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The Deemer Clause: A Legislative Savior for Self-funded Health Insurance Plans under the Employee Retirement Income Security Act of 1974

Julie K. Swedback

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THE DEEMER CLAUSE: A LEGISLATIVE SAVIOR FOR SELF-FUNDED HEALTH INSURANCE PLANS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

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I. INTRODUCTION

Employer-sponsored health care costs are out of control. Since the mid-seventies, the cost of providing medical benefits to employees has increased well above inflation in medical care costs. In 1988 alone, medical care costs per employee rose to an annual average of $2354, an 18.6% increase over 1987. Citing cost containment as the number one health benefit concern, employers have searched for creative and more economical means of providing medical benefits. Self-funded health insurance plans have provided one method for employers to decrease health care benefit costs. Compared to true insurance plans, self-funded plans afford employers greater latitude and control over their employee benefit plans. Several options exist for employers who choose to self-fund their employee benefit plans. Under a purely self-funded (also called self-insured) plan, the employer assumes 100% of the risk for benefits provided and does not contract with any other entity to limit its liability.

Additionally, the employer may choose to partially self-fund its employee benefit plan and to purchase excess stop-loss insurance. "Under this arrangement, the employer customarily accepts liability

2. William P. Brady, Funding Arrangements and Excess Stop-Loss Insurance for Self-Funded Health Plans, in SELF INSURANCE supra note 1, § VI, at 3. Although these costs have been increasing since the mid-1970s, the 1988 cost increase was unprecedented. Id.
3. Beech, supra note 1, at 4-6.
4. Brady, supra note 2, at 3-4.
5. Under a true insurance plan, i.e., one which is fully-insured, an employer purchases an employee welfare plan from an insurance company and pays a set premium per employee per month. Under this contract, the employer assumes no risk and is only responsible for the premium payment to the insurance company. Approximately 20% of the market remains fully-insured. Brady, supra note 2, at 6.
7. Id. at 7.
8. Id. at 7. An employer may purchase stop-loss insurance coverage from a state-regulated insurance company to minimize the dollar amount of claims the employer will pay. For example, an employer may decide to self-insure the risk of paying claims, either on an individual employee basis or in an aggregate amount, up to a certain amount. Once the employer has paid out claims up to this amount, the insur-
for payment of all health plan costs and, in turn, contracts with an
insurance company for excess stop-loss coverage to minimize its ex-
posure to unlimited benefits liability."9

Finally, employers who self-fund their benefits generally hire
"third party administrators" (TPAs) for the sole purpose of adminis-
tration and payment of benefits. The average cost of administration
by a TPA is 4.7% of paid claims.10

As a result of their special nature, self-funded employee benefit
plans cannot be reached by state insurance regulatory schemes. In-
stead, via the preemption clause11 and the deemer clause12 of the

ance company, with which the employer has contracted, assumes responsibility for
additional claims under the plan. Id.

A majority of appellate courts hold that the purchase of stop-loss insurance cov-
erage by a self-funded employee benefit plan does not destroy the plan's self-funded
nature. See Insurance Bd. Under Social Ins. Plan of Bethlehem Steel Corp. v. Muir,
819 F.2d 408 (3d Cir. 1987); Moore v. Provident Life & Accident Ins. Co., 786 F.2d
922 (9th Cir. 1986); see also United Food & Commercial Workers v. Pacyga, 801 F.2d
1157 (9th Cir. 1986). In Pacyga, the Ninth Circuit explained why the purchase of
stop-loss insurance coverage does not destroy a plan's self-funded nature:

[S]top-loss insurance cannot be termed health insurance, nor can it be said
that the Plan is providing an insurance contract to its participants. The
stop-loss coverage provides for payment to the Plan . . . to reimburse the
Plan in the event that it must pay out more than a certain amount in claims
in a given year. The 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. Thus, no in-
surance is provided to the participants, and the Plan should properly be
termed a non-insured plan . . . .

Id. at 1161-62. Contra Michigan United Food & Commercial Workers Unions v.
Baerwaldt, 767 F.2d 308 (6th Cir. 1985) (holding that state-mandated benefit laws
apply to self-funded employee benefit plans where the plan has purchased stop-loss

9. Brady, supra note 2, at 7. Courts have generally held that this arrangement
does not change the benefit plan's self-funded status, even though the plan has dis-
tributed a portion of its risk to an insurance company. See supra note 8.

10. Brady, supra note 2, at 8.

U.S.C. § 1144(a) (1988) (preemption clause). "Except as provided in subsection (b)
of this section [the savings clause], the provisions of this subchapter and subchapter
III of this chapter shall supersede any and all State laws insofar as they may now or
hereafter relate to any employee benefit plan . . . ." Id.


Neither an employee benefit plan . . . nor any trust established under such a
plan, shall be deemed to be an insurance company or other insurer, bank,
trust company, or investment company or to be engaged in the business of
insurance or banking for purposes of any law of any State purporting to
regulate insurance companies, insurance contracts, banks, trust companies,
or investment companies.

Id.

Appellate courts have noted that the deemer clause protects ERISA plans from
being "deemed" insurers or in the business of insurance by a state solely to get the
plan to fall under the state's insurance regulation. See Metropolitan Life Ins. Co. v.
Employee Retirement Income Security Act of 1974 (ERISA), federal law regulates self-funded employee benefit plans. Hence, self-funded employee benefit plans do not pay state premium tax, do not have to comply with state mandated minimum coverage requirements, and do not have to keep state mandated reserves.

Given these unique advantages, approximately 35% of all Minnesota employers have chosen to offer medical benefits to their employees through self-funded plans. Although self-funded employee benefit plans are not adaptable to meet every employer's needs, statistics demonstrate that employers are turning to self-funded plans at an increasing rate.

Massachusetts, 471 U.S. 724 (1985) (drawing, in dicta, a distinction in regulation between self-funded and funded insurance benefit plans); see also FMC Corp. v. Holiday, 111 S. Ct. 403 (1990) (importing dicta from Metropolitan Life). But see Northern Group Servs., Inc. v. Auto Owners Ins. Co., 833 F.2d 85 (6th Cir. 1987) (stating that the proper inquiry regarding the application of the deemer clause to self-funded plans should be determined on case-by-case basis as to whether the state regulation involved affects a central concern of ERISA which Congress sought to protect).

15. Strand, supra note 14, at 45.
16. See Douglas C. Grabham, Choosing to Self-Insure: Issues for Employers to Consider, in SELF INSURANCE supra note 1, § I. Grabham states, "a general rule of thumb indicates that employers should not self-fund medical benefits if the group of employees under the plan is small [under 300] or contains a large percentage of high utilizers of health care—such as retirees." Id. at 7.
17. Percentage of employers with self-funded plans in 1990 statistics (1989 statistics are enclosed in parentheses):

<table>
<thead>
<tr>
<th></th>
<th>Self-funded with stop-loss</th>
<th>Self-funded without stop-loss</th>
<th>Self-funded total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All responding employers:</td>
<td>43% (35%)</td>
<td>17% (17%)</td>
<td>59% (52%)</td>
</tr>
<tr>
<td>Responding employers, by region:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>40% (33%)</td>
<td>11% (14%)</td>
<td>52% (47%)</td>
</tr>
<tr>
<td>Mountain</td>
<td>45% (43%)</td>
<td>20% (14%)</td>
<td>64% (57%)</td>
</tr>
<tr>
<td>North Central</td>
<td>47% (40%)</td>
<td>19% (19%)</td>
<td>66% (59%)</td>
</tr>
<tr>
<td>South Central</td>
<td>51% (39%)</td>
<td>23% (25%)</td>
<td>74% (64%)</td>
</tr>
<tr>
<td>New England</td>
<td>46% (29%)</td>
<td>16% (15%)</td>
<td>62% (44%)</td>
</tr>
<tr>
<td>Mid-Atlantic</td>
<td>27% (23%)</td>
<td>17% (18%)</td>
<td>43% (11%)</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>48% (39%)</td>
<td>12% (12%)</td>
<td>59% (51%)</td>
</tr>
</tbody>
</table>


From 1982 through 1986, the percentage of large employers (over 1000 employees) who self-funded their employee benefit plans increased from 43% to 67%. Brady, supra note 2, at 1.
This Note will discuss the scope of ERISA's preemption and deemer clauses with regard to interpretations made by both the federal and state courts vis-à-vis self-funded health benefit plans. The anomalous distinction drawn by the courts in interpreting ERISA's effect on self-funded, versus fully-insured, plans leads not only to disparate treatment of plan beneficiaries but also subverts Congress' original intent in enacting ERISA. Additionally, this Note will suggest alternative measures that courts could use to ensure uniformity and equity for employee benefit plans.

II. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

In 1974, under the Ford Administration, Congress enacted the Employee Retirement Income Security Act to create uniformity and to control abuses in pension and benefit plans. Previous attempts, through state and federal regulation, were inadequate in preventing abuses in the pension and benefit area. ERISA's draft-

19. In the introduction to the statute, Congress defined the policy goals of ERISA:

[T]he policy of [ERISA is] to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.


Further, Congress designed ERISA legislation to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.


Finally, Congress underscored the necessity of ERISA legislation by emphasizing that the "growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial," as well as noting "that the operational scope and economic impact of such plans is increasingly interstate . . . ." ERISA § 2(a), 29 U.S.C. § 1001(a) (1988).

