Small Employers and Group Health Insurance: Should ERISA Apply?

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I. INTRODUCTION

Employers usually find it necessary to offer health insurance benefits to their employees in order to attract and retain those employees. For a small employer, often the only practical means of meeting this need is to purchase a group health insurance policy from an insurance company (as opposed to establishing a self-funded plan). Problems arise, however, when an employee sues the insurer for denial of benefits. If the employee sues in state court under any of the myriad possible state causes of action, the insurer will most likely allege preemption of all state claims under the Employee Retirement Income Security Act of 1974 ("ERISA") and remove the case to federal court. The claimant thus faces the inconvenience of removal from his or her chosen forum as well as the possibility that ERISA will preempt his or her state law claims.

Once in federal court, the court determines whether removal was proper by answering "the preliminary question: Does an ERISA welfare benefit plan exist?" An ERISA plan exists if the employer has "established or maintained" the plan within the meaning of ERISA's def-
inition of "employee welfare benefit plan." Thus far, courts have failed to formulate a satisfactory interpretation of that definition. The confusion among courts has resulted in uncertainty in the law of health insurance and increased litigation on the issue of what constitutes an ERISA plan. Recently, for instance, a federal district court, noting "the increased removal of actions to this court on the 'bare-bones' contention that federal question jurisdiction exists as a result of ERISA preemption," issued a fourteen-page "standard order... set[ting] forth the current state of the law as to (1) the requirements for the establishment of an ERISA welfare benefit plan; and (2) the broad preemptive scope of ERISA and this court's resultant jurisdiction." Undoubtedly, many small employers, thinking they had merely purchased an insurance policy for themselves and their employees, do not even become aware of ERISA until litigation arises.


(1) The terms "employee welfare benefit plan" and "welfare plan" mean 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....

6. See, e.g., Brady v. Empire Blue Cross/Blue Shield, 732 F. Supp. 678 (W.D. La.), rev'd without opinion, 915 F.2d 692 (5th Cir. 1990), in which a federal district court judge resorted to a footnote to explain that while recent cases suggest that most policies are covered by ERISA, the courts have not yet gone so far as to declare that all insurance policies are, by definition, a plan for ERISA purposes. Since the policy in the present instance has few of the features required for ERISA coverage, if we were to call this a plan, we would, in effect, be doing what courts have so far been loath to do in declaring that all policies, regardless of their purchase, administration and other features, are under ERISA's control. In short, if we were to call this an ERISA plan, we would be unable to declare any policy anything other than an ERISA plan, making state insurance law extraneous.

Id. at 680 n.1. After holding that an ERISA plan did not exist in the case before him, the judge noted (in another footnote) the unusual difficulty of the decision and continued as follows:

This court, however, is not playing poker and cannot pass. We must make a decision and, after consulting the most recent jurisprudence, we are satisfied that there are better reasons for holding this an insurance policy only, rather than calling this an ERISA plan.

Id. at 681 n.2. The Fifth Circuit Court of Appeals subsequently reversed the case without opinion.


8. Id.

Because of ERISA's "powerful pre-emptive force," the issue of whether a particular insurance policy is an ERISA plan is of crucial importance to claimants. State laws may provide common law or statutory remedies for recovery of damages caused by an insurer's wrongful denial of benefits. These remedies usually derive from state tort or contract law and often provide for compensatory damages, punitive damages or penalties, and attorney's fees. The need for such remedies to control insurer misconduct is particularly acute since an insurance company's "fiduciary role lies in perpetual conflict with its profit-making role as a business." Yet, despite the insurer's inherent conflict of interest, ERISA will preempt all state law remedies for improper claims processing if the insurance policy is characterized as an "employee welfare benefit plan" under ERISA. And although the plaintiff may amend his or her complaint to state a cause of action under ERISA, ERISA provides a plan participant or beneficiary with essentially only one cause of action: an action to recover benefits due under the terms.

11. See, e.g., id. at 43-44, 107 S. Ct. at 1551 (plaintiff sought compensatory and punitive damages for claims of tortious breach of contract, breach of fiduciary duties, and fraud under Mississippi common law of bad faith); Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990) (statute providing treble damages and attorney's fees for unfair and deceptive trade practices under Texas Insurance Code was codification of common law doctrine of negligent misrepresentation); Weiner v. Blue Cross of Md., 730 F. Supp. 674 (D. Md. 1990) (plaintiff awarded a total of $700,000 in compensatory damages, $6.5 million in punitive damages, and $1.4 million in attorneys' fees for claims of fraud, negligence, and intentional infliction of emotional distress against insurance company); Cramer v. Association Life Ins. Co., 569 So. 2d 533 (La. 1990) (Louisiana statute providing double damages and attorney's fees for failure to timely pay claim).
12. Brown v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556, 1561 (11th Cir. 1990). For an example of egregious insurer misconduct, see Cataldi v. Louisiana Health Serv. and Indemn. Co., 456 So. 2d 1373 (La. 1984), where, after the plaintiff's three-year-old daughter was diagnosed as having brain cancer, the insurer increased the premium over 250% and the deductible 5,000% while decreasing major medical coverage by 92%.
of the plan plus discretionary attorney’s fees and costs. As pointed out by Justice Doggett of the Texas Supreme Court:

[T]he workers ERISA was intended to protect lack a remedy for wrongs unaddressed by the statute, while the companies targeted by Congress employ ERISA as an effective shield against responsibility for wrongful processing of claims. . . . Under ERISA, insurers who provide group benefit plans have little incentive to deal promptly and fairly with employee participants.

