drexelbrook Engineering Co. v. Travelers Indemnity Co.*, 710 F.Supp. 590 (E.D. Penn. 1989) (state law requiring health plans to notify members of a right to convert coverage under a terminating group plan to individual coverage, as applied to a partially funded plan, was subject to the deemer clause and preemption by ERISA).

In addition, the Fifth Circuit, in *Brown v. Granatelli*, 897 F.2d 1351, 1353 (5th Cir 1990), found that a state mandated-benefit statute requiring individual and group health insurance policies to provide coverage for newborn babies did not apply to an employer plan by virtue of its stop-loss insurance because such insurance had rarely been implemented. Thus, the court failed to reach the issue of whether or not ERISA preempted a state law as applied to a partially funded plan via its stop-loss insurance. *Id.* Such analysis only complicates the issue of ERISA preemption as applied to partially funded plans. Under *Brown*, a court must further determine the specific incidence and application of a plan's stop-loss insurance.

53. *Michigan United Food and Commercial Workers Union v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985).

mandated-benefit statute fell within the scope of the deemer clause as applied to a partially funded plan. In *Baerwaldt*, an employer purchased group insurance policies from an insurance provider, or insurer, whereby the employer agreed to pay all health and welfare benefits up to a certain amount.⁵⁴ In addition, the insurer agreed to pay any additional benefits if a claim exceeded that amount.⁵⁵ Thus, the plans constituted partially funded plans.

Contrary to the employer's wishes, the insurer sought to provide all plan participants with coverage to treat drug and alcohol abuse pursuant to state law.⁵⁶ However, in light of *Metropolitan Life*, the court concluded that such state mandated-benefit statutes were not subject to ERISA preemption by virtue of the insurance savings clause.⁵⁷ The court further held that, regardless of the stop-loss nature of the insurance purchased by the plan, "[a]s long as the plans purchase insurance from 'an insurer offering health insurance policies' . . . the [plan's] policies must include the substance abuse coverage [as required by state law]."⁵⁸ Hence, even though the court cited and discussed the deemer clause, the court did not hold that the such law, as applied to a partially funded plan, was excepted from the insurance savings clause and thus subject to preemption by ERISA.⁵⁹

In *Northern Group Services Inc. v. Auto Owners Ins. Co.*⁶⁰ the Sixth Circuit again found that a state law, as applied to a partially funded plan, fell within the insurance savings clause barring ERISA preemption. In *Northern Group Services*, several employer health care plans "contained coordination of benefits provisions that purport to make the liability of the plans secondary to state mandated no-fault automobile insurance."⁶¹ A group of no-fault automobile insurers contended that state law required "liability under such [state mandated] no-fault coverage [remained] secondary to other health [plan] coverage."⁶²

The court held that the state law coordinating benefits between a no-fault automobile insurer and a health care plan was subject to the insurance savings clause and thus excepted from preemption by ERISA. Further, the court found that the plan was not self-funded for purposes of the deemer clause because such plan was funded to the extent of its stop-loss insurance.⁶³

54. *Id.* at 310.

55. *Id.*

56. *Id.*

57. *Baerwaldt*, 767 F.2d at 312.

58. *Id.* at 312-13.

59. *Id.* at 311-13.

60. *Northern Group Services Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987).

61. *Id.* at 87.

62. *Id.* at 86.

63. *Id.* at 91.

In *Lincoln Mutual Casualty Co. v. Lectron Products Inc.*, the Sixth Circuit revisited the Michigan state coordination of benefits law, as applied between no-fault insurers and partially funded plans, in light of the Supreme Court's decision in *FMC. Lincoln Mutual Casualty Co. v. Lectron Products Inc.*, 970 F.2d 206 (6th Cir. 1992). The court reversed its holding in *Northern Group Services* and concluded that the state coordination of benefits law, as applied to partially funded plans, did not fall within the ambit of the deemer clause. *Id.* at 210. The court reasoned that such law "would directly regulate the [partially funded plan]" whereas the deemer clause only permitted a state to indirectly regulate an partially funded plan by way of a stop-loss insurer's contracts or relations with such fund. *Id.*

Note that even though the court refused to apply the deemer clause to the state coordination of benefits law, it did not reverse its prior holding in *Northern Group Services* or *Baerwaldt* that a par-

IV. CONCLUSION

Currently, neither the Supreme Court nor the federal circuits have conclusively and uniformly answered the question of whether a state law affecting a partially funded plan

- (1) constitutes a self-funded plan subject to preemption by ERISA under the deemer clause, or
- (2) continues to qualify under the insurance savings clause as an exception to preemption by ERISA.

The resolution of this issue, however, does not speak to the larger problem of ERISA preemption as between self-funded and unfunded plans. As Justice Stevens noted in his dissent in *FMC*:

The Court's construction of [the ERISA preemption provisions] draws a broad and illogical distinction between benefit plans that are funded by the employer [(self-funded plans)] and those that are insured by regulated insurance companies [(unfunded plans)]. Had Congress intended this result, it could have stated simply that "all State laws are pre-empted insofar as they relate to any [self-funded] employee plan."⁶⁴

From the standpoint of the beneficiaries of ERISA plans, who after all are the primary beneficiaries of the entire statutory program—there is no apparent reason for treating [self-funded] plans differently from [unfunded] plans. Why should a [self-funded] plan have a right to enforce a subrogation clause against an injured employee [or a right to refuse to provide coverage to newborn babies with congenital defects⁶⁵] while an [unfunded] plan may not?⁶⁶

Two competing objectives have created this curious distinction between self-funded and unfunded plans for purposes of ERISA preemption.