20. Initially Congress had attempted to control the abuses occurring in employee benefit plans through tax regulation. See I.R.C. § 401(a) (1982) (repealed 1986). Under section 401(a), Congress designated "qualified plans" which allowed employers to take an immediate deduction for contributions and allowed plan participants to defer taxation until the plan's proceeds were actually received. James D. Hutchinson & David M. Ifshin, Federal Preemption of State Law Under the Employee Retirement Income Act of 1974, 46 U. Chi. L. Rev. 23, 27 (1978). Section 401(a) of the Internal Revenue Code required that a qualified plan be "intended for the exclusive benefit of employees and their beneficiaries, it may not discriminate in favor of shareholders, officers or highly compensated employees, it must cover a minimum percentage of all em-
ers thus focused on carving out an area of "exclusive federal concern." 21

A. Structure of ERISA

The Department of Labor and the Department of the Treasury have joint jurisdiction over employee benefit plans. 22 To make this area one of "exclusive federal concern," Title I of ERISA establishes "substantive regulatory standards governing employee benefit plans covered by the Act." 23 Further, Congress divided Title I into five parts: Part One defines reporting and disclosure requirements for both pensions and welfare benefit plans. 24 Part Two "creates minimum vesting standards and strict participation requirements for employee pension benefit plans." 25 Part Three contains funding requirements for employee pension plans. 26 Part Four details "fiduciary standards for the management of employee pension and welfare benefit funds." 27 Part Five regulates the "administration and enforcement provision of ERISA which applies to both employee

ployees, and it must meet minimum vesting and termination rules." Id. at 26-27. But see Lawrence Allen Vranka, Jr., Comment, Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern, 42 Vand. L. Rev. 607, 611 (1989) (provisions of section 401(a) "could be avoided by employers who could afford to forego the tax benefits of a 'qualified' plan.").

Additionally, through the Labor-Management Relations Act of 1947, Congress attempted to regulate employee benefit plans by prohibiting employers from paying money "to a union or employee trust, for the sole and exclusive benefit of the employees of such employer ...." Id. at 611 n.19 (citing 29 U.S.C. §§ 141-187 (1988)).

In 1958, Congress enacted the Welfare and Pension Plan Disclosure Act to require compulsory disclosure and filing duties aimed at controlling the "diversion of funds by speculation, overly generous commissions to favored companies (some in collusion with plan administrators), and other such questionable activities." M. Bernstein, The Future of Private Pensions 47-48 (1964). Because of limitations placed on the bill by the House, effective disclosure methods were difficult to achieve. Aside from an amendment regarding criminal penalties to the law in 1961, the Act "did not prescribe proper plan practices or provisions to enhance the effectiveness of plans." Id.

Interestingly, much of the state and federal legislation that had attempted, but failed, to control abuses pre-ERISA, served as a basis for the codification of ERISA to create one uniform act.

21. See Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981); see also supra note 19 for a description of Congress’ policy goals of ERISA.

pension and welfare benefit plans." From the perspective of state insurance regulators, Part Five of Title I, specifically section 514, has presented the most interpretative problems.

B. Structure of Section 514

To enforce the goals of ERISA, the drafters developed a three-step process to determine the impact of ERISA on state laws. First, the drafters constructed a broad preemption clause stating, "Except as provided in subsection (b) of this section [the savings clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ...." Thus, "ERISA involved not only the creation of new law but also the displacement of a large body of existing state law." During the House and Senate debate, ERISA's drafters clearly contemplated that federal courts would develop a body of federal common law to replace the state common law remedies that fell outside of traditional state insurance regulation.

28. Id. Congress defined an employee welfare benefit plan as follows:

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


Prior to the passage of the bill, both House and Senate had disagreed as to the expansiveness of the preemptive reach. "Initially, both the House and Senate versions of the bill preempted only those state laws concerning ERISA's 'fiduciary, reporting and disclosure responsibilities' or relating to 'the subject matter' it was to regulate. Both versions also contained a savings clause for state insurance regulation, but neither contained any deemer provision." FMC Corp. v. Holliday, 885 F.2d 79, 87 (3d Cir. 1989). The final bill, as adopted, contained a much broader scope of preemption than originally considered. Senator Javits explained this change: "The change sprang from the concern that the more specific formulation 'raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation,' and a desire to err on the side of Federal uniformity." Id. (citing 120 Cong. Rec. 29,942 (1974)).

30. Hutchinson & Ifshin, supra note 20, at 34.

31. Senator Javits, one of ERISA's main sponsors remarked: "It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. 29,942 (1974).
Subsequent case history has demonstrated that courts have not fulfilled Congress’ expectation.\textsuperscript{32}

\textsuperscript{32} The reality of this expectation is still doubtful 18 years after the passage of the bill. In 1987, the Sixth Circuit Court of Appeals acknowledged Congress’ specious expectation:

Over the years states . . . have developed a substantial and complex body of common law and statutory principles to resolve questions of priority that arise when multiple coverage produces conflicts of the type presented in this case [i.e. a state law requiring coordination of benefits in Michigan’s No-Fault Automobile Insurance Act]. This corpus of law embodies principles of restitution and risk allocation that have evolved from acquired state experience and expertise. Although these rules may be imperfect and display some minor variation from state to state, in the aggregate they nonetheless represent an interconnected and complex network of generally applicable laws with which the nation’s insurers have grown familiar.

. . . In the absence of any particular federal interest in uniformity that would inform the development of federal common law on this issue, what federal common law we might develop surely would mostly parrot the principles already developed by the state courts. Moreover, application of a federal rule of common law here would trigger a substantial risk of “disrupt[ing] commercial relationships predicated on state law.”


ERISA’s civil enforcement provision provides a good example of the absurdity which results from the lack of federal common law. Although ERISA purports to contain an exclusive civil enforcement remedy provision, an anomalous result arises when federal courts must resort to state law in the absence of an ERISA remedy. ERISA’s sole civil enforcement provision arises under section 502(a):

\[\text{[A]}\text{ plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant’s rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator’s improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of the fiduciary. In an action under these civil enforcement provisions, the court in its discretion may allow an award of attorney’s fees to either party.}\]


Federal courts find themselves in a conundrum when faced with a legal issue for which ERISA provides no remedy. In the absence of an ERISA remedy, federal courts may turn to the most analogous state statute for guidance. However, the characterization of the plaintiff’s claim is a question of federal law. See, e.g., Johnson v. State Mut. Life Assurance Co., 942 F.2d 1260, 1262 (8th Cir. 1991) (citing Wilson v. Garcia, 471 U.S. 261 (1985)).

In Johnson, nearly 10 years after her husband’s death, plaintiff brought suit against an insurance company alleging breach of contract for failure to pay accidental death benefits. The insurance company argued that, because the proceeds were payable from an ERISA benefit plan, plaintiff’s action should be one for breach of trust. In Missouri, the statute of limitations for breach of contract is 10 years and for breach of trust is five years. ERISA also contains a statute of limitations for actions alleging a breach of trust under an ERISA plan. See ERISA § 413, 29 U.S.C. § 1113 (1988). However, this action is limited to suits “claiming breach of an ERISA trustee’s fiduciary duties.” Johnson, 942 F.2d at 1262.

The court found that borrowing the state statute of limitations for breach of trust proffered a paradoxical result: “It cannot be consistent with congressional intent to
Second, to mitigate the harsh impact of the preemption clause on the displacement of state power, ERISA's drafters included a "savings clause," which returned to the states the power to regulate traditional areas of commerce—insurance, banking, and securities.33 State law that regulates these three areas is thus "saved" from the broad sweep of ERISA's preemption clause.

Third, the drafters modified the scope of ERISA's savings clause through the "deemer clause."34 The deemer clause qualifies the savings clause by providing that an employee benefit plan cannot be deemed an insurance company solely for the purpose of a state law which "purport[s] to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."35

Those responsible for interpreting ERISA's deemer clause have found a mire of poor legislative drafting.36 Emerging from this entanglement of clauses, however, the United States Supreme Court has attempted to establish uniformity.37 Lower courts have interpreted the Court's position to be that ERISA, because of the deemer

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35. Metropolitan Life, 471 U.S. at 739 (noting that the preemption and deemer clauses of ERISA, "while clear enough on their faces, perhaps are not a model of legislative drafting").
36. Metropolitan Life, 471 U.S. at 739 (noting that the preemption and deemer clauses of ERISA, "while clear enough on their faces, perhaps are not a model of legislative drafting").
clause, allows a distinction "between true insurance companies, which are subject to state law, and employee benefit plans, which are exempt from state regulation even though they exhibit some of the same risk-distributing characteristics as traditional insurance."38 Because of this distinction, ERISA plan beneficiaries "insured" through their employer's self-funded benefit plan may not receive the same privileges or protections afforded through a true insurance plan governed by state regulation.39

Much of the litigation involving ERISA stems from the distinction drawn between self-funded and fully-insured plans.40 Those plain-

regards to a self-funded employee benefit plan subrogation claim. In dissent, however, Justice Stevens argued strenuously that the majority's decision
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. . . . From the standpoint of the beneficiaries of ERISA
plans—who after all are the primary beneficiaries of the entire statutory pro-
gram—there is no apparent reason for treating self-insured plans differently
from insured plans.

Id. at 411 (Stevens, J. dissenting); see also infra note 105 and accompanying text.


39. The most significant disadvantage for a self-insured plan participant centers
on the employer's financial solvency. ERISA's regulatory scheme does not provide
adequate guidelines to secure a plan's financial solidity. State regulators have voiced
two concerns regarding the absence of funding guidelines for self-funded employee
benefit plans: "The first is the possibility that inadequate amounts of money will be
set aside to pay benefit claims. The second is the danger that plan managers will use
benefit monies as operating capital." Brummond, supra note 22, at 117 n.474 ( cita-
tions omitted).