These results are at odds with the two principal goals Congress sought to achieve by enacting ERISA. Congress enacted ERISA to protect workers’ benefits from administrator abuse, and to encourage employers to establish employee benefit plans. The problem with applying ERISA to small-employer plans is that ERISA provides less protection of workers’ insurance benefits than state tort, contract, and insurance law remedies would provide, while at the same time ERISA offers small employers little incentive to establish employee benefit plans. Since ERISA neither protects the benefits of employees of small employers, nor encourages small employers to establish benefit plans, it is unlikely that Congress intended ERISA to apply in such cases. Thus, until Congress amends ERISA to exclude small-employer plans expressly, courts should consider the impact of ERISA on small-employer plans as well as the goals of ERISA as a whole in construing ERISA’s definition of “employee welfare benefit plan.”

This comment concludes that where small employers purchase employee group health insurance through commercial insurers, coverage under ERISA fails to promote either of the Act’s dual goals of protecting workers’ benefits and encouraging employers to form employee benefit plans. Part II of this comment describes these goals and provides an overview of the pertinent features of the Act, including its provisions

15. 29 U.S.C. § 1132(a) and (g) (1988). See infra text accompanying notes 71-77.
17. ERISA provides:
It is hereby declared to be the policy of this chapter 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.
18. See supra notes 10-16 and accompanying text and infra text accompanying notes 152-66.
19. See infra text accompanying notes 174-76.
COMMENTS

regarding preemption and civil enforcement. Next, through an examination of cases in which the existence of ERISA plans was at issue, Part III traces the development of judicial interpretations of ERISA as applied to small-employer plans. Part IV analyzes the application of ERISA to small-employer plans in light of the goals Congress sought to achieve by regulating employee benefit plans and in light of the impact of ERISA's preemption and civil enforcement provisions on small employers and their employees. Finally, the comment recommends in Part V that courts interpret ERISA's definition of "employee welfare benefit plan" in a manner consistent with the Act as a whole; thereby excluding small-employer plans from ERISA coverage, or alternatively that Congress amend ERISA to exclude small-employer plans expressly.

Although this comment is not intended to question the effectiveness of ERISA as applied to self-insured employee welfare benefit plans, the comment relies heavily on the distinction between "insured" and "self-insured" plans. An "insured" plan is one which is funded by the purchase of insurance from a commercial insurer. The employer simply applies to the insurance company for a group insurance policy to offer to its employees. Often a minimum percentage of the total number of employees must enroll, and the employer must pay a percentage of the premiums. The employer collects the balance of the premiums through payroll deductions and forwards the total to the insurance company. The employer may distribute enrollment forms, claim forms, and policy certificates to its employees, and may update the enrollment status of employees, but the insurance company processes all claims and administers the insurance fund.

In contrast, a "self-insured" or "uninsured" employee welfare benefit plan is funded exclusively or partially by the employer's and employees' combined contributions. The employer may administer the fund and process claims, or it may contract with an insurance company or a professional plan administrator to provide these services. A plan is partially funded when it purchases "stop-loss" insurance to protect its assets in the event of catastrophic claims. Although courts have disagreed over whether to treat partially funded plans as "insured" or "self-insured" for purposes of ERISA preemption, these plans will be con-

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22. E.g., self-insured plans which purchased stop-loss insurance were treated as self-insured plans for purposes of ERISA preemption in Brown v. Granatelli, 897 F.2d 1351 (5th Cir. 1990) and Moore v. Provident Life & Acc. Ins. Co., 786 F.2d 922 (9th Cir. 1986). But see Michigan United Food & Commercial Workers Union v. Baerwaldt, 767 F.2d 308 (6th Cir. 1985), cert. denied, 474 U.S. 1059, 106 S. Ct. 801 (1986), where the court treated a self-insured plan with stop-loss coverage as an insured plan. See also, Engel, supra note 21, at 443-46 (discussing partially insured plans).
considered "self-insured" for purposes of this comment since at least part of the insurance fund is controlled directly or indirectly by the employer.

Because a self-insured plan, by definition, must be "established or maintained" by an employer, such a plan is probably always an ERISA plan. But creating a self-insured plan requires a significant number of employees and considerable financial and administrative resources, all of which a small employer could be expected to lack. Consequently, most small employers are unable to establish self-insured plans; instead, they must purchase insurance in order to provide benefits for their employees. Furthermore, while there is little doubt that ERISA's comprehensive regulation of self-insured plans has substantially achieved the goals Congress intended, the differences are great between self-insured and insured plans. It follows that effective regulation of self-insured plans does not preclude the possibility that ERISA fails when applied to insured plans, at least when those plans are purchased by small employers.

II. PURPOSE AND PROVISIONS OF ERISA

Congress enacted ERISA in 1974 in response to public outcry for reform of laws regulating employee benefit plans. ERISA regulates two types of employee benefit plans: pension plans and employee welfare benefit plans. Although this comment is concerned only with ERISA as applied to certain employee group health insurance plans, an understanding of the problems ERISA was designed to address is necessary to appreciate that small employers and their employees are not faced with the same problems and that, consequently, application of ERISA to small-employer plans is not justified and actually defeats Congress's goals of protecting small employers and their employees.

23. See Mary Anne Bobinski, Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured, 24 U.C. Davis L. Rev. 255, 295-96 (1990). According to Bobinski:

Larger firms are better able to self-insure for several reasons. First, a relatively large number of employees is necessary to spread the risk of a large payout. Second, economies of scale in plan development and implementation are only reached with relatively large numbers of employees. Finally, companies that self-insure must be prepared to face possibly complicated benefits administration and larger fluctuations in cash flow.


