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The Employment Retirement Income Security Act: An Unkindly Illusion

By John O. Ifediora*

Prologue

The Corcorans lost their unborn child because a benefit administrator for United Healthcare determined that hospitalization was not medically necessary.¹ They Sued. But because their benefit plan was governed by ERISA, they were denied any remedy, state or federal, for an outcome that may have been the result of a ghastly mistake. The Kuhls may be forgiven if, in their private moments, expressed a sense of companionship, for they also have a tale of equal gravitas. In 1993, they brought suit against Lincoln National Plan of Kansas City, citing wrongful death because the health plan delayed authorization of heart surgery.² The judge dismissed the case; he had to. A plaintiff who sues under ERISA is entitled to either specific performance or recovery of cost of services denied; wrongful death is not a proper ground for recovery. Too bad!

Introduction

In 1967, Senator Jacob Javits sponsored a pension reform bill that later became what is currently known as ERISA, but formally, the

Employment Retirement Income Security Act.³ Enacted in 1974, ERISA was the federal government's response to very painful abuses of pension plans in the 1960s, two of which are particularly noteworthy: the 1963 termination by Studebaker of its pension plan that covered 4000 employees, leaving them without the promised benefits and no recourse;⁴ and the gross misuse of the Central Teamsters Pension fund that left beneficiaries empty handed after laboring for 20 years or more.⁵ Upon enactment of ERISA, Senator Javits remarked that the central goal of the act is "[t]o maintain the voluntary growth of private pension and employee benefit plans while at the same time making needed structural reforms in such areas as vesting, funding, and termination so as to safeguard workers against loss of their earned or anticipated benefits...."⁶ Ironically, the major provision in ERISA, its preemption clause, has created more uncertainty about the adequacy and soundness of health care benefits than any other federal legislation that purports to protect workers' welfare. Since ERISA does not regulate the content of employer provided health care plans, it relies instead on disclosure, administrative requirements, and fiduciary

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obligations to minimize employer indiscretion and abuses.

ERISA expressly provides that state laws that regulate employer-provided benefit plans should have no effect, unless such laws regulate insurance.⁷ Moreover, if benefit plans are self-funded, they are also exempt from state insurance regulations. This complete preemption of states' ability to oversee benefit plans offered by employers has created a regulation-free zone in which the states have no power to regulate, and the federal government has not bothered to regulate the content of employee benefit plans.⁸

The thrust of this paper is that ERISA, while well-intentioned, detracts inordinately from employees' welfare through its overly restrictive preemption clause. It will be argued that because the various provisions of the act unduly constrain employees' economic choices, their right to contract freely, and the ability of plan beneficiaries to seek legal recourse generally available to those covered by non-ERISA plans, employees will be better served if the act is restructured to address these issues. Part II of the paper will discuss the implementation of ERISA within the context of the US health care system. Part III discusses the constitutional basis for ERISA and its preemption clause; Part IV provides a policy analysis and remedial measures. Part V will conclude.

II. ERISA In The Context Of The US Health Care System

The blatant misuse and outright misappropriation of pension funds in the 1960s notwithstanding, the need for health care reform was already beginning to inform and shape the debate on how to manage the nation's overly inefficient health care delivery system.⁹ This need for greater efficiency meant

looking at different models for delivering health care services, and through this effort the managed care industry was born; and in short order, ERISA came into existence. As crafted, ERISA provides uniform federal guidelines and regulations for the administration of employee benefits and pension plans. While the act does not require employers to offer benefits, it does, however, require those that offer employee benefits to abide by the act's mandates.¹⁰

The US is unique amongst the industrialized nations in the extent to which private insurance is relied on to finance health care services. Expenditure on private insurance in 1996, for example, amounted to \$390 billion or 33% of total expenditure on health insurance;¹¹ the federal government, philanthropic institutions, and state governments paid the rest.¹² This disproportionate reliance on private insurance is the direct consequence of government subsidies through tax policies; employer contributions toward employee health insurance are exempt from taxation under the federal income tax scheme.¹³ A better understanding of private financing of health care in the US is, perhaps, enhanced by focusing on the structure of third-party payers. This group may be divided into two camps: one is the traditional indemnity insurance and service benefit plans that simply offer blanket coverage for health risks, and will indemnify patients for covered health care expenditures or pay the health care provider directly; the other is the managed care group such as HMOs, PPOs (preferred provider organizations), and a host of managed care plans. The trend towards this latter group has been remarkable; so much so that only about 4% of private insurance is currently covered by the traditional fee-for-service plans.¹⁴ Managed care is now the fashionable mode of health care delivery in the nation.¹⁵