Self-funded plan participants may also not benefit from state mandated coverage
laws because the employer may decide not to include a mandated coverage in its
employee benefit plan. Thus protective measures required by the states may not
reach self-funded plan participants. See id. at 84 (noting many state insurance depart-
ments have specified benefit laws which have upgraded the quality of employee bene-
fit plans). ERISA, however, prevents these state schemes from reaching self-funded
employee benefit plans.

Finally, self-funded plans cannot be required to contribute to Minnesota's Com-
Markman, 490 F. Supp. 981, 982 (D. Minn. 1980); see also infra notes 151-161 and
accompanying text. Enacted in 1976, MCHA created a fund to insure persons who
have chronic medical conditions and are unable to obtain medical insurance. See
Minn. Stat. § 62E.10 (1990). All insurance companies and health maintenance orga-
nizations (HMOs) are contributing members to MCHA and share in MCHA's annual
losses. Id. § 62E.10, subd. 5. Inequities arise because self-funded plans do not con-
tribute, even though a self-funded plan's participants may be eligible to receive bene-
fits under MCHA. See id. § 62E.14, subds. (c), (d).

40. The United States Supreme Court's holdings have clearly categorized the po-
lar extremes. At one end is the purely self-funded employee benefit plan which must
only comply with the mandates of ERISA law. At the opposite end is the employee
benefit plan which purchases a fully-insured group health insurance plan through an
insurance company and is thus indirectly regulated by the state. See Metropolitan Life,
471 U.S. at 747 (distinguishing between federal regulation of self-funded plans and
tiffs that have dared to enter the thicket of ERISA's preemption clause have found little but confusion within the courts.

III. United States Supreme Court's Handling of Self-Funded ERISA Questions

Historically, the seminal purpose behind ERISA legislation was to eradicate abuses within the pension plan area. Yet, given the scant legislative history specifically addressing employee benefit plans, in contrast with the voluminous legislative history addressing pension plans, the inclusion of employee benefit plans into ERISA appears to have been a congressional afterthought. Due to this lack of congressional guidance, courts have had to rely not only on fundamental preemption principles but also on their interpretation of statutory state regulation of insurance companies which provide insurance contracts to employee benefit plans).

The Court's most recent opinion purported to resolve the conflict between self-funded and insured plans once and for all. FMC Corp., 111 S. Ct. at 403. However, the Court's opinion in FMC Corp. was inadequate in two ways. First, the Court, while purporting to resolve the conflict, merely relied on its previous opinions. FMC Corp. added nothing novel to the reasoning set forth in Metropolitan Life. Second, the Court failed to justify, or even clarify further, the basis upon which it drew the line between self-funded health plans and fully-insured health plans. The continued litigation in the state courts and the split of opinion among the circuits post-Metropolitan Life and pre-FMC Corp. should have informed the Court of the need for further explanation.

The Court has yet to address the gray area between these two polar extremes. The gray area consists, in part, of self-funded plans which purchase stop-loss coverage from an insurance company. See supra note 8 for an explanation of stop-loss coverage. This variety of self-funded plan remains problematic because the plan combines elements of both poles. Because the majority of self-funded plans do purchase stop-loss coverage from an insurance company, the potential for continued litigation in the lower courts remains high. See supra note 17 for a percentage of self-funded plans which purchase stop-loss coverage. The inability of the lower courts to cull guidance from the Court's purported resolution of the issue is evidenced by the continued split of opinions among the circuit courts. See supra note 8.


The task force's report (commonly referred to as the Wirtz Report) acknowledged the inadequacies of existing federal regulations in the area of employee welfare plans. Id. at 166 n.19. The first comprehensive reform legislation, however, was not introduced in Congress until 1967. Id. at 166; see also supra note 20 for a discussion of early congressional attempts to control abuse in employee welfare plans.

42. See infra notes 162-169 and accompanying text.

43. Preemption issues may arise whenever both the federal government and a state government desire to regulate a specific activity or to promulgate laws which seek to control the same sphere of activity. See generally William W. Bratton, Note, The Preemption Doctrine: Shifting Perspectives on Federalism and the Burger Court, 75 COLUM. L.

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Rev. 623, 624-39 (1975) (discussing the origins and contemporary development of the preemption doctrine).

Over the years, the scope of preemption principles has been, and is still being, refined by the courts. Two general schools of thought have emerged to determine the scope and application of preemption principles.

A minority view holds that the ability of the federal government to preempt state laws lies in the nature of concurrent state-federal power. This view maintains that preemption occurs only when the subject matter of preemption cannot be adequately regulated by the states. The majority theory, however, holds that the power of the federal government to preempt state laws is based on the supremacy clause of the United States Constitution. This conventional theory focuses on legislative and statutory intent as the ultimate standard for judicial analysis.

Brummond, supra note 22, at 93 (citations omitted).

Neither view, however, has emerged as a bright-line test for preemption. One commentator noted cynically that the Court's "decisions in this area take on an ad hoc, unprincipled quality, seemingly bereft of any consistent doctrinal basis." Id. at 95 (quoting Bratton, supra, at 624).

Yet, preemption issues seem to fall generally into two categories: "conflict and interference cases" and "occupying the field cases." Brummond, supra note 22, at 94. In 1963, the United States Supreme Court created a two-prong test to determine whether federal regulations concerning commerce preempt state law. Florida Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132 (1963). In Florida Lime, the Court stated that federal law prevails when either the nature of the regulated subject matter permits no other conclusion, or when Congress has clearly shown an intent to preempt state laws. Id. at 142.

Thus, under the initial prong of the Florida Lime test, courts first address whether there is a conflict between state and federal law. "Most cases in this area fall somewhere on a spectrum between the situation where federal law directly mandates action forbidden by the state, or vice versa, and the situation where the federal and state laws operate in completely unrelated spheres." Brummond, supra note 22, at 94.

On the other hand, a court must apply a much broader standard to find that Congress, in enacting federal legislation, has sought to "occupy the field." Under this analysis, the existence of a conflict or interference between state and federal law is irrelevant. Here the court will look only to the federal law to determine whether or not preemption applies. The Court has enunciated several standards for courts to consider when analyzing the "occupy the field" principle. Considerations include the following:

The scheme of federal regulation may be so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it. Or the Act of Congress may touch a field in which the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject. Likewise, the object sought to be obtained by the federal law and the character of obligations imposed by it may reveal the same purpose. Or the state policy may produce a result inconsistent with the objective of the federal statute.


While congressional intent is oftentimes discernible from legislative history, ERI-ISA history contains scant legislative debate to guide the courts in determining congressional intent. "One of the principal reasons for this lack of a clear manifestation of intent is the fact that Congress, 'embroiled in controversy over policy issues, rarely anticipates the possible ramifications of its acts upon state law.'" Brummond, supra note 22, at 95 (citation omitted).

The reach of preemptive power has changed according to the makeup of the
language to determine the scope of ERISA’s preemption clause.44

A. Federal Preemption

Shortly after ERISA’s enactment, its constitutionality was challenged.45 The courts concluded that the Tenth Amendment6 posed no bar to ERISA’s operation because Congress correctly determined that employee benefit plans affect interstate commerce and thus war-
rant federal intervention. Furthermore, preemption of contemporaneous state legislation was necessary to accomplish the legislative purposes of ERISA. Because the Supremacy Clause states that the "Constitution, and the Laws of the United States . . . shall be the supreme law of the Land," the Constitution itself allows for preemption of state laws that "interfere with, or are contrary to the laws of Congress." However, the "exercise of federal supremacy is not lightly to be presumed."

The language of ERISA's preemption clause itself confirms Congress' purported intent to exclusively occupy the field. The courts used long-established preemption principles to determine here that Congress had "unmistakably ordained" to control this aspect of commerce. While it was correct to conclude that Congress' intent to control employee benefit plans was clear on its face, the scope of the preemption and deemer clauses remained problematic for the courts because Congress employed vague language in its construction of the statute. Thus, the Court turned to principles of statutory interpretation to elucidate congressional intent regarding the scope of ERISA's clauses.

B. Statutory Interpretation

The United States Supreme Court has dealt extensively with statutory interpretation questions in ERISA. In the past decade, the Court has made several attempts to address the interpretative problems regarding the interrelationship of the clauses in section 514 of ERISA. Noting that courts must "'begin with the language of the statute, and ask what public purpose it seeks to accomplish in order to determine the range of activities it seeks to regulate,'" the presumption lies against preemption of state power. Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977) (quoting Florida Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142 (1963)).

48. See id.
49. U.S. CONST. art. VI, cl. 2.
52. See supra note 29 and accompanying text for a discussion of the scope of the preemption clause; see also supra note 43.
53. Most recently, the United States Supreme Court dealt with the statutory interpretation of ERISA's preemption clause stating, "'Preemption may be either express or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose.'" FMC Corp. v. Holliday, 111 S. Ct. 403, 407 (1990) (quoting Rath Packing Co., 430 U.S. at 525).
employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose,’ 55 the Court carefully and consecutively addressed each significant phrase within section 514’s clauses.56 Although the Court, specifically in its interpretation of the “deemer clause,” has established a trend toward allowing a distinction between fully-insured plans and self-insured plans, the constant flux within the health care industry creates the potential for continued state action challenging the Court’s holdings.