A. Purpose of ERISA

Before 1974 workers were often subject to severe pension plan vesting provisions as well as the possibility of premature plan termination resulting in loss of accrued benefits.26 The closing of the Studebaker Automobile Company in 1963, for instance, left 4,400 workers without pensions or with reduced pensions even though the pension plan had been well funded and the workers' pension rights were vested.27 Plan funds were also subject to misuse by plan administrators as revealed by House and Senate committee investigations in the 1950's and 1960's.28 Further, employers with employees in more than one state encountered multiple and conflicting state regulations which presented obstacles to efficient administration of benefit plans.29 In short, the need to protect workers from pension plan abuses and to protect employers from multiple and conflicting state regulations prompted Congress to enact ERISA.

ERISA addressed the need to protect workers by establishing fair vesting standards30 and strict funding requirements.31 To protect against loss of vested benefits in the event of plan termination, the Act established a termination insurance program.32 The Act also established stringent reporting and disclosure guidelines,33 imposed fiduciary obligations on plan administrators,34 and, in order to enforce compliance, created causes of action on behalf of plan participants and the Secretary of Labor.35

ERISA addressed the need to protect employers from multiple and conflicting state regulations by preempting all state laws which "relate to" employee benefit plans.36 By assuring uniform regulation of employee benefit plans, the Act's broad preemption provision was designed to

27. Gordon, supra note 25, at 8. See also, Jennings, supra note 25, at 4-5.
28. Gordon, supra note 25, at 6-10. See also Jennings, supra note 25, at 5-6.
29. See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9, 107 S. Ct. 2211, 2216 (1987), where the court described the problem of inconsistent and conflicting state regulations as follows:
   A plan would be required to keep certain records in some states but not in others; to make certain benefits available in some states but not in others; to process claims in a certain way in some states but not in others; and to comply with certain fiduciary standards in some states but not in others.
31. Id. §§ 1081-86.
32. Id. §§ 1301-1405.
33. Id. §§ 1021-31.
34. Id. §§ 1101-14.
35. Id. §§ 1131-41.
36. Id. § 1144(a).
facilitate the administration of plans covering employees in more than one state in order to encourage employers to establish employee benefit plans and to enable them to maintain benefit levels.\(^3\)

Thus, ERISA's vesting standards, funding requirements, termination insurance, reporting and disclosure guidelines, and fiduciary obligations are aimed primarily at self-insured pension and welfare benefit plans\(^3\) and have limited utility as applied to employee group health insurance policies purchased from commercial insurers. Moreover, because small employers typically do business in only one state, they have little need to be protected from multiple and conflicting state regulations.

**B. Preemption**

The issue of ERISA preemption arises only after a court concludes that an employee welfare benefit plan exists within the meaning of ERISA.\(^3\) Where an employer has not established or maintained such a plan, state law governs.

A comprehensive analysis of ERISA preemption is beyond the scope of this comment. On the other hand, ERISA preemption may directly affect the rights and remedies of claimants who sue for recovery of benefits under insurance policies purchased by their employers. Accordingly, this discussion will be limited to an analysis of the effects of ERISA preemption on employees' claims for benefits under group health insurance policies purchased by small employers.

ERISA's *preemption clause* states that "the provisions of ERISA shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."\(^4\) However, the preemption clause is modified by a *savings clause* which provides that

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38. See 29 U.S.C. § 1001 (1988), Congressional Findings and Declaration of Policy, which states:

The Congress finds . . . that despite the enormous growth in [employee benefit] plans many employees with long years of employment are losing anticipated *retirement* benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate *funds* to pay promised benefits may be endangered; that owing to the termination of plans before requisite *funds* have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits . . .

Id. § 1001(a) (emphasis added).


40. 29 U.S.C. § 1144(a) (1988). See Shaw v. Delta Air Lines, 463 U.S. 85, 96-98, 103 S. Ct. 2980, 2899-2901 ("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," id. at 96-97, 103 S. Ct. at 2900, and ERISA's "pre-emptive scope [is] as broad as its language," id. at 98, 103 S. Ct. at 2901).
"nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance ...." ERISA's preemption scheme is further complicated by the deemer clause, which provides:

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

To summarize, if a state law "relates to" an employee benefit plan, it is preempted. But if the law "regulates insurance," it is saved from preemption by the savings clause. Finally, under the deemer clause, even a state law which "regulates insurance" is preempted if it attempts to regulate an employee benefit plan. In short, the only state laws which are not preempted are those which regulate insurance and which are applied solely to insurance companies or insurance contracts as opposed to employee benefit plans.

The extent of ERISA preemption in any particular case depends on the distinction between self-insured and insured plans. Since self-insured plans are funded by employers rather than insurance companies, state laws which regulate insurance are preempted and do not regulate self-insured plans. In contrast, the same state laws regulate insured plans because those laws are saved from preemption by the savings clause when applied to insurance companies.

The Supreme Court in Metropolitan Life Insurance Co. v. Massachusetts made it clear that the distinction between insured and self-insured employee welfare benefit plans is critical in determining whether state laws will be preempted. In that case, a Massachusetts statute required health insurance policies to provide certain minimum mental health care benefits. In holding that the law was not preempted when applied to group health insurance policies issued by insurers of ERISA plans, the Court stated:

We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.
The Court also noted that its interpretation of ERISA’s preemption provisions was consistent with the McCarran-Ferguson Act, which provides that “[t]he 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.”

It seems clear that while Congress has refused to permit states to “deem” self-insured ERISA plans to be insurance companies for purposes of state laws regulating insurance, it has at the same time acknowledged the desirability of state regulation of insurance contracts and insurance companies. Accordingly, it might also seem that ERISA preemption would have little or no effect on employees’ claims for benefits under group health insurance policies purchased by their employers. However, at least two types of state laws remain preempted by ERISA whether those laws are applied to self-insured or insured plans. State laws which are preempted when applied to insured plans include those which do not “regulate insurance” within the meaning of the savings clause, and those which provide state remedies for improper processing of claims for benefits.