The above classification feeds directly into the more useful distinction for our immediate purpose, the distinction between private payers subject to federal oversight and those subject to state regulations. In the recent past, state governments were the primary regulators of private health insurance. This fact was made perfectly clear in the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011, that confirmed the primacy of states in the area of health care regulation, and forbade interference from the federal government.¹⁶ Thus, for a very long period, the relationship between insurers and the insured was governed by state regulations, and state common law of contract and tort. However, beginning in 1974, with passage of ERISA, states' authority to regulate the most common form of private health insurance, employee health benefits, was sharply curtailed. ERISA established uniform national standards for employee benefit plans and preempts, to a very large extent, state regulation of these plans. Nonetheless, states still retain full authority to regulate individual and group insurance policies that do not relate to employee benefit plans.

Statistically, approximately 70% of the privately insured gets their coverage through employment-related benefit plans that are subject to ERISA.¹⁷ Of this group, about 33% of beneficiaries is covered under self-funded employee benefit plans that are completely exempt from state regulation by ERISA.¹⁸ The remaining 39% is non-self-funded ERISA plans subject to state regulation only to the extent that relevant state laws are considered to regulate insurance.¹⁹ Thus, state laws that regulate employee benefit plans but do not regulate insurance are preempted by ERISA. While ERISA continues to perplex, it is noteworthy that states remain primarily responsible for regulating many health plans that are subject to ERISA as well as insurance plans not subject to ERISA, e.g. individual

health insurance plans, group insurance plans covering state employees, local government employees or church employees. Indeed, ERISA covers only employee benefit plans established and maintained by an employer as part of employment compensation package for its workers. This does not include individual health plans purchased by employees outside their employment, and without contributions from the employer.²⁰

Remedies under ERISA for participants wrongfully denied treatment are remarkably limited. An aggrieved plan participant, for example, can only bring legal action to recover denied benefits, and these benefits are restricted to specific performance or reimbursement for actual services received outside the plan.²¹ Thus, ERISA has no provision for punitive damages. A plan participant can sue the plan administrator for breach of fiduciary duties, but any recovered damages go to the plan, not to the aggrieved participant because the act views the plan as the damaged party in such litigations.²²

III. Constitutional Basis for ERISA

At the outset, it must be taken as given that the concept of federalism embodied in the US constitution requires a certain degree of concurrency of state and federal legislative authority.²³ Thus, the states and the federal government may enjoy concurrent legislative authority over specific subject areas for which Congress is granted the powers enumerated in Article 1.²⁴ In instances of concurrent jurisdiction, two unique constitutional instruments — the Supremacy and Commerce clauses, and express congressional preemption — serve as mediating devices. For our immediate objective, two kinds of preemption may be distinguished: constitutional and legislative. Constitutional preemption refers to the Supremacy Clause of the Constitution that requires preemption of any state law that

conflicts with or is inconsistent with federal law. Moreover, in instances when Congress has yet to act, the “dormant Commerce Clause” may be invoked to invalidate state laws that unreasonably burden interstate commerce which Congress has the Article 1 power to regulate.²⁵ Thus, when Congress has the constitutional power to regulate but has not exercised this power, the dormant commerce clause empowers courts to invalidate any state law that unduly interferes with interstate commerce.²⁶

Legislative preemption occurs when Congress expressly invalidates state laws in areas which Congress has the constitutional authority to regulate, e.g. interstate commerce.²⁷

Furthermore, Congress may implicitly preempt state regulation by showing its intent to occupy an area exclusively, even though no federal law embodying such intent is in conflict with state regulations. ERISA’s preemption clause, by the above classification, is a legislative preemption. The act, in relevant part, states that ERISA “shall supersede any and all state laws in so far as they relate to any employee benefit plan.”²⁸ Thus, in adjudicating ERISA cases, courts must engage in statutory interpretation of the act’s provisions to ascertain whether in ERISA Congress claimed all or a fraction of the concurrent jurisdiction.