1. The Preemption Clause and the “Relates to” Language

ERISA’s preemption clause states that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”57 To determine the scope of ERISA’s preemption clause, the United States Supreme Court first examined which state laws were superseded by ERISA’s preemption clause.58

In measuring the breadth of ERISA’s preemptive effect, the Court had to define which state laws “related to” employee benefit plans. Shaw v. Delta Air Lines, Inc.59 represented the Court’s first look at determining the scope of ERISA’s preemption clause. In the early eighties, several airlines and other employers sought injunctive relief in federal court regarding the pregnancy provisions of the New York Human Rights Law and the New York Disability Benefits Law.60 The combined effect of the laws forbade employment discrimination on the basis of pregnancy and required employers to offer disability benefits for pregnancy and other nonoccupational disabilities.61

The employers contended that, insofar as the New York Human Rights Law related to employee benefit plans, ERISA operated to preempt state law.62 Arguing for the broadest interpretation of the preemption clause, the employers claimed that the state could not

55. FMC Corp., 111 S. Ct. at 407 (quoting Park ‘N Fly, Inc. v. Dollar Park and Fly, Inc., 469 U.S. 189, 194 (1985)). The Court also noted 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.” Id. (quoting Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984)). Unfortunately, Congress gave little guidance as to its intent, hence the copious amount of case history attempting to interpret each significant provision.
56. Id.
59. Id. at 95.
60. Id. at 88. The New York Human Rights Act forbids employment discrimination on the basis of pregnancy. The Disability Benefits Law requires employers to pay sick leave benefits to pregnant employees unable to work. Id.
61. Id. at 88-90.
62. Id. at 92.
directly regulate ERISA-covered benefit plans. The New York Commissioner of Human Rights, on the other hand, zeroed in on section 514(d) of ERISA which provides, "§ 514(a) [the preemption clause] shall not 'be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States.'" The Commissioner argued that New York’s Human Rights Law provided "a means of enforcing the Pregnancy Discrimination Act of 1978 which made discrimination based on pregnancy unlawful under Title VII of the Civil Rights Act of 1964."

After embarking on a long analysis of the "relates to" language of ERISA’s preemption clause, the Court found that the New York Human Rights Law and the Disability Benefits Law most definitely related to employee benefit plans. Applying the "plain meaning" test, the Court held, "A law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Because the New York Human Rights Law related to employee benefit plans, the law could be preempted, but "only insofar as it prohibit[ed] practices that [were] lawful under federal law.”

Thus, the Court interpreted the language employed by Congress to denote the expansive breadth of the preemption clause. Most courts have accepted this broad definition of "relates to" and generally have found that many state laws "relate" in some way to employee benefit plans.

63. Id. at 100-101.
64. Id.
65. Id. Because Congress allowed for joint state/federal jurisdiction to enforce the provisions of Title VII, construing ERISA to preempt the New York state law entirely would invalidate and impair the state’s right to enforce a provision of Title VII. Id. at 102.
66. Id. at 96.
67. The Court adopted the Black’s Law Dictionary definition to reach the plain meaning of the language used by Congress: "‘Relate. To stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with.’” Id. at 97 n.16 (quoting BLACK’S LAW DICTIONARY 1288 (6th ed. 1990)).
68. Id. at 96-97.
69. Id. at 108.
70. Congress’ purpose in constructing a broad preemption clause was to ensure the uniform regulation of employee welfare plans. Thus, where a patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, the courts have maximized the breadth of the preemption clause to effect congressional intent. See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987). Given “the breadth of the preemption clause, courts will rarely find state laws to be beyond its scope.” See Jackson v. Martin Marietta Corp., 805 F.2d 1498, 1499 (11th Cir. 1986).
2. The Savings Clause and Laws that "Regulate Insurance"

The incorporation of the savings clause71 into ERISA returned all regulatory and legislative power regarding insurance, banking, and securities to the states. Two years after Shaw, the Court analyzed which state laws "regulated insurance" within the meaning of the savings clause.

a. Metropolitan Life Insurance Co. v. Massachusetts72

In 1979, the Massachusetts Attorney General sought an injunction forcing Metropolitan Life Insurance Company to comply with a state statute requiring all insurers to provide minimum coverage for mental health benefits.73 After a trial, a permanent injunction was issued.74 This judgment was affirmed on appeal.75

In Metropolitan Life, the Court first concluded that the Massachusetts statute76 requiring certain minimum mental health care benefits related to employee welfare plans.77 Thus the state law was preempted—unless it regulated insurance within the scope of the savings clause. In its opinion, the Supreme Court ruled that the Massachusetts statute at issue regulated the business of insurance as defined in the McCarran-Ferguson Act.78 Cases interpreting the scope of the McCarran-Ferguson Act have developed three criteria to determine whether an employee benefit plan has engaged in the business of insurance: "[F]irst, whether the practice has the effect of transferring or 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."79 Generally, a self-funded

71. See supra note 33.
73. Id. at 734. The statute required that any Massachusetts resident "insured under a general health insurance policy, an accident or sickness insurance policy, or an employee health-care plan that cover[ed] hospital and surgical expenses" receive specified minimum mental health benefits. Id. at 727.
74. Id. at 735.
76. See MASS. GEN. LAWS ANN. ch. 175, § 47B (West Supp. 1985).
77. Metropolitan Life, 471 U.S. at 739.
78. Id. at 743. Under the McCarran-Ferguson Act, Congress explicitly stated, "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." McCarran-Ferguson Act § 2, 15 U.S.C. § 1012(a) (1988).
79. Metropolitan Life, 471 U.S. at 743 (emphasis in original) (quoting Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982)). Comparing the three McCarran-Ferguson criteria, one court held, "No one factor is dispositive; rather each is instructive." United Food & Commercial Workers v. Pacyga, 801 F.2d 1157, 1161 (9th Cir. 1986).
employee benefit plan will fail to meet the third criterion and hence will not have engaged in the business of insurance.80

Relying on basic preemption principles, the Court, in Metropolitan Life, declined to narrow the scope of the savings clause:

[A]s in any pre-emption analysis, "'[t]he purpose of Congress is the ultimate touchstone.'" Where the pre-emptive effect of federal enactments is not explicit, "courts sustain a local regulation 'unless it conflicts with federal law or would frustrate the federal scheme, or unless the courts discern from the totality of the circumstances that Congress sought to occupy the field to the exclusion of the States.'"81

Even though Congress sought to occupy the field, the Court con-

80. Volumes of material have been published which describe the nature of the "business of insurance." On one level, the concept of insurance is easily defined: "In its simplest form, . . . insurance is 'an arrangement for transferring and distributing risk.'" Brummond, supra note 22, at 68 (citation omitted). On another level, these simple insurance concepts may be used by entities which do not constitute an insurance company per se (e.g., a self-funded employee benefit plan).

ERISA specifically requires that courts pinpoint laws which regulate insurance. See ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1988). But ERISA does not specify if its reference to insurance means the insurance industry per se or other entities which utilize generally accepted insurance principles.

Two schools of thought have emerged to describe the scope of insurance. The first emphasizes the process of transfer and views the purpose of insurance from the perspective of the insured: "Insurance is a device for the reduction of the uncertainty of one party, called the insured, through the transfer of particular risks to another party, called the insurer, who offers a restoration, at least in part, of economic losses suffered by the insured." Brummond, supra note 22, at 68 (quoting IRVING PFEFFER, INSURANCE AND ECONOMIC THEORY 53 (1956)). The second school of thought delves into the concept of "pooling of risk." Under the "pooling of risk" theory, any one individual's risk is lessened by the aggregation of many insured individuals, all of whom share the other's risks. Id. at 69.

A close examination of the nature of self-funded employee benefit plans demonstrates that, in practice, an employer who self-funds its benefit plan satisfies most of the elements of insurance as defined by the above schools of thought:

First, self-insurance is a "method for dealing with uncertainty concerning loss." Second, the "pooling" school of thought describes precisely the function of self-insurance: self-insurance attempts to eliminate uncertainty by distributing risk among a large number of similarly exposed individuals. Third, the risk of loss associated with illness, death and other insurable events is transferred from employees (insureds) to the self-insured benefit plan (insurer). Finally, self-insured plans establish a risk reserve from premium income (employer contributions) to satisfy benefit claims which arise on account of contractual contingencies (plan benefit obligations).

Id. at 77.

Although the McCarran-Ferguson Act embodies all of these fundamental concepts, the Act's third criterion specifies that the "practice must be limited to entities within the insurance industry." Unfortunately courts have latched on to the literal wording of the statute without examining the fact that, in reality, self-funded plans operate on the bases clearly established by the insurance industry.

81. Metropolitan Life, 471 U.S. at 747-48 (citations omitted); see also supra note 43 for a discussion of the scope of preemption issues.
cluded that Congress also intended, by virtue of the savings clause, to allow states to regulate insurance. Because Massachusetts' mandated benefit law regulated insurance within the scope of the savings clause, the Court held that it was saved from ERISA's preemptive effect.\textsuperscript{82} However, the Court qualified its ruling: the state mandated benefit law was saved from federal preemption only in the case of "insurance contracts purchased for plans subject to ERISA."\textsuperscript{83}

The Court acknowledged that its holding drew a distinction between self-insured and fully-insured plans.\textsuperscript{84} However, the Court explained that the distinction is one that "Congress is aware of and one it has chosen not to alter."\textsuperscript{85} Moreover, the Court justified the distinction based on its interpretation of the "deemer clause."\textsuperscript{86} Had the Court stopped before drawing this line between true insured plans and self-funded plans, much of the subsequent litigation would have been avoided.