In determining whether a state law regulates insurance within the meaning of the savings clause, courts have sought guidance from federal jurisprudence interpreting the phrase “business of insurance” as used in the McCarran-Ferguson Act. According to that jurisprudence, a law regulates the “business of insurance” if it (1) has the effect of transferring or spreading a policyholder’s risk, (2) regulates an integral part of the policy relationship between the insurer and the insured, and (3) is limited to regulation of entities within the insurance industry. In *Metropolitan*, the Massachusetts mandated-benefit law met all three criteria because it effected the sharing of the risk of mental health care, limited the type of insurance an insurer could sell to policyholders, and imposed requirements only on insurers. Hence, the law regulated the “business of insurance” and therefore was saved from preemption.

46. See FMC Corp. v. Holliday, 111 S. Ct. 403 (1990), where the Court stated:
   By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress’ presumed desire to reserve to the States the regulation of the “business of insurance.”
   Id. at 410.
49. Id. at 743, 105 S. Ct. at 2391.
50. Id., 105 S. Ct. at 2391.
In *Pilot Life Insurance Co. v. Dedeaux,* the Supreme Court applied the same factors to a claim of bad faith under Mississippi common law for an insurer’s failure to pay insurance benefits. The common law of bad faith did not affect the transferring or spreading of a policyholder’s risk, did not define the relationship between the insurer and the insured, and developed from general principles of tort and contract law available in any Mississippi breach of contract case. Since the law met none of the McCarran-Ferguson criteria, it did not regulate the “business of insurance” and therefore was preempted. A common-sense view of the word “regulates,” said the Court, “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.”

Perhaps more significantly, the *Pilot Life* Court held that in actions by ERISA-plan participants and beneficiaries asserting improper processing of claims for benefits, ERISA’s civil enforcement remedies are exclusive. “[T]he federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.” In other words, even if a state law regulates insurance, ERISA preempts the law anyway if it provides a cause of action and remedy for improper processing of claims.

In *Cramer v. Association Life Insurance Co.*, the Louisiana Supreme Court interpreted *Metropolitan and Pilot Life* to create a distinction between state laws which regulate the substantive terms of insurance contracts, and laws which merely regulate aspects of transacting the business of group insurance. Since ERISA does not regulate the substantive content of welfare benefit plans, the court reasoned, state laws which regulate the substantive terms of insurance contracts are not preempted. Such laws include, in addition to mandated-benefit laws...

52. Id. at 50-51, 107 S. Ct. at 1554-55.
53. Id. at 51, 107 S. Ct. at 1555.
54. Id. at 50, 107 S. Ct. at 1554.
55. Id. at 52, 107 S. Ct. at 1555.
56. Id. at 54, 107 S. Ct. at 1556.
57. Id., 107 S. Ct. at 1556. See also Gonzales v. Prudential Ins. Co. of Am., 901 F.2d 446, 452 n.21 (5th Cir. 1990):

Under such an interpretation, the role of the savings clause would be limited to sparing from preemption substantive insurance laws that could be enforced through some vehicle other than a private cause of action, such as an administrative or judicial enforcement action for declaratory or injunctive relief brought by the state’s insurance regulatory authority.
59. Id. at 541.
60. Id.
like the one in Metropolitan, those which regulate grace periods, conversion privileges, and cancellation of benefits.61 On the other hand, ERISA's comprehensive civil enforcement scheme regulates the practice of claims handling, so laws which regulate aspects of transacting the business of insurance are preempted.62 Such laws include those which provide tort or contract remedies for bad faith or breach of contract, like the one in Pilot Life, as well as those which provide remedies for unfair insurance practices, unfair trade practices, and negligent misrepresentation.63

The Cramer analysis reveals two idiosyncracies of ERISA preemption. First, the fact that ERISA does not regulate the substantive content of welfare benefit plans fails to explain why states are permitted to regulate the content of insured plans but are not permitted, because of the deemer clause, to regulate the content of self-insured plans. The Metropolitan Court simply concluded that "[s]uch disuniformities .... are the inevitable result of the congressional decision to 'save' local insurance regulation."64 But the distinction serves to reinforce the notion that the two types of plans are quite different and therefore require different treatment.

Second, in view of the recognition of the need for different treatment of insured and self-insured plans, it seems inconsistent to require both types of plans to be treated the same with regard to laws which regulate aspects of transacting the business of insurance. Concededly, as the Pilot Life Court pointed out, ERISA's comprehensive civil enforcement scheme "represents a careful balancing of the need for prompt and fair claims settlement procedures against public interest in encouraging the formation of employee benefit plans."65 As will be recalled, however, ERISA's goal of encouraging the formation of employee benefit plans was to be achieved through uniform regulation of such plans.66 But while uniformity facilitates the administration of large self-insured plans, it has limited utility for insured intrastate plans, especially since those plans are nonetheless subject to state regulation of insurance contracts.67 Moreover, since small employers lack this counterbalancing need for uniformity, wholesale preemption of state causes of action and remedies for

62. Cramer, 569 So. 2d at 541.
64. Metropolitan, 471 U.S. at 747, 105 S. Ct. at 2393.
66. See supra text accompanying note 37.
67. See supra text accompanying notes 58-61.
improper processing of claims needlessly frustrates ERISA's goal of protecting employees from abuses by plan administrators.