ERISA’s Preemptive Powers

The issue of complete preemption has been a major source of discomfort for plan participants. A state regulation that provides plan beneficiaries with remedies or grounds for legal action that are similar to or in conflict with the civil enforcement provisions of section 502(a) of ERISA are subject to “complete preemption” because they trigger a federal jurisdiction doctrine.²⁹ Complete preemption occurs when a federal law “completely preempts an area that any civil complaint raising this select group of claims is necessarily

federal in character.”³⁰ This provision empowers plan administrators to force the removal of cases filed in state courts to federal courts, in the main, because remedies under ERISA, as previously mentioned, are restricted to equitable relief. Another form of preemption under ERISA is the “conflict Preemption” mechanism of section 514(a) that goes into effect when a state law “relates to” the benefit plan, unless the state law is “saved” by the saving clause of section 514(b)(2)(A). Yet another clause, the “deemer” clause of section 514(b)(2)(B) provides that an employer-based benefit plan cannot be deemed to be in the business of insurance to be regulated by state law.³¹

A vital, albeit controversial, provision in ERISA is the ability to preempt state government regulations when there is a conflict between ERISA’s provisions and the state law. Many private sector employers have found particular favor in this preemption instrument, and have thus relied on it to expand employment benefits to workers with the expectation that their benefit plans will not be subject to the maze of state regulations.³² To fully understand the preemption clause, it is important to first notice that states have traditionally enjoyed the privilege to regulate the business of insurance. But with enactment of ERISA, state regulations are “saved” from preemption if the state law regulates insurance proper, and does not “relate to” benefits plans.³³ However, the “deemer” clause forbids re-characterization of an employer-based plan as health insurance that may be subject to state regulation. Hence if an employer elects to self-insure and assumes all attendant risks, the benefit plan is exempt from state regulations. But employers that do not want to self-insure, and thus avoid the financial risk of insurance, may purchase insurance products for their employees with the understanding that the benefit plan will be subject to state regulations.³⁴

While it is customary for states to regulate in areas also within the influence of federal law so long as there is no conflict with federal laws, ERISA's preemption clause provides that it supercedes all state laws that affect any employee benefit plan. A significant exception to this preemption clause allows states to regulate health care providers and insurance companies. However, ERISA also provides that states may not consider employer-sponsored benefit plans as insurers.³⁵ In sum, the direct consequences of the preemption clause are: (1) employer-sponsored health plans cannot be regulated by state laws; (2) insurance companies that provide coverage to employer-sponsored plans may be regulated by states; and (3) states cannot regulate self-funded employer-sponsored health plans.³⁶ This leads to the important distinction between self-insured plans that "bear the risk" of insurance, and thus are outside the reach of state laws, and insured employer plans which states can indirectly influence by regulating the insurance companies that service them. Regardless of how they are funded, both types of plans are governed by ERISA. The number of employees covered by self-insured plans vary amongst states, but an estimated 40% of employees covered by employer-sponsored plans nationally is enrolled in self-insured plans.³⁷

When a state regulation or law is challenged under ERISA's preemption clause, courts begin by asking two basic questions: (1) Does the state provision "relate to" an ERISA governed plan? This question engages the following issues – any direct reference to ERISA plans, regulation of the same areas as ERISA, regulates ERISA plans benefits, administration or coverage, and imposition of substantial costs on ERISA plans, (2) Is the state law "saved" from preemption because it only regulates insurance? To avoid preemption the state law must be found not to affect an ERISA governed plan or be found to be a law regulating only

insurance.³⁸ For over twenty-five years, the US Supreme Court has interpreted ERISA's preemption clause broadly to invalidate scores of state regulations that either directly or indirectly affect employer-sponsored health benefit plans. These rulings severely curtailed the ability of state policymakers to craft healthcare finance programs needed to provide general access to healthcare. However, in 1995, two Supreme Court decisions provided the flexibility states were sorely lacking. In the *Traveler Insurance* decision, the Court upheld part of New York's hospital rate-setting program that allowed the state to impose surcharges on medical bills covered by insurers except those paid by Blue Cross.³⁹ This program helped defray costs that Blue Cross incurred as the insurer of last resort in the state. While this inordinately burdened insurers other than Blue Cross, the Court held that the program was outside ERISA's preemption clause because it was a general tax law enacted under the state's public health regulatory authority that did not target ERISA plans, and affected every purchaser of healthcare. This decision was significant because it ended the presumption of unlimited preemptive powers of ERISA. In the 1997 *De Buono* decision, the Court applied similar reasoning, and upheld New York's authority to tax healthcare providers even when the tax imposed added burden on ERISA plans.⁴⁰