In \textit{Pilot Life Insurance Co. v. Dedeaux},\textsuperscript{87} Justice O'Connor refined the Court's interpretation of which laws truly regulated insurance within the meaning of the savings clause. Building on the Court's prior holding in \textit{Metropolitan Life}, Justice O'Connor found that Mississippi state laws of bad faith and fraud—in the broadest sense—do relate to employee benefit plans.\textsuperscript{88} However, even laws that relate to benefit plans may avoid preemption, by way of the savings clause, if the plaintiff can show that the law is one that regulates insurance.\textsuperscript{89}

In \textit{Pilot Life}, the United States Supreme Court reversed the Fifth Circuit Court of Appeals' judgment in favor of a plaintiff alleging common law breach of contract, breach of fiduciary duty, and fraud

\textsuperscript{82} \textit{Metropolitan Life}, 471 U.S. at 746.
\textsuperscript{83} \textit{Id.} at 758.
\textsuperscript{84} \textit{Id.} at 747.
\textsuperscript{85} \textit{Id.} In 1977, a congressional activity report discussed the different treatment between self-insured plans and fully-insured plans:
To the extent that [certain programs selling insurance policies] fail to meet the definition of an "employee benefit plan" [subject to the "deemer clause"], state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these "products."
\textit{Id.} at n.25 (citing H.R. REP. No. 1785, 94th Cong., 1st Sess. 48 (1977)).
\textsuperscript{86} \textit{Metropolitan Life}, 471 U.S. at 748; \textit{see also infra} notes 96-99. 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, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies or investment companies.
\textsuperscript{87} 481 U.S. 41 (1987).
\textsuperscript{88} \textit{Id.} at 47-48.
against an insurance company for improper processing of claim for benefits.90 Employing a common sense test,91 Justice O'Connor greatly narrowed the impact of the savings clause:

A common-sense view of the word "regulates" would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law.92

Additionally, the Court found that the Mississippi state law of bad faith met only one of the McCarran-Ferguson criteria93 needed to establish the law as one that regulates insurance.94 The Court noted that Mississippi's "common law of bad faith may be said to concern 'the policy relationship between the insurer and the insured.' The connection to the insurer-insured relationship is attenuated at best, however."95

3. The Deemer Clause and "Laws Purporting to Regulate Insurance"

Applying the insured-uninsured distinction drawn in Metropolitan Life, the Court, in FMC Corp. v. Holliday,96 held that ERISA preempted a Pennsylvania anti-subrogation law where the employee welfare plan seeking subrogation was self-funded.97 Succinctly put, "Our interpretation of the deemer clause makes clear 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 [self-funded], the State may not regulate it."98

90. Pilot Life, 481 U.S. at 43-44.
91. Courts often use the "common sense" or plain meaning approach to interpret statutory language. One federal judge, however, warned courts to heed too literal of a reading:

Courts cannot amend statutes in the guise of interpreting them, and they must presume that Congress meant what it said. But the presumption, though heavy, is rebuttable. It is not yet the prevailing federal rule that "there is no surer way to misread any document than to read it literally."

Guiseppi v. Walling, 144 F.2d 608, 624 (2d Cir. 1944) (L. Hand, J., concurring), aff'd sub nom. Gemsco, Inc. v. Walling, 324 U.S. 244 (1945).
92. Pilot Life, 481 U.S. at 50 (emphasis added).
93. See supra notes 79-80 and accompanying text for a discussion of the McCarran-Ferguson criteria.
94. Pilot Life, 481 U.S. at 51.
95. Id. at 50-51.
97. Id.
98. Id. at 411. Prior to the United States Supreme Court's decision in FMC Corp., circuit courts were split as to whether self-funded plans could be governed by state regulatory schemes. Compare Reilly v. Blue Cross & Blue Shield United, 846 F.2d 416, 425 (7th Cir. 1988) ("State laws arguably 'regulating insurance' are preempted
While not unique in its opinion, *FMC Corp.* is important because it purported to resolve the conflict among the circuits between the treatment of self-funded and fully-insured plans. On review, the United States Supreme Court in *FMC Corp.* upheld the distinction it had drawn in *Metropolitan Life* and stated that the deemer clause barred states from regulating any aspect of any employee benefit plan that was self-funded. The Court’s opinion thus quashed any end-run maneuvers that some dissenting lower courts had tried.

Additionally, the Court noted that its interpretation of the deemer clause was “respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation.” Citing the McCarran-Ferguson Act, the Court found, “Congress provided that 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.’”

Future plaintiffs who seek to challenge the Court’s distinction do, however, have one friend left on the bench. In dissent, Justice Stevens noted that the *FMC Corp.* majority drew a “broad and illogical distinction between benefit plans that are funded by the employer and those that are insured by regulated insurance companies.” In fact, Justice Stevens urged the majority to remember that plan beneficiaries were the ones whom Congress sought to protect.

99. *FMC Corp.*, 111 S. Ct. at 407. Eleven days before the Third Circuit’s ruling in *FMC Corp.*, the Eighth Circuit Court of Appeals had addressed an almost identical set of facts and had reached the opposite conclusion. Baxter v. Lynn, 886 F.2d 182 (8th Cir. 1989).

100. *FMC Corp.*, 111 S. Ct. at 411.

101. Id. at 410 (citing *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977) (preserving “historic police powers” to the states absent a “clear and manifest” directive from Congress).


104. Id. at 411.
There is no apparent reason for treating self-insured plans differently from insured plans.... The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. If Congress had intended such an irrational result, surely it would have expressed it in straightforward English.\textsuperscript{105}

Essentially then, through judicial interpretation, the United States Supreme Court has determined congressional intent and the interplay of the clauses as follows:

The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that "regulat[e] insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.\textsuperscript{106}

IV. EIGHTH CIRCUIT'S HANDLING OF SELF-FUNDED ERISA QUESTIONS

A. Baxter v. Lynn\textsuperscript{107}

Christopher Baxter, a minor, was injured while riding as a passenger in his grandmother's car. His father's self-funded employee health plan (the Fund) paid for Christopher's medical expenses incurred in the accident.\textsuperscript{108} The driver of the second vehicle, Charlene Lynn, had no automobile insurance. However, Christopher's grandmother carried an automobile insurance policy with Allstate, which provided for $25,000 of uninsured motorist coverage, along with medical payment coverage of $5,000.\textsuperscript{109}

The Baxters sued both Lynn and Allstate in state court. Allstate, not denying its liability to pay $30,000, interpled the Fund and had no further involvement in the case.\textsuperscript{110} The issue in Baxter was the validity of a subrogation provision within the self-funded employee health care plan against the third party recovery rights accorded by the Allstate plan.\textsuperscript{111}

\textsuperscript{105} Id. at 411-12.
\textsuperscript{106} Id. at 407.
\textsuperscript{107} 886 F.2d 182 (8th Cir. 1989).
\textsuperscript{108} Id. at 184. The Fund paid medical expenses amounting to $23,305.00. Id.
\textsuperscript{109} Id.
\textsuperscript{110} Id. Allstate interpled the Fund because the policy included a clause subrogating the Baxter's right of recovery from third persons. Id.
\textsuperscript{111} Id. at 188. The applicable provision arguably created a subrogation lien for benefits paid to the Baxters by Allstate. Id. at 186-87.

http://open.mitchellhamline.edu/wmlr/vol18/iss3/17
First, the Baxters asserted that common law principles disallowed subrogation claims against uninsured motorist benefits and contended that the Fund had "a contractual obligation, independent of Allstate's obligation, to pay for the medical expenses arising from the automobile accident."112 The Eighth Circuit Court of Appeals rejected the plaintiff's argument based on its interpretation of the preemption analysis previously set forth by the Supreme Court.113

The Eighth Circuit Court of Appeals acknowledged that, in a general sense, the state law of subrogation does relate to the insurance industry and holders of insurance contracts, but a state's subrogation law does "not regulate the insurance industry directly. Application of differing state subrogation laws to plan providers throughout the United States would frustrate ERISA's uniform treatment of benefit plans."114 Thus, the state anti-subrogation law was not the type of insurance law that could be saved from preemption, and the Fund was entitled to subrogation.115

Second, the Baxters argued that the plan's subrogation provision applied only to recoveries from the person who was responsible for the injury, Charlene Lynn.116 Because the recovery proceeds flowed from Christopher's grandmother's insurance policy, the subrogation clause was inapplicable. The applicable subrogation clause read:

In the event the Fund pays benefits on behalf of any Covered Individual, for illness or injury for which the Covered Individual has the right to recover, the Fund shall be subrogated to the Covered Individual's rights of recovery, to the extent of benefits paid, against any person or entity who may be responsible.117

The Fund interpreted this clause as allowing subrogation against "any recovery made by or on behalf of Christopher Baxter, regardless of the source of that recovery."118 The parties' disagreement over construction of ambiguous terms within an insurance contract evolved into a standard of review question.119 The court decided that the district court had adopted the wrong standard of review and remanded with instructions for de novo review consistent with its earlier opinions.120

112. Id. at 185.
114. Baxter, 886 F.2d at 186.
115. Id. at 187.
116. Id.
117. Id. (emphasis added).
118. Id. (emphasis in the original on "any"; emphasis added on "source").
119. Id.
120. Id. at 188; see also Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).