It should be pointed out that the Comprehensive Omnibus Budget Reconciliation Act of 1985 ("COBRA") amended ERISA by requiring employers who participate in group health plans to continue to provide health coverage to employees who leave work under certain statutorily prescribed circumstances. COBRA thus represents the first attempt of ERISA to regulate the substantive terms of employee welfare benefit plans. Because ERISA's civil enforcement remedies are exclusive, it seems likely that COBRA will preempt conflicting state laws even though such laws regulate the substantive terms of insurance contracts and even when those laws are applied to insured plans.

However, COBRA includes an important provision which states that COBRA "shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year." In other words, employers with fewer than 20 employees are exempt from coverage under COBRA. Thus, COBRA preemption may be of no consequence to many small employers or their employees. But COBRA's small-employer exemption is strong evidence of Congress's awareness that uniform regulations serve little purpose with regard to small-employer plans.

In sum, employees asserting claims for benefits under insurance policies purchased by small employers find that neither ERISA nor COBRA preempt their claims for enforcement of state laws which regulate the substantive terms of group health insurance policies. However, employees' claims for remedies under state laws regulating aspects of transacting the business of insurance are preempted. As a result, ERISA's civil enforcement provisions contain the sole remedies for employees asserting causes of action for improper processing of claims for benefits.

C. Civil Enforcement

ERISA provides that a "participant or beneficiary" of an employee benefit plan may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . ." A participant or beneficiary may also bring actions

71. Id. § 1132(a)(1).
72. Id. § 1132(a)(1)(B).
to obtain a statement of benefits, to recover statutory penalties for failure of a plan administrator to comply with a request for a statement of benefits, and for injunctive or other equitable relief to enforce ERISA rights. In any of these actions, the court may also award attorney’s fees and costs.

Under ERISA, then, an employee who believes simply that he or she has been wrongfully denied benefits essentially has only one cause of action: an action to recover benefits due under the terms of the plan, with a chance of recovering attorney’s fees and costs. Despite the fact that an insurer’s wrongful refusal to pay medical expenses may itself be as financially debilitating as an illness, ERISA permits no remedy for the resulting damages.

Furthermore, litigation under ERISA is likely to be lengthy and expensive. ERISA authorizes state and federal courts to have concurrent jurisdiction over individual claims for benefits, which means that the plaintiff has the option to file the action in state court. The defendant, however, then has an absolute right to remove the claim to federal court, subject only to compliance with the general procedural requirements of the federal removal statute. This is true notwithstanding the well-pleaded complaint rule enunciated in Louisville & Nashville Railroad Co. v. Mottley, whereby a cause of action arises under federal law only when the plaintiff’s well-pleaded complaint raises issues of federal law. Under ERISA, even if the plaintiff’s complaint raises only state law causes of action, the defendant can assert an ERISA preemption

73. Id. § 1132(a)(4).
74. Id. § 1132(a)(1)(A).
75. Id. § 1132(a)(2).
76. Id. § 1132(g)(1).
77. See, e.g., Weiner v. Blue Cross of Md., 730 F. Supp. 674 (D. Md. 1990), where the plaintiff incurred medical expenses as a result of tragedies suffered by two of his sons. One son was diagnosed with AIDS and later died, and the other was rendered a quadriplegic in an automobile accident. Although the insurer eventually paid all contractual obligations under the policy, it had discontinued payments for eight months and had resumed payments only after the plaintiff filed suit to compel their continuation. The plaintiff then filed another suit in state court for state common law claims of fraud, negligence, and intentional infliction of emotional distress. Fortunately for the plaintiff, the defendant insurer failed to remove the case or to raise the defense of ERISA preemption, and a jury awarded a total of $700,000 in compensatory damages and $6.5 million in punitive damages, as well as $1.4 million in attorneys’ fees. In contrast, had the case been governed by ERISA, ERISA preemption would have left the plaintiff without a remedy.
81. 211 U.S. 149, 29 S. Ct. 42 (1908).
defense and thereby "convert[] the related claim into a federal question"82 for purposes of removal. The rationale for this exception to the well-pleaded complaint rule is that "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character."83

The plaintiff may challenge removal jurisdiction only after the defendant has removed the action to federal court.84 The defendant then has the burden of establishing the propriety of removal85 by showing that three requirements have been met: first, that the health insurance coverage is part of an ERISA plan;86 second, that plaintiff's cause of action falls within the "sweep" of the preemption clause and is not excepted from preemption by the savings clause;87 and third, that the cause of action states a claim for which Congress provided an "exclusive federal cause of action for resolution of such disputes."88 Under the law as it now stands, meeting the first requirement is fairly easy in most cases, as will be shown in Part III of this comment. Also, as shown in the above discussion of ERISA preemption, the second and third requirements are easily met in most cases because ERISA preempts all state actions providing remedies for improper processing of claims,89 and ERISA's civil enforcement provisions provide the sole cause of action for asserting a claim for benefits due under an ERISA plan.90 Once the defendant establishes that the plaintiff's state cause of action is preempted, the cause of action may be recharacterized to state a claim arising under ERISA.91

One may wonder why a plaintiff, by filing an action in state court, would risk the inconvenience of removal to federal court. Perhaps the question is whether such a plaintiff is even aware that he or she is suing for benefits under an ERISA plan rather than under a simple group health insurance policy. Such lack of notice is not improbable,

83. Taylor, 481 U.S. at 63-64, 107 S. Ct. at 1546.
85. Davis, 746 F. Supp. at 46.
86. Thomas, 769 F. Supp. at 369.
87. Davis, 746 F. Supp. at 47.
89. See supra text accompanying notes 62-63.
90. See supra text accompanying notes 55-57.
for although ERISA imposes certain disclosure, reporting, and filing requirements on plan administrators,92 these requirements are not prerequisites to coverage under ERISA and do not arise until it is determined that ERISA covers a plan.93 It is therefore not surprising that in one case,94 certain employees of a plan insurer, "though vested with substantial control over the administration of the [plan], had little to no knowledge of ERISA nor the rights afforded by the Act or requirements of a fiduciary . . ." and "testified that they did not understand the meaning of the word 'fiduciary.'"95

To summarize, ERISA's civil enforcement scheme provides a plan participant or beneficiary with a cause of action to recover benefits due under an employee benefit plan, and this cause of action is exclusive because ERISA preempts all state law causes of action for improper processing of claims. In addition, since the issue of whether an ERISA plan exists often does not arise until after the plaintiff has filed an action in state court, those claims are subject to almost certain removal to federal court.