IV. Policy Analysis: The Benefits Are Too One-Sided

An employer that elects to establish a pension and health care benefit plan is encouraged to do so by the federal government. This encouragement comes by way of tax subsidies or tax-exemption.⁴¹ The benefits become more remarkable if the employer also assumes the risk of self-insurance. By becoming self-funded, the employer avoids entirely the inconveniences of state regulation through the

Deemer Clause of ERISA. In this instance the self-funded plan enjoys two distinct advantages: tax exemption, and freedom from state regulatory provisions. But the advantages do not end here, for there is the issue of how the fund is actually funded, or more to the point, who actually funds the plan?

A closer look at the funding mechanism shows that employees are in fact the sole providers of funds to the plan. Economic principles inform us that an employer will only hire labor if the market value of labor's productivity is at least equal to the wage. But the wage labor receives must be equal to its entire compensation package. This package naturally includes wages and any employment related benefits. Thus, if labor, at the margin, is worth \$10 per hour to the employer, it will be an economic anomaly for the employer to offer a cent higher than ten dollars. But more often than not, labor does not know its actual value in production, and because it lacks this information it will settle for a lower wage rate. The employer, however, has this market information when bargaining with labor, and since labor is receiving less in wages, the employer can afford to contribute the difference to labor's pension or health care benefit plan. From this simple example, it is clear that labor actually bears the burden of employment benefit plans, and not the employer. So far the advantages to the employer remain the same: tax exemption, and exception from state regulation.

But what about the risk factor, the assumption that self-funded plans run the risk of financial insolvency if the level of claims far exceed contributions to the fund?⁴² This assumption quite clearly is an economic fiction, for no self-respecting employer will voluntarily assume such risk. The fact is that most self-funded employers purchase stop-loss insurance coverage from third-party insurers, and since ERISA does not forbid this practice, it has

become customary practice.⁴³ Thus, the grounds for justifying the above-mentioned advantages quickly evaporate. But since employers that self-fund are usually large operators, there is also the attendant benefit of economies of scale that comes with size. These large employers tend to seek and receive significant discount from third-party insurers due to the number of employees covered. This is an added advantage, for it tends to reduce the cost of employment. But the biggest benefit to the employer is yet to be added, and this comes from the fact that under ERISA, if the plan administrator wrongfully withholds benefits and the beneficiary suffers physical or economic harm, courts can only authorize payment for benefits withheld. The administrator (and by extension, the employer) cannot be held liable for damages.⁴⁴ This is the real advantage; employees, nonetheless, continue to bear the burden of ERISA-governed plans. But this burden is, to a certain extent, mitigated by the fact that employment benefits provided in the form of health benefits are not subject to taxation.

Possible Remedial Measures

Given the uneven interpretation of benefits due to the Preemption Clause, removal of this clause, and permitting injured beneficiaries to sue their health plans for injuries sustained due either to a health plan's independent action or to malpractice of a health plan's provider will level the playing field, and provide equal treatment to those enrolled in ERISA regulated plans as well as to those enrolled in state-regulated insurance plans. In order for beneficiaries to receive adequate benefits under their health plans, two needs must be met: first, beneficiaries need sufficient information regarding the financial incentives impacting physicians' decision-making so that the beneficiary can make informed choices as to when to follow a physician's advice or seek additional care; second, beneficiaries need

quick, effective mechanisms for challenging health plan benefit determinations and utilization decisions.

Under the current state of affairs, there appears to be little to compel health plans to give beneficiaries information regarding financial incentives or contractual requirements placed upon health care providers, particularly physicians, to make referrals, to refer to only particular providers, or to limit diagnostic procedures or treatments rendered.⁴⁵ Patients typically accept physicians' advice without knowledge of any such contractual restrictions or financial incentives. A few legislative enactments have tried to address this issue, but they have failed to provide for adequate disclosure.⁴⁶ The federal government has recently begun to require managed care plans which cover Medicare and Medicaid enrollees to give information regarding such plan incentives to enrollees upon request, but there are no similar provisions protecting non-governmental enrollees.⁴⁷ Since many managed care plans specifically prohibit plans from providing information to patients, a number of states have passed anti-gag laws which prohibit contractual restrictions on a physician's ability to communicate with his or her patients.⁴⁸ These provisions prohibit a managed care plan from restricting provider-communications, and in the case of governmental enrollees, compel disclosure upon request; however, neither compels full or complete disclosure to patients. This oversight remains problematic and should be corrected by legislative enactments that mandate full disclosure of a plan's contractual commitments.