Baxter adopted the standard of review determined in Bruch:
B. Provident Life & Accident Insurance Co. v. Linthicum\textsuperscript{121}

In 1987, the Linthicum family was injured in an automobile accident.\textsuperscript{122} Christy Linthicum, a daughter of the insured, incurred severe injuries and required extensive medical treatment, amounting to over $100,000.\textsuperscript{123} In 1988, the Linthicums commenced an action in state court against the other driver and recovered $225,000 through settlement.\textsuperscript{124} In response, Provident, administrator of the self-funded health plan, filed a medical lien against the Linthicums, claiming subrogation rights against their third-party recovery on the basis of its employee health plan contract.\textsuperscript{125}

In November 1989, Provident filed an action against the Linthicums for declaratory and injunctive relief.\textsuperscript{126} Defending on the basis of equity, the Linthicums contended that, under Arkansas state law, “subrogation was unconscionable and in violation of the public policy of the state and that . . . an insurer had no right of subrogation where the compensation recovered by the insured from the tortfeasor is less than the insured’s actual loss.”\textsuperscript{127} The Linthicums claimed that the state anti-subrogation statute traditionally fell within the ambit of state insurance regulation and thus was “saved” from ERISA preemption, notwithstanding the deemer clause provision or the employee welfare plan’s self-funded nature.\textsuperscript{128}

The Eighth Circuit Court of Appeals did not dispute that Christy Linthicum had received far less compensation from the tortfeasor than was necessary to “make her whole.”\textsuperscript{129} Nonetheless, relying on \textit{Baxter},\textsuperscript{130} the court rejected respondent’s argument and held that,

\begin{itemize}
  \item If the Fund’s plan gives its trustees the discretion to interpret the meaning of the subrogation clause, . . . this interpretation is subject to the arbitrary and capricious standard of review. If no such authority is provided for in the plan, however, the dispute must be resolved by a \textit{de novo} review of the plan’s terms and other manifestations of the parties’ intent. \\
  \textit{Baxter}, 886 F.2d at 187 (citing \textit{Bruch}, 489 U.S. at 955). In \textit{Baxter}, the Fund’s plan granted no such authority to its trustees, thus the district court should have conducted a \textit{de novo} review. \textit{Id.}
\end{itemize}

\textsuperscript{121} 930 F.2d 14 (8th Cir. 1991).
\textsuperscript{122} \textit{id.} at 15.
\textsuperscript{123} \textit{id.} Thomas and Patricia Linthicum’s injuries were less severe. Their medical expenses totaled $3,676.55. \textit{Id.}
\textsuperscript{124} \textit{id.}
\textsuperscript{125} \textit{id.} Provident also filed a motion to intervene which was denied. \textit{Id.}
\textsuperscript{126} \textit{id.}
\textsuperscript{127} \textit{id.}
\textsuperscript{128} \textit{id.} at 16.
\textsuperscript{129} \textit{id.} at 15-16.
\textsuperscript{130} See \textit{id.} at 16. The \textit{Baxter} court addressed a nearly identical set of facts and relied on analysis set forth in United States Supreme Court decisions. See \textit{Baxter} v. Lynn, 886 F.2d 182, 184-86 (8th Cir. 1989).

The Third Circuit reached a contrary result, ruling that a Pennsylvania anti-sub-
because the employee health plan was self-funded, ERISA operated to preempt any state anti-subrogation law or state policy.131 The court affirmed the district court’s ruling and ordered the Linthicums to reimburse Provident in the amount of $105,737.17.132

C. Impact on Baxter and Linthicum of Self-Funded Nature of ERISA Plan

The only distinguishable characteristic between the health care plans offered by the employers in Baxter and Linthicum and a health care plan purchased by an employer via an insurance company is the source of funding to pay medical claims. In both Baxter and Linthicum, the employer self-funded its benefit plan. Had these plans been “insured plans,” the Fund could not have subrogated the Baxter’s recovery on their injured son, nor would Christy Linthicum have received far less compensation than she was entitled to under equitable principles. The result in both of these cases begs the question rogation statute withstood the preemptive force of ERISA’s deemer clause as applied to self-funded employee benefit plans. See FMC Corp. v. Holliday, 885 F.2d 79, 90 (3d Cir. 1989), vacated, 111 S. Ct. 403 (1990); see also supra notes 96-99 and 106 and accompanying text.

In FMC Corp., the Third Circuit held that the proper inquiry under the deemer clause is “whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the pre-emption provisions. The court, reviewing a state insurance law, should inquire whether that law conflicts with any substitute mandate in ERISA.” Id. at 89-90; see also Northern Group Servs., Inc. v. Auto Owners Ins. Co., 833 F.2d 85 (6th Cir. 1987) (holding that courts must look to the nature of the state law itself and balance the federal interest in uniformity against the displacement of traditional state regulation), cert. denied, 486 U.S. 1017 (1988).

In 1990, the United States Supreme Court granted certiorari to resolve the conflict between the circuits. Reversing the Third Circuit in FMC Corp., Justice O’Connor interpreted the deemer clause to exclude self-funded employee benefit plans from “state laws that ‘regulat[e] insurance’ within the meaning of the savings clause.” FMC Corp. v. Holliday, 111 S. Ct. 403, 409 (1990). Simply put, Justice O’Connor stated:

[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation “relate[s] to” the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not “saved” because they do not regulate insurance. State laws that directly regulate insurance are “saved” but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

Id.


132. See Linthicum, 930 F.2d at 16.
whether individual plan participants should suffer for the sake of "uniformity in the regulation of employee benefit plans" where, in reality, the uniformity is nonexistent.

V. MINNESOTA COURTS’ HANDLING OF SELF-FUNDED ERISA QUESTIONS

The Minnesota Supreme Court has followed the Eighth Circuit Court of Appeals and the United States Supreme Court in its decisions regarding self-funded insurance plans. Although the State of Minnesota has been a national leader in innovative insurance regulation,133 the Minnesota Department of Commerce has still been unable to crack the stronghold of ERISA’s preemption clause regarding self-funded employee benefit plans.134

A. Hunt v. Sherman135

In 1981, Jeffrey Hunt severely injured his hand in a power lawn-mower operated by the defendant.136 The plaintiff’s father brought suit for “negligence by an adolescent lawnmower operator and negligent entrustment by the minor’s parents.” 137 The parties settled the


In addition, the Act specifically requests permission “to regulate self-insured health plans to the same extent as insurance companies.” Id. § 19, subd. 2. Finally, subd. 3 highlights the expansiveness of legislative efforts to circumvent the prior holdings of the Court by seeking an exemption that would “permit the state to enact or adopt other state laws relating to health coverage that would, in the judgment of the commissioner of commerce, further the public policies of this state.” Id. § 19, subd. 3. In light of the trend established by the United States Supreme Court, the success of the state’s request is doubtful.

134. See Minnesota Chamber of Commerce v. Hatch, 672 F. Supp. 393 (D. Minn. 1987) (barring insurance commissioner from requiring self-funded benefit plans to file security or surety bond with the Minnesota Department of Commerce); St. Paul Elec. Workers Welfare Fund v. Markman, 490 F. Supp. 931 (D. Minn. 1980) (permanently enjoining the Minnesota Commerce Department from requiring self-insurers to contribute to the Minnesota Comprehensive Health Association).

135. 345 N.W.2d 750 (Minn. 1984).

136. Id. at 751.

137. Id.
suit for $100,000, and both parties agreed that the award did not fully compensate the plaintiff for his injury.\footnote{Id.} Plaintiff received medical compensation through his father’s self-insured employee benefit plan, which intervened and sought reimbursement for the medical expenses paid pursuant to the subrogation provision in the plan contract.\footnote{Id.}

On appeal, the plaintiffs attempted to garner support from a footnote in the United States Supreme Court’s opinion in \textit{Shaw v. Delta Air Lines, Inc.}\footnote{See \textit{Hunt}, 345 N.W.2d at 753.} In \textit{Shaw}, Justice Blackmun noted, “Some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.”\footnote{Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983).} Thus, on the basis of \textit{Shaw}, the plaintiffs argued that because Minnesota’s state subrogation law did not relate to the plan, the state law was not preempted by ERISA.\footnote{\textit{Hunt}, 345 N.W.2d at 753.}

In addition to using \textit{Shaw}, the plaintiffs urged the court to consider the Minnesota rule of law established in \textit{Westendorf v. Stasson}.\footnote{330 N.W.2d 699 (Minn. 1983).} The \textit{Westendorf} rule states that an insurer “is not entitled to reimbursement in the absence of full recovery.”\footnote{Id. at 701.} Alternatively, plaintiffs asserted that, even if the state subrogation law did relate to the plan, the law was nonetheless saved from preemption by ERISA’s savings clause.\footnote{\textit{Hunt}, 345 N.W.2d 699 (Minn. 1983).} The Minnesota Supreme Court rejected both arguments and affirmed the district court’s grant of subrogation rights to the plan.\footnote{Id. at 753-54.}

Interpreting the relationship between ERISA’s savings clause and the deemer clause, the court stated,

\begin{quote}
Although it is true that [the savings clause] does not pre-empt state law dealing with insurance companies or with insurance contracts, the state subrogation law at issue in the instant case involves no insurance. . . . Because the ERISA Plan in this case does not involve insurance, the insurance exception is wholly inapplicable.”\footnote{Id.}
\end{quote}

In a dissenting opinion, Justice Yetka focused more accurately on the characterization of the plan at issue.\footnote{\textit{Id.} at 754 (Yetka, J., dissenting).} Justice Yetka deemed the plan an insurance contract and argued, therefore, that the savings clause preserved the plaintiff’s state law cause of action. Justice

\begin{footnotes}
\item Id.
\item Id. Jeffrey Hunt incurred medical expenses amounting to $8,371.17. \textit{Id.}
\item See \textit{Hunt}, 345 N.W.2d at 753.
\item \textit{Shaw v. Delta Air Lines, Inc.}, 463 U.S. 85, 100 n.21 (1983).
\item \textit{Hunt}, 345 N.W.2d at 753.
\item \textit{Westendorf v. Stasson}, 330 N.W.2d 699 (Minn. 1983).
\item \textit{Id.} at 701.
\item \textit{Id.} at 753.
\item \textit{Id.} at 753-54.
\item \textit{Id.}
\item Id. at 754 (Yetka, J., dissenting).
\end{footnotes}
Yetka reasoned that the correct result is that the plan should not be reimbursed until the injured party is compensated in full.149