As noted previously, Congress crafted ERISA's exclusive civil enforcement scheme in the interest of encouraging the formation of employee benefit plans through uniform regulation of such plans.96 Again, however, most small employers have little need for uniformity, and can, in some cases, be hurt by the exclusive enforcement scheme. Furthermore, the fact that such employers are often unaware they have established ERISA plans seriously undermines the notion that ERISA encourages the formation of such plans. Finally, whatever scant need for uniformity may exist in such cases is outweighed by the need of employees to have available the wide array of state causes of action that an individual purchaser of the exact same policy would have at his disposal.97

III. JURISPRUDENCE INTERPRETING ERISA

For reasons already suggested and to be discussed more fully in Part IV, this comment takes the position that ERISA should not apply

95. Id. at 383. See supra notes 6-9 and accompanying text.
96. See supra text accompanying notes 36-37 and 65-67.
to employee group health insurance policies purchased by small employers. This position finds support in *Taggart Corp. v. Life & Health Benefits Administration*,\(^9\) where the United States Court of Appeals for the Fifth Circuit stated: "Considering the history, structure and purposes of ERISA, we cannot believe that that Act regulates bare purchases of health insurance where . . . the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits."\(^99\)

*Taggart* involved a corporation which subscribed to Security Multiple Employers Trust ("SMET")\(^100\) in order to provide health insurance for the corporation's owner and sole employee, Stanley M. Kansas, and his family. SMET provided a service for employers too small to qualify for group rates on their own, such as the Taggart Corporation. Employers subscribed to SMET and became members of a "group" of subscribers. SMET then pooled the "group's" premiums and purchased group insurance on their behalf, thereby enabling the subscribers to qualify for group rates. When Kansas claimed benefits for his wife, SMET informed him that the insurer was denying coverage because of alleged misrepresentation in his insurance application. Kansas brought suit in federal court under ERISA, alleging that SMET was an ERISA plan.

The court quickly dismissed the claim on the grounds that SMET was established and operated by independent businessmen for personal profit and that neither the Taggart Corporation nor any other employer or employee organization participated in SMET's day-to-day operation or administration.\(^101\) Therefore, SMET was "neither established nor maintained by a 'statutory employer' or 'employee organization' . . ."\(^102\) within the meaning of ERISA's definition of "employee welfare benefit plan."\(^103\)

More importantly, the court rejected the Secretary of Labor's contention in its amicus brief that the Taggart Corporation had established an ERISA plan by merely subscribing to SMET. The court first noted that "ERISA's legislative history demonstrates that its drafters were principally concerned with abuses occurring in respect of private pension

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99. Id. at 1211.
101. *Taggart*, 617 F.2d at 1210.
102. Id.
assets." The court then distinguished the Taggart Corporation's group health insurance policy from other employee benefit plans:

The supposed Taggart "plan" has no assets and is liable for no benefits. There is nothing to be placed in trust, so there is no trust. The corporation did no more than make payments to a purveyor of insurance, patently for tax reasons. . . . There simply exist no assets for ERISA's statutory safeguards to protect. Nor do the statute's vesting and funding goals militate in favor of finding a "plan" here, since those provisions expressly except "welfare" plans from their coverage. . . . On the other hand, Congress has elsewhere clearly distinguished between "health plans" and "health insurance." I.R.C. §§ 105(a), 105(e) . . . . That Congress has thus chosen to treat the two separately reinforces our conclusion that ERISA "plans" are broader in concept than pure insurance transactions of the sort involved here.

The court nowhere limited its holding to cases involving an employer with a sole employee, although in effect later courts would do so. Nor, as would later courts, did the Taggart court strictly construe the statutory language which provides that an ERISA plan may be "established or maintained . . . through the purchase of insurance or otherwise . . . ." Rather, the court considered "the history, structure and purposes of ERISA . . . ." in order to discern the intent of the drafters. The court concluded that the drafters were primarily concerned with protecting plan assets. ERISA's purpose, therefore, was "[t]o forestall misappropriation and misuse of such funds . . . ."

Significantly, the Taggart court seemed to be striving toward a distinction between self-insured and insured employee group health plans. It recognized early that whereas Congress has good reason to regulate self-insured plans, that reason does not apply in the case of insured

105. Id. (citations omitted).
107. See, e.g., Memorial Hosp., 904 F.2d at 240 and 243 n.9; Donovan, 688 F.2d at 1371.
110. Id.
plans. An insured plan, suggests Taggart, should not be covered by ERISA because "[t]here simply exist no assets for ERISA's statutory safeguards to protect."\textsuperscript{111} Thus, the Taggart Corporation's "bare purchase[] of health insurance"\textsuperscript{112} did not qualify for coverage under ERISA.