V. Conclusion

A major Supreme Court decision in 1992 brought to the fore the glaring absence of responsive state and federal regulations in employee benefit plans governed by ERISA.⁴⁹ The court rejected the appeal of a patient

infected with the HIV virus whose employer had replaced its ERISA benefit plan that provided a maximum coverage of \$1 million with one that capped its benefits at \$5000.⁵⁰ This is remarkable because at least 70% of employers that offer employment-based health insurance benefits has the ability to change benefit levels under ERISA, and remain unaccountable to state and federal regulatory agencies.⁵¹ This built-in flexibility allows employers to restrict access to health care, terminate health care coverage when plan beneficiaries need it most, and discriminate against employees on the basis of medical condition.

The consequences of the McGann decision, and others like it, specifically in light of ERISA's provisions, are contrary to its presumed public policy goals of providing adequate healthcare coverage for every plan beneficiary, preventing discrimination against employees with chronic diseases, and ensuring that beneficiaries are not subject to termination of their benefits when they make health care related claims.⁵² This deficiency should be corrected by amendments to ERISA that allow state governments to craft adequate statutory provisions that address the unique needs of both employers and employees in the various states.

The goals of ERISA, as a matter of public policy, are noble. The need to safeguard pension and health plans remains cogent; however, the means by which ERISA proposes to achieve its stated objectives have been less than salutary to the welfare of covered employees. Unquestionably, the preemptive powers of ERISA have marginalized and detracted from what is otherwise a valuable public policy. ERISA's preemption clause continues to be the source of outlandish decisions that deny plan beneficiaries their right to meaningful compensations when plan administrators inflict harm. The clause is also

responsible for the absence of state regulations that should provide protection to plan members when ERISA fails to properly protect their welfare. This imperfection notwithstanding, ERISA continues to be serviceable; if only the preemption clause is amended to allow for concurrent jurisdiction.

Notes And References

¹ See *Corcorans v. United Healthcare*, 988 F.2d 97 (10th Cir. 1993).

² See *Kuhls v. Lincoln National Plan*, 498 U.S. 133 (1995).

³ In 1974, Congress enacted the Employee Retirement Income Security Act, 29 U.S.C.A § 1001 et seq.

⁴ See Mitchell, O.S., and Angrew; "Scale Economies in Private Multiemployer Pension Systems" *Industrial and Labor Relations Review* 4(July, 1981): 522-530.

⁵ *Ibid.*

⁶ See legislative history of, 29 U.S.C.A § 1001 et seq.

⁷ See *Jass v. Prudential Health Care Plan, Inc.* 88 F.3d 1482 (7th Cir. 1996)

⁸ See Brief of the U.S. Secretary of Labor as Amicus Curiae in *Dukes v. United States Health Care System of PA.*, 848 F. Supp. 39 (E.D. Pa. 1994)

⁹ See Robert J. Brandon, Tracy Stelzer, and John M. Benson, "Bridging the gap experts and public views on health care reform," *Journal of American Medical Association* 269(19), May 19 1993. 2573-2578.

¹⁰ ERISA only governs employee benefit plans established and maintained by employers to provide benefits to their employees. It does not reach health insurance purchased by individuals as individuals or health benefits not provided through employment-related plans, such as uninsured motorist insurance policies or workers' compensation. Certain church and government-sponsored plans are

also not covered. Furthermore, ERISA does not regulate group insurance offered by insurers to the employees of a particular establishment without employer contributions or administrative involvement. See *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F2d 1208 (5th Cir. 1980).

¹¹ See Karen Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs* 18(3), May/June 1999.

¹² *Ibid.*

¹³ See Jennifer A. Campbell, "Health Insurance Coverage: 1998", *Current Population Reports P. 60-208*, U.S Census Bureau, 1999.

¹⁴ See William B. Swartz, "The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief," *Journal of the American Medical Association* 257(2), January 9, 1998, 220-224.