First, ERISA seeks to regulate employer welfare benefit plans consistent with the general purpose and objective under ERISA to, *inter alia*, ensure the "financial soundness" of such plan and its ability to satisfy payment obligations to plan members.⁶⁷ Given the sweeping preemption clause under ERISA, Congress has decided that these goals may be achieved by exclusive, uniform federal regulation of any employer health care plan under ERISA. Indeed, it is likely that imposing varying state industry-specific insurance regulations of reporting, licensing, premium taxes, and capitalization requirements upon an employer would inhibit the growth of employer-provided health care plans.⁶⁸

tially funded plan did not constitute a self-funded plan for purposes of the deemer clause.

64. *FMC Corp.*, 498 U.S. at 65-66 (Stevens, J., dissenting).

65. This type of state mandated benefits statute was at issue as applied to a partially-funded plan in *Brown. Brown*, 897 F.2d 1351 (5th Cir. 1990).

66. *FMC Corp.*, 498 U.S. at 65-66 (Stevens, J., dissenting).

67. 29 U.S.C. § 1001(a) (1996).

68. It is likely that state laws formulated to regulate insurers within the insurance industry would prove problematical for employers seeking to provide health plans to its employees. If state insurance regulations applied:

. . . a welfare plan would have to be operated as an insurance company in order to comply with the detailed regulatory requirement of state insurance codes designed with the typical operations of insurance companies in mind. It presumably would be necessary

Second, states have a genuine interest and, by virtue of the McCarran-Ferguson Act, the right to regulate the business of insurance.⁶⁹ Apart from standards regarding disclosure, reporting and licensing and the general operation and maintenance of an insurance business,⁷⁰ it can be argued that a state may be more sensitive and responsive to the needs of its citizens and can thus tailor requirements upon insurance policies and plans provided by insurers and employers according to regional needs.⁷¹

Further, under the sweeping reach of the preemption clause, only federal law may substantially regulate "employer welfare benefit plans." Since the provisions of ERISA generally regulate only employer pension plans, this has left "a vacuum in the body of law regarding welfare [health care plans]."⁷² Coupled with the recent failure of President Clinton's Health Care Reform Plan,⁷³ the public continues to endure a system of health care under employer plans that is, by and large, substantively unregulated.

As a result, states have an interest in limiting federal ERISA preemption concerning the provision of health care benefits under any health care plan. This would permit states to respond to the needs of its citizens and impose substantive regulations in a field Congress has neglected.

Thus, in furtherance of the objectives of ERISA, the preemption clause should confer exclusive federal jurisdiction only upon the requirements of reporting, disclosure, fiduciary responsibility and general operation and maintenance of any partially funded or self-funded employer health care plans.⁷⁴ This would comport with Congress' determination that such uniform reporting requirements would promote the financial health of employer health care plans.⁷⁵ In addition, in deference to state interests, the scope of the preemption clause should be limited to permit states to regu-

to form a captive insurance company with prescribed capital and surplus, capable of obtaining a certificate of authority from the insurance department of all states in which the plan was 'doing business,' establish premium rates subject to approval by the insurance department, issue policies in the form approved by the insurance department, pay commissions and premium taxes required by the insurance law, hold and deposit reserves established by the insurance department Thus, it can be seen that the real issue is not whether uninsured [(self-funded)] plans [or partially funded plans] are to be regulated under state insurance laws, but whether they are to be permitted.

Raymond Goetz, *Regulation of Uninsured Plans Under State Insurance Laws*, WIS. L. REV. 319, 320-21 (1967).

69. 15 U.S.C. § 1012 (1996). See also *supra* note 15.

70. See *supra* note 65.

71. See, e.g., *Baerwaldt*, 767 F.2d at 310 (state mandated-benefit statute requiring insurers to provide coverage for the treatment of substance abuse was based upon the legislative finding that approximately 750,000 state citizens require treatment for drug and alcohol abuse).

72. Jeffrey Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX. REV. 615, 618 (1995).

73. See Daniel Franklin, WASHINGTON MONTHLY, *Tommy Boggs and the Death of Health Care Reform* (April 1995).

74. Presumably, state insurance regulations adequately ensure that insurers of unfunded plans remain financially sound to the extent that such insurers can satisfy its obligations to plan participants.

75. In a recent decision the Supreme Court unanimously held that a state law requiring hospitals to impose surcharges against commercial insurance policies purchased by employers for use in employer health care plans did not fall within the preemption clause. *NY State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995). Although the Court expressly held that the preemption clause should not be limited to "subject matters covered by ERISA, [such as] reporting, disclosure, fiduciary responsibility and the like," the case is significant in that the Court has abandoned the plain meaning approach in construing the scope and limit of the preemption clause. *Id.* at 1677, 1680.

late the business of insurance as applied to self-funded, partially funded and unfunded plans. This would eliminate any disparate provision of benefits as between self-funded, partially funded and unfunded plans. Thus, such plans would be subject to state and federal mandated-benefit statutes.

To that end, section 514(b)(2)(B) (the deemer clause) should be deleted from ERISA. Further, section 514(a) should be amended to read as follows:

“ . . . the provision of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to the *operation and maintenance of any employee welfare benefit plan*.

For purposes of this section, the terms

- “*operation and maintenance*” include reporting, disclosure, vesting, funding, fiduciary responsibility, licensing, and capitalization requirements.”
- “*employee welfare benefit plan*” includes any employee welfare benefit plan under section 3(1) which is partially or completely funded by an employer or employee organization.”

These revisions would simultaneously further the competing objectives of ERISA and state insurance regulation for the benefit of employer health care plan participants.

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