In Donovan v. Dillingham,\textsuperscript{113} the Eleventh Circuit agreed with the holding and reasoning of the former Fifth Circuit\textsuperscript{114} in Taggart that SMET was not an employee welfare benefit plan. The court also agreed with the holding that the Taggart Corporation itself had not established an ERISA plan, quoting the Taggart district court's finding that ""the subscription agreement by Stanley M. Kansas . . . simply involv[ed] the purchase of insurance by plaintiff, Stanley M. Kansas, for himself and his family.""\textsuperscript{115} But the court found that the reasoning of the Taggart opinion encourages too broad an interpretation. . . . If Taggart implies that an employer or employee organization that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot be said to have established or maintained an employee welfare benefit plan, we disagree. To that extent Taggart shall no longer be binding in the Eleventh Circuit.\textsuperscript{116}

The issue in Donovan was whether subscribers to a multiple employer trust ("MET") had established employee welfare benefit plans, thereby giving rise to fiduciary duties on the part of the trustees of the MET. The trustees, relying on Taggart, argued that ERISA did not apply because the subscribers had merely purchased group health insurance. The court first construed ERISA's definition of "employee welfare benefit plan" to require (1) a plan, fund, or program (2) established or maintained (3) by an employer or employee organization or both (4) for the purpose of providing health care or other benefits (5) to participants or their beneficiaries.\textsuperscript{117} The court then enunciated a test for

\textsuperscript{111} Id.

\textsuperscript{112} Id.

\textsuperscript{113} 688 F.2d 1367 (11th Cir. 1982) (Godbold, C.J.) (en banc).

\textsuperscript{114} On October 1, 1981, the Fifth Circuit was divided to create the new Fifth and Eleventh Circuits. Since the Eleventh Circuit had adopted as precedent the decisions of the former Fifth Circuit handed down before October 1, 1981, see id. at 1370 n.3, Taggart was binding on the Eleventh Circuit until Donovan overruled Taggart in part. Id. at 1375; see infra text accompanying note 116.


\textsuperscript{116} Donovan, 688 F.2d at 1375.

\textsuperscript{117} Id. at 1371.
determining whether a "plan, fund, or program" had been "established or maintained" by an employer: "whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." Finally, the court applied the test to the MET subscribers and held that the employers or unions had established employee welfare benefit plans by furnishing health insurance to their employees or members.

Unlike the Taggart court, the Donovan court seemed to attach no significance to the distinction between insured and self-insured plans. Rather, it characterized the purchase of insurance as "only a method of implementing a plan, fund, or program and [as] evidence of the existence of a plan but . . . not itself a plan." Whereas the Taggart court stressed the fact that Congress clearly distinguished between "health plans" and "health insurance," the Donovan court, by means of strict statutory construction, blurred that distinction. In so doing, it disregarded "the history, structure and purposes of ERISA . . ." so carefully considered in Taggart.

A federal district court applied the Donovan reasoning in Davis v. Time Insurance Co. In that case, T.E. Cook Construction Company ("Cook") subscribed to a MET for the purpose of providing group insurance for its five employees and their dependents. When the wife of an employee was denied benefits by the insurer, she filed suit in state court alleging bad faith under Mississippi law. The defendant removed the action to federal district court and alleged preemption under ERISA.

After quickly concluding that Cook's subscription satisfied "all the statutory and precedential requirements for compliance under ERISA" as spelled out in Donovan, the court nevertheless took pains to distinguish Taggart. Predictably, it contrasted the Taggart Corporation's single employee with Cook's five employees. It also made much of the fact that the Taggart Corporation made payments to SMET, whereas Cook made payments directly to the insurance company. In addition, the court noted that in Taggart, SMET chose the insurance company, the policy, and the coverages, whereas in the case before it Cook himself made those decisions. Finally, the court pointed out that, unlike the Taggart Corporation, Cook executed an Employer Participation Agreement which

118. Id. at 1373.
119. Id. at 1375.
121. Id.
123. Id. at 1320.
“provided that the employees had an interest in the subject policy and that the employer assumed control and responsibility for administration [of] . . . the group policy and its benefits as they related to the employer unit.”

In its assertion that “the Fifth Circuit limited its holding in Taggart to those situations in which ‘the purchasing employer neither directly or [sic] indirectly owns, controls, administers or assumes responsibility for the policy or its benefits,’” the Davis court implied that the circumstances surrounding Cook’s subscription to the MET warranted a finding that Cook actually owned, controlled, administered, and assumed responsibility for the insurance policy and its benefits. If this is the Davis court’s interpretation of the quoted language, it is unpersuasive. In view of Taggart’s emphasis on ERISA’s goal of safeguarding plan assets, a more meaningful interpretation would require an employer to own all or part of the insurance funds and be an administrator, manager, or trustee of those funds; to make decisions concerning how the plan assets are invested and whether or not to grant claims; and to be subject to suit by employees whose claims are denied. In other words, a more persuasive interpretation of the Taggart language would require an ERISA plan to be self-insured.

A federal district court followed Taggart in Clark v. Golden Rule Insurance Co., a case factually on all fours with Davis. Clark Custom Guns, Inc. (“Clark”) purchased a group health insurance policy from the defendant insurer through a MET. Clark contributed fifty percent of the monthly premiums for the plaintiff and four other employees, forwarding the total premium directly to the insurer. Whereas the Davis court relied on identical facts to distinguish Cook’s activities from those of the Taggart Corporation, the Clark court held that Clark neither established nor maintained an employee welfare benefit plan. The court reasoned:

There simply is no substantive distinction between the level of participation by Taggart Corp. and that of Clark Custom Guns, Inc. Plaintiff, as the owner of the entity, merely purchased insurance that was sold to him by an independent agent. Claims were submitted to and processed through Golden Rule. The only assets contributed were premiums paid by plaintiff’s business.