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ See Jennifer A. Campbell, "Health Insurance Coverage: 1998", *Current Population Reports P. 60-208*, U.S Census Bureau, 1999.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ *Ibid.*

²¹ *New York Conference of Blue Cross and Blue Shield plans v. Travelers, Ins. Co.*, 514 U.S. 645 (1995).

²² ERISA preempts claims in which a beneficiary seeks to recover damages for improper benefit determinations. In *Pilot Life v. Dedeaux*, the US Supreme Court reviewed a case in which a beneficiary sought damages under state tort and contract law from an insurance company that determined eligibility for an employer's long-term disability plan and limited the plaintiff to his ERISA remedies. This reasoning has been applied by the Supreme

Court in the health care context in *Spain v. Aetna Life Insurance Co.* where the Court found that the health plan's determination that a bone marrow transplantation was not a covered benefit for the plaintiff's condition and was preempted by ERISA.

²³ See *Nealy v. U.S. Healthcare HMO*, 844 F. Supp.966 (S.D.N.Y. 1994)

²⁴ See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

²⁵ *Ibid.*

²⁶ See *Jass v. Prudential Health Care Plan, Inc.* 88 F.3d 1482 (7th Cir. 1996)

²⁷ See legislative history of , 29 U.S.C.A § 1001 et seq

²⁸ *Ibid.*

²⁹ On the grounds of section 502(a), courts have allowed ERISA plans to remove into federal court claims that were originally brought in state courts but could have been filed under section 502(a) in a federal court. Such removal is permitted under the "complete preemption" exception to the well-pleaded complaint rule. The well-pleaded complaint rule essentially allows removal only when the case implicates a federal law. However, under the complete preemption exception to this rule, federal jurisdiction is permitted when Congress has comprehensively preempted an area of law that any claim within it is brought under federal law, hence it's removal to federal court. See *FMC v. Holliday*, 498 U.S. 52, 58 (1990).

³⁰ Sections 502(a) and 514(a) of ERISA preemption are not coextensive. That a law suit involves a law that might be preempted as relating to an employee benefits claim does not mean that the claim could be brought under section 502(a), and thus subject to complete preemption. Frequently, federal courts remand suits that could not have been brought under section 502(a) claims to state courts for resolution of section 514(a) preemption issues.

See *Pilot Life v. Dedeaux*, 481 U.S. 41, 47 (1987).

³¹ The deemer clause offers a remarkable incentive for businesses to self-insure. Self-insurance, however, also comes with its own set of disadvantages: the added burden of administering the plan, and open-ended liability. But these issues, as previously explained, are usually transferred to third parties. The courts, nonetheless, have consistently held that employer plans remain self-insured, even though they are reinsured through stop-loss plans, and prohibit state regulations of stop-loss coverage for self-insured plans. See *Lincoln Mutual Casualty v. Lectron products, Inc.* 970 F.2d 206 (6th Cir. 1992).

³² The tax policy of the federal government is another contributor to the high cost of health care in recent decades. Tax deductibles and exclusions for medical expenses and health insurance premiums encourage the purchase of health insurance, particularly that including coverage of routine care, thus promoting growth in third-party payments. Contributions from employers to employee health insurance are nontaxable. Moreover, individuals may deduct all medical expenses over 7.5% of income. In this manner, employees are encouraged to take additional income in the form of insurance benefits and to use deductible medical service.

³³ See Sec. 514(a) , 29 U.S.C.A § 1001 et seq

³⁴ See *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 363 (1999)

³⁵ *Ibid.*

³⁶ See *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1997)

³⁷ Some plans provide that primary care physicians lose compensation each specific time referral is made to a specialist. Other plans set-up risk-pools from which specialists are paid, and if there are funds remaining after a certain period of time, the physicians who were responsible for keeping the referral rates down receive part of the funds. Some other plans provide other types of direct or indirect financial incentives.

³⁸ See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

³⁹ See *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995).

⁴⁰ See *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

⁴¹ See Robert J. Brandon, Tracy Stelzer, and John M. Benson, "Bridging the gap experts and public views on health care reform," *Journal of American Medical Association* 269(19), May 19 1993. 2573-2578.