B. St. Paul Electrical Workers Welfare Fund v. Markman150

In St. Paul Electrical Workers, a group of self-funded employee benefit plans challenged a Minnesota insurance statute devised to create the Minnesota Comprehensive Health Insurance Act of 1976 (MCHIA).151 The operation of MCHIA is threefold:

First, it requires that every health and accident insurer shall offer to Minnesota residents qualified policies or unqualified policies containing a specified amount of major medical coverage. Qualified policies are those which provide certain statutorily mandated benefits or the actuarial equivalent of those benefits. Second, employers who offer health care plans to their employees must make available to them a certain type of qualified plan. Finally, the Act creates the Comprehensive Health Association and charges it with operating a comprehensive health insurance plan designed to offer policies to individuals who are unable to obtain health and accident insurance through normal channels. The Association is also available to reinsure qualified policies issued by individual carriers.152

Additionally, the statute required all "'insurers, self insurers, fraternals and health maintenance organizations' to join the association... Failure to maintain membership in the association [could] result in termination of the member's right to do business in the state.'"153

The self-insurers, arguing on the basis of federal preemption under ERISA, claimed that the MCHIA unjustly subjected them to "'substantive and reporting requirement provisions of the state insurance laws.'"154 The Minnesota District Court agreed and permanently enjoined the insurance commissioner from enforcing the obligations submitted under the MCHIA against self-insurers. The court found that the deemer clause of ERISA precluded a state from directly regulating an employee benefit plan as a traditional insurer and, where "'Congress' command [was] explicitly stated in the stat-

149. Id.
151. Id. at 932.
154. Id. at 933. The reporting requirements for self-insurers include, among other things, the cost of self-insurance. Other state law requirements include a continuation provision allowing employees to continue insurance for six months following termination, a conversion provision allowing a transfer from group to individual coverage, and specific minimum coverage requirements. Id.
However, four years prior to *St. Paul Electrical Workers*, a group of insurers unsuccessfully challenged the state's ability to regulate the substantive requirements of employee benefit plans through MCHIA. In *Insurers' Action Council, Inc. v. Heaton*, the plaintiffs argued that MCHIA's requirement to offer specified types of benefits to employees through their employee benefit plans was preempted by ERISA.157

Rejecting this argument, the Minnesota District Court broadly construed the savings clause of ERISA, finding, "the conflict between the challenged state insurance law and ERISA has to be very clear in order to trigger the preemption provision." Additionally, the court distinguished between the substantive requirements of ERISA which relate only to reporting requirements and fiduciary duties and have nothing to do with the substantive requirements of MCHIA.159

Finally, the court examined the relationship between ERISA and the McCarran-Ferguson Act, noting that ERISA itself "shall not be construed to supersede any law of the United States. The McCarran-Ferguson Act mandates that the business of insurance shall be regulated by the states. In light of these statutory considerations, the ultimate success of plaintiffs' preemption claim is questionable at best."160

VI. ANALYSIS

A. Did Congress Really Intend to Distinguish Between Self-Funded and Fully-Insured Employee Benefit Plans?

Several arguments exist to reason that Congress did not intend to distinguish between self-funded plans and fully-insured plans. First, a close investigation of ERISA's legislative history demonstrates that Congress' primary goal for promulgation of ERISA legislation focused directly on controlling abuses in the private pension plan area.161 While ERISA's legislative history provides ample evidence

155. *Id.* at 934 (citing dictum in Jones v. Rath Packing Co., 430 U.S. 519, 525 (1979)); see also supra note 43.
157. *Id.* at 926. Plaintiffs focused on the definitions in ERISA and specifically argued that, since health and accident insurance is defined as an "employee welfare benefit plan," it is also an "employee benefit plan" and MCHIA was preempted. *Id.*
158. *Id.*
159. *Id.* The reporting and disclosure provisions are the only substantive parts of ERISA which relate to health and accident insurance.
160. *Id.* (citations omitted).
161. See Brummond, supra note 22, at 115. "Volumes of testimony before the House Committee on Education and Labor and the Senate Committee on Labor and
of the exhaustive congressional thought process involved in protecting employees in the pension plan area, Congress devoted "[o]nly a very small segment of this testimony [on pension-related abuses] to the problems relating to employee welfare benefit programs. As a result, many of the regulatory provisions found in Title I of ERISA apply only to employee pension benefit plans."162

Second, the lack of congressional debate over the interrelationship of the preemption clause, the savings clause, and the deemer clause demonstrates that Congress itself may not have been aware of the ultimate impact of its legislation. In fact, "every preemptive section in pension-related bills was worded so that federal law would supersede state law only in those specific areas regulated by the federal bill."163 The now problematic preemptive effect of section 514's "deeming language" was not added until February 28, 1974, when the House passed its version of the bill.164

During Conference Committee discussions, the "entire thrust of the preemption language was reversed; instead of preempting state laws only insofar as they regulated the same areas explicitly regulated by ERISA, section 514(a) was changed to preempt all state laws unless otherwise excluded."165 Congress became aware of these changes only ten days before the final vote, when the Committee filed its report.166

In 1974, when the conferee's report came up for approval, the state of the country was such that, during the month of August, Congress had focused upon other matters of national concern.167 "It would be naive to suppose that... any serious attention could have been devoted to such matters as the status of an obscure preemption provision in a 250-page federal statute."168

At the point of promulgation, congressional committees had

Public Welfare focus on pension-related abuses and how such abuses can be corrected." Id.

162. Id. at 115.
163. Id.; see also id. at 115 n.466.
164. Id. at 116.
165. Id.
166. "Congress could not possibly have understood the nature of the critical conferee changes." Id. at 115. Congress devoted almost no attention to the language of section 514. Id.
167. During the month of August 1974, when the conference committee's report was before Congress, Richard Nixon stepped down from the office of the Presidency.
168. In view of the fact that the present language of section 514 was inserted by the Conference Committee at a very late hour, after no congressional hearings, and with little explanatory comment, serious doubts can be raised regarding congressional intent to broadly preempt state laws regulating employee welfare benefit plans.

Id. at 116.
worked on reform legislation in the area of pension plans and employee benefit plans for nearly twelve years. Thus, the lack of legislative debate in the area of employee benefit plans, combined with the significant historical events of 1974, lends credence to the theory that congressional members were not fully aware of the significant impact ERISA legislation would cast on employee benefit plans and perhaps may not have intended to distinguish self-funded plans from fully-insured plans.

B. Differences in the Nature of Self-Funded Plans Versus Fully-Insured Plans

1. Distinguishing Between the True Characteristics of Self-Funded and Fully-Insured Benefit Plans

While an employer has the choice to fund its own benefit plan or to purchase a plan from an insurance company, the only distinguishable difference, required state regulations aside, in the nature of the benefit plan is the source of the funding. Even when an employer chooses to fund its own benefit plan, the plan provides a benefit schedule, assumes liability through a contractual document for payment of claims accorded by the benefit schedule, and designates the amount of employee contribution based on insurance principles of risk distribution.

The difference between the plans becomes even less discernible where an employer self-funds its own plan but purchases excess stop-loss coverage from an insurance company to limit its liability for catastrophic losses.169 Likewise, if a self-funded employee benefit plan hires a third party administrator to process its employees' claims through an administrative services-only contract, the plan es-

169. While the United States Supreme Court has never considered what effect the purchase of stop-loss insurance has on self-funded employee benefit plans, circuit courts continue to grapple with the issue. The Fifth Circuit Court of Appeals recently held that a stop-loss policy which limited a self-funded benefit plan's liability to $30,000 per employee did not convert the plan's self-funded nature into an insured plan. See Brown v. Granatelli, 897 F.2d 1351, 1355 (5th Cir. 1990). In Granatelli, the court looked beyond form to the "substance of the relationship between the plan, the participants, and the insurance carrier." Id. The majority opined that a $30,000 level of employer liability was sufficient to show that the employer's plan was not merely acting as a "conduit for claims from participants to the [stop-loss carrier]." Id.; see also Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991) (holding that purchase of $25,000 per participant stop-loss coverage does not convert self-funded plan into an insured plan); Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Ass'n, 771 F. Supp. 771 (E.D. La. 1991) (holding that purchase of stop-loss coverage at $40,000 individual level did not destroy self-funded status of plan). But see State Farm Mut. Auto. Ins. Co. v. American Community Mut. Ins. Co., 659 F. Supp. 635 (E.D. Mich. 1991) (determining that a plan purchasing only $5,000 per employee stop-loss policy is essentially an insured plan for purposes of ERISA preemption).
sentially uses the insurance expertise of a true insurance company yet retains its self-funded status as well as the associated advantages.

Dissenting court opinions depict the practical reality of these differences: Supreme Court Justice Stevens noted the "broad and illogical distinction" drawn by the majority in *FMC Corp.* and claimed, "there is no apparent reason for treating self-insured plans differently from insured plans."  

Minnesota Supreme Court Justice Yetka also dissented in *Hunt* on the ground that the self-funded employee benefit plan at issue was "really an insurance contract, bringing it within the exception provided by" the savings clause.  

2. **Distinguishing Between Federal Control of Pension Plans and Employee Benefit Plans**

ERISA drafters sought to protect the "voluntary nature" of employee benefit plans by facilitating administration and ensuring uniformity. Yet, from an employer's perspective, pension plans are equally voluntary. However, a close look at the structure of ERISA demonstrates that the drafters built in many more safeguards to protect pension plan participants than employee benefit plan participants. Case history illustrates the inequities which arise from this lack of safeguards for self-funded benefit plan participants. Thus, the drafters, while attempting to promote voluntary employee benefit plans, ignored their main objective—protection of plan participants.

At least one commentator has argued that ERISA's federal regulatory scheme is inappropriate to govern the area of employee benefit plans. While Congress may have adequately incorporated safeguards to control abuses in the pension plan area through ERISA legislation, employee benefit plans, by their distinguishable nature, are ill-suited to that same protective scheme.  

Employee benefit plans differ from pension plans in several ways. First, employee benefit plans "require a specific regulatory approach

172. *See Brummond, supra* note 22, at 117. Even a cursory glance at the structure of Title I demonstrates that less than half of its regulatory provisions apply to employee benefit plans. For example, Brummond notes that Part One applies only to employee benefit plans with greater than 100 participants; Parts Two and Three apply only to pension plans. *Id.* While Parts Four and Five provide fiduciary standards and an enforcement provision, Brummond argues that these provisions are ill-suited to control employee benefit plans. *Id.*  
173. Unfortunately Congress lumped together both pension plans and employee welfare plans under one federal act without taking into consideration their dissimilar natures.
tailored to their individual purposes and needs." 174 ERISA regulatory provisions do not address these individual needs. For example, ERISA's fiduciary standards relating to self-funded benefit plans do not "take into account both the short-term nature of benefit claims and the danger of unregulated self-insurance." 175 Furthermore, Parts Four and Five of Title I do not provide guarantees that a welfare benefit plan will meet its obligations when they become due. Apparently the drafters of ERISA were not as concerned with the funding of welfare benefit plans as they were with the funding of pension benefit plans; they provided funding guidelines for the latter but not the former. 176 Thus, ERISA's regulatory scheme does not offer adequate safeguards to employee benefit plan participants.

C. Disparity and Disuniformities Created by Distinguishing Between Self-Funded and Fully-Insured Benefit Plans

1. Employee Expectations

From an employee's perspective, as long as funding for the employee benefit plan exists, the actual source of funding is irrelevant. Generally speaking, most employees are probably not even aware that ERISA allows a distinction between benefit plans that are self-funded by their employers and benefit plans that are purchased by their employers. Most employees only care that they receive benefits.

Employees have developed expectations which evolve directly from traditional insurance concepts established by the insurance industry, common law principles of equity, and indirectly from insurance schemes created by state regulatory agencies. Plaintiffs like the Hollidays, the Linthicums, and the Hunts have found these expectations dashed by the courts' holdings that, in very simple terms, the sole reason they lost was because their employee benefit plans were self-funded.

2. Employer-Employee Relationship

Allowing an employer ultimate decision making power over claims

174. Id. at 117.
175. Id. Brummond also notes, "There are at least two dangers [to allowing federal control of self-funded benefit plans] which concern state insurance regulators. The first is the possibility that inadequate amounts of money will be set aside to pay benefit claims. The second is the danger that plan managers will use benefit monies as operating capital.

Id. at 117 n.474 (citations omitted).
176. Id. at 117 (noting, "there appears to be no justification for this omission").
payment may jeopardize the employer-employee relationship.\textsuperscript{177} Even though federal law allows employers to tailor their self-funded benefit plans to meet their own needs, employers may find themselves in a difficult position to explain to a needy employee why its own self-funded benefit plan does not provide the same protections which are guaranteed through the state regulatory agency.\textsuperscript{178}

D. Impact of the Courts' Holdings on Self-Funded Plans

While the ultimate congressional intent behind ERISA legislation may be magnanimous, the lack of congressional guidance defining the scope of this intent has left courts in a quandary. Congress has clearly stated its objective: ERISA legislation is focused on controlling employer abuses in employee welfare programs. More specifically, ERISA is designed to protect plan participants.\textsuperscript{179} Yet, the impact of the legislation focuses more on the facilitation of uniform administration of regulatory standards regarding employee benefit plans from the perspective of employers. In \textit{Fort Halifax Packing Co. v. Coyne},\textsuperscript{180} the United States Supreme Court emphasized this position, stating that to require plan providers to design their programs in an environment of differing State regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.\textsuperscript{181} Thus, a "patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation . . . . Preemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations."\textsuperscript{182} However, the Court here assumed that uniform administrative requirements for employers will, in turn, provide uniform safeguards for plan participants.

While logically this assumption has merit, in practice, the assumption holds true only if the notion is applied \textit{uniformly} to both self-
funded plans and fully-insured plans. By drawing a distinction between these plans, the Court has established a trend allowing disuniformity in protective safeguards for plan participants in employee benefit programs. Obsequiously, lower courts have followed.

VII. Alternatives

To some, the passage of ERISA created a "moratorium of indefinite length on the passage of [state] health insurance laws." One judge was troubled by the possibility that "workers whom ERISA was primarily intended to protect may be better off with state health insurance laws than without them, and the efforts of states . . . to ensure that their citizens have low-cost comprehensive health insurance may be significantly impaired by ERISA's preemption of health insurance laws." 184

The solution to the problems presented can be looked at as an all or nothing situation: Congress could obliterate the savings clause and adopt a comprehensive federal policy to regulate health insurance, or Congress could obliterate the deemer clause and thus return to the states entirely the power to regulate employee benefit plans. While the latter approach is favorable, other compromises may exist to achieve a more equitable effect without the elimination of large portions of ERISA.

First, Congress should amend ERISA to provide substantive, mandated benefit protection for all employee benefit plans. Provisions would be determined on the basis of the needs of the general welfare. To address these societal needs, most states have adopted minimum mandated benefit standards for mental health treatment, drug treatment, and pregnancy.

Second, Congress should provide that self-funded benefit plans which purchase excess stop-loss coverage would lose their self-funded status. This provision would discourage employers from self-funding solely to gain the associated economic advantages when, in fact, the employer has passed off part of its liability to an insurance company.

Third, Congress could allow states the power to regulate more closely companies that act as third party administrators (TPAs). In reality, many of the services provided by TPAs stem directly from

184. Id. Judge Renfrew advised federal legislators to heed the admonition of Justice Brandeis to the federal courts that to "stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation." Id. (quoting New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).
traditional insurance practices.186 While many TPAs, or claims administrators, receive a percentage of the claims paid on behalf of a self-funded benefit plan, neither the plan nor the TPA pays anything into the state by way of premium tax.187

Fourth, self-funded plans should be required to participate in comprehensive health acts such as the Minnesota Comprehensive Health Insurance Act.188 Under St. Paul Electrical Workers Welfare Fund,189 self-funded plans are exempt from paying into the state fund. This exemption not only denies the state fund needed monies but also unjustifiably forces state health maintenance organizations and insurance companies to bear the entire financial burden for needy state participants.

VIII. CONCLUSION

Since its enactment, ERISA has successfully controlled abuses within the pension plan area. However, both Congress and, in turn, the courts need to address the acknowledged inequities resulting from the distinction between self-funded and fully-insured benefit programs. Congress has clearly stated that the primary purpose of ERISA legislation is to protect and secure the benefits of employees and plan beneficiaries. While the legislation has succeeded in attain-

186. See Insurance Bd. of Bethlehem Steel Corp. v. Muir, 819 F.2d 408 (3d Cir. 1987). In Muir, the appellant self-funded its employee benefit plan but contracted with Pennsylvania Blue Cross/Blue Shield ("BCBS") for administrative services. Id. at 409. BCBS made initial claim determinations, issued BCBS insurance cards and claim forms, and processed plan participant's claims "in accordance with [BCBS's] regular office procedures." Id.

The Third Circuit reversed the district court and held that, because the employer remained solely responsible for funding claims payment, BCBS, notwithstanding its use of traditional insurance practices, did not function in the capacity of an insurer. Rather, it provided administrative services only. Id. at 412; see also Moore v. Provident Life & Accident Ins. Co., 786 F.2d 922 (9th Cir. 1986). In Moore, the employer established a trust fund to self-fund its employee benefit plan. Id. at 924. The trust fund contracted with Provident Life & Accident Insurance Company and adopted the "terms and provisions of a Provident group policy as its own . . . ." Id. Additionally, the trust fund hired a TPA, but Provident "retained the privilege to review the administrator's determination of the amount of benefits and to defend or settle any action filed on a claim for benefits under the Plan." Id. In response to a plan participant's state law action against Provident, the Ninth Circuit held, "Provident's role . . . . was not that of an insurance company but that of an administrative overseer." Id.

187. See Brummond, supra note 22, at 78 (noting that a distinct advantage, from the employer's viewpoint, is that self-insured employee benefits plans can usually avoid state premium taxes); see also Turza & Halloway, supra note 41, at 201-02.

188. MINN. STAT. § 62E.01 (1990).

ing this end for pension plans, the means provided by ERISA, in the area of employee benefit plans, have failed.

Health care costs will continue to soar, and employers will continue to search for ways to reduce their health care costs. Without some sort of equitable and uniform standard for all employee benefit plans to follow, disparity and disuniformity will continue to affect the general welfare. Whether additional controls come through stricter federal or state regulatory schemes, one thing is obvious from the case law: the Court’s interpretation of the current legislation, which distinguishes self-funded and fully-insured benefit plans, fails to provide uniformity and fairness for plan participants.

Julie K. Swedback