⁴² The relevant factors in determining health care coverage are health care needs and sound actuarial assessment of costs. Individual employers should not be afforded the freedom to make value judgments, unsupported by data, about which diseases or illnesses should be covered, excluded from, or subjected to differential limitations in health care plans. Moreover, allowing employers to eliminate coverage for certain diseases or forms of treatment is also undesirable because it increases the number of persons who either will be left without access or whose health care costs will be born by the already overburdened publicly supported programs, such as Medicaid and Medicare, state or locally operated hospital facilities.

⁴³ See US Government Accounting Office Report, B-276104, July 16, 1998. Employer-based managed care plans: ERISA's effect on remedies for benefit denials and medical malpractice.

⁴⁴ In *Fox v. Health Net*, 147 F3d 1039 (9th Cir. 1998) a beneficiary of an insured plan was refuse an autologous bone marrow transplant for breast cancer. The delay in receiving the treatment, due to the plan's denial, was found to be a contributing factor to the patient's death and the plaintiffs were awarded \$89 million. In contrast, the Court of Appeals for the Tenth Circuit held in *Cannon v. Group Health* that ERISA preempted a claim for damages for the death of plaintiff's wife after the health plan postponed authorization of autologous bone marrow transplant. The Court held that the plaintiff's only remedy was to sue for cost of benefits but since such benefits were never actually received, the plaintiff had no remedy.

⁴⁵ A typical contractual provision of a managed care plan requires that all referrals made by the physician of a patient covered by the plan to another physician be made only to other physicians under contract with the health plan. This requirement is to be followed regardless of the referring physician's medical judgment as to where a referral must be made.

⁴⁶ See US Government Accounting Office Report, B-276104, July 16, 1998. Employer-based managed care plans: ERISA's effect on remedies for benefit denials and medical malpractice.

⁴⁷ Medicaid covers three primary groups: the blind and disabled, the elderly, and poor women and children. The amount spent amongst them is about equal. Medicaid payment for medical cost increased from \$55 billion in 1987 to \$91 billion in 1992, a 63% increase. The growth in spending for poor

women and children was more remarkable; spending rose by 12.1% per year in the same period. Spending also grew rapidly for the blind (7.6 per year), and for the elderly (9.7 per year). Originally, Medicaid coverage for the poor was limited to recipients of AFDC. The intent was to limit the program to single women with children and income of about half the poverty line or less. From 1987 Medicaid eligibility was expanded to cover more than AFDC recipients. By 1992, all pregnant women, and children below age six in families with income below 133% of poverty were eligible for Medicaid, and so were all children with income level below 100% of the poverty line, and born after September 30, 1983. See Paper by Mark Duggan, "Hospital ownership and public medical spending" *The quarterly Journal of Economics*, 2000.

⁴⁸ On October 7, 1999, The US House of Representatives voted 275 to 151, with 206 democratic votes, to support an amendment to ERISA, Title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986, to protect consumers in managed care plans. See [999-2000] 2 Cong. Index (CCH) 37, 126 Oct. 7, 1999.

⁴⁹ John McGann was employed by the H&H Music Company when he learned in 1987 that he was infected with the HIV virus. After McGann began to make health insurance claims seeking reimbursement for medical expenditure, the employer eliminated the existing benefit plan. This plan had provided maximum coverage of \$1 million for all diseases. The new plan adopted by H&H Music Company still allowed coverage up to \$1 million for all other diseases except AIDS, which was capped at \$5000. In 1989 McGann brought suit alleging that his rights under section 510 of ERISA had been violated. Section 510 of ERISA protects against discrimination in plan coverage, and states in relevant part, "It

shall be unlawful for any person to discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan." ERISA further prohibits employers from discharging employees to avoid economic effects of making substantial payments from their benefit plans. McGann's pleadings alleged that the decision to terminate the existing group health plan was a response to his claims for reimbursement, and that the current cap of \$5000 was put in place to deprive him of his rightful benefits. The Court of Appeals held that H&H Music Company did not violate section 510 of ERISA, and concluded that when an employer's group insurance plan clearly states that the plan may be amended or terminated, the employer is free to do so even though such action may adversely affect employees' benefits. McGann v. H&H Music Company, 946 F2d 401 (5th Cir. 1991).

⁵⁰ Ibid.

⁵¹ See Wing, Kenneth, R; *The Law and the Public's Health*, Chicago: Health Administration Press, 1999

⁵² See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).



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