124. Id. at 1321.
125. Id. at 1320.
127. 737 F. Supp. 376 (W.D. La.), aff’d on other grounds, 887 F.2d 1276 (5th Cir. 1989).
There is no evidentiary basis permitting this court to conclude that Clark Custom Guns, Inc. directly or indirectly owned, controlled, administered or assumed responsibility for the policy or its benefits. . . . Because the facts in this case are virtually indistinguishable from those in Taggart, the holding in Donovan . . . does not require a different result. 128

Clearly, the Davis and Clark courts had two very different ideas about what constitutes an ERISA plan. The Davis court adopted Donovan’s reasoning and found that Cook’s purchase of insurance for the benefit of its employees amounted to establishment of an employee welfare benefit plan. On the other hand, the Clark court, after citing Taggart extensively and recognizing Donovan, found that the same activities on the part of Clark amounted to a mere purchase of insurance. Again, considering ERISA’s policies of protecting plan assets and worker well-being, the Taggart reasoning makes more sense as applied to the facts in Davis and Clark.

Notwithstanding the strength of its reasoning, Taggart appeared doomed when the Fifth Circuit seemed to adopt the Donovan test unreservedly in Memorial Hospital System v. Northbrook Life Insurance Co. 129 The relevant facts were again almost identical to the earlier cases. The employer, Noffs, Inc. (“Noffs”), purchased a group health insurance policy from an insurer through a MET. Noffs contributed half the monthly premiums for its employees and forwarded the total premium directly to the insurer. The court applied the Donovan test to these facts and held that because “a reasonable person could ascertain the intended benefits under Noffs’ plan, a class of plan beneficiaries, the source of financing for the plan, and procedures for receiving benefits,” 130 the policy in question was in fact an ERISA plan.

In countering the plaintiff’s argument that Noffs had merely purchased an insurance policy, the court focused on Noffs’ intent to provide benefits to its employees, and on the existence of an “employer-employee-plan relationship.” 131 The court explained:

Although we held in Taggart that the purchase of an insurance policy does not, in and of itself, establish the existence of an ERISA plan, we certainly did not hold, contrary to Memorial’s argument, that an employer’s purchase of health insurance offers no evidence of an intent to provide such a plan. . . .

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128. Id. at 382-83 (citations omitted).
129. 904 F.2d 236 (5th Cir. 1990) (King, J.).
130. Id. at 243.
131. Id.
Unlike Taggart, the present case does not involve the bare purchase of insurance by a lone employee through a MET. Noffs, a statutory employer, has chosen to provide welfare benefits to all of its full-time employees through the purchase of a group insurance policy. Noffs is solely responsible under the policy for submitting monthly premiums directly to Northbrook by the premium due dates. The fact that Noffs' administrative functions under the policy are minimal is perfectly in keeping with its intent that Northbrook administer the plan as well as insure it. There is, thus, an employer-employee-plan relationship that was lacking in Taggart.132

Thus, following the Eleventh Circuit's reasoning in Donovan, the Fifth Circuit abandoned its earlier position that the drafters of ERISA did not intend the Act to regulate a plan without any "assets for ERISA's statutory safeguards to protect."133 After admitting that "one of the principal goals of ERISA is the protection of plan assets held in trust for the benefit of plan participants and beneficiaries,"134 the court simply cited the statute's language in which "ERISA specifically envisions that an employer may establish an employee welfare benefit plan 'through the purchase of insurance or otherwise.'"135 But the court failed to explain how strict construction of the statute and rejection of the rationale it had adopted in Taggart would promote the goals of ERISA.

Less than a year after Taggart appeared to be laid to rest, however, the Fifth Circuit resurrected it in Kidder v. H&B Marine, Inc.,136 where the court, in a per curiam opinion, retreated somewhat from its extreme position in Memorial Hospital. Once again, the facts involved an employer, H&B Construction ("H&B"), which purchased a group health insurance policy for its employees and paid a percentage of the premiums. H&B argued that under Taggart its bare purchase of insurance did not establish an ERISA plan, and that "some degree of active involvement ... [was] necessary to establish an ERISA plan."137 Based on Donovan and Memorial Hospital, the court rejected H&B's argument, concluding that H&B's "payment of premiums on behalf of its employees is 'substantial evidence that a plan, fund, or program [was] established.'"138

132. Id. at 242 (citations omitted).
136. 932 F.2d 347 (5th Cir. 1991) (Thornberry, J.) (per curiam).
137. Id. at 352.
138. Id. at 353, quoting Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982).
Significantly, however, the court displayed a lack of conviction in its own reasoning when it admitted that H&B's "argument has force and, had there been no other relevant precedents, might have persuaded us to reverse the district court's judgment or at least to remand the case for redetermination." The court seemed anxious to make it clear that neither Taggart nor Clark had been overruled, for while it affirmed the district court's holding, it rejected "the district court's apparent reasoning that the payment of premiums alone is sufficient to create a plan ... ." The district court had relied almost exclusively on a Secretary of Labor regulation which provided that the term "employee welfare benefit plan" does not include a group insurance program offered by an insurer to employees under which (1) the employer makes no contributions, (2) employee participation is completely voluntary, (3) the employer's sole functions are to advertise the availability of the plan, and (4) the employer receives no consideration. In criticizing the district court's construction of the regulation, the court explained:

On a literal reading of the court's opinion, the court appears to have construed the regulation to say that if any one of the four listed factors does not appear, then the insurance program is included within the definition of an employee welfare benefit plan . . . . This reading of the regulation, we admit, is not compelled by the language of the regulation itself. That is, the language, [sic] compels only the reading that the four conditions are jointly sufficient for exclusion; it does not compel the reading that the conditions are also individually necessary for exclusion. On the other hand, neither is this reading of the regulation

139. Id. at 352.
140. Id. at 353.
141. The pertinent Secretary of Labor regulation provides:
[T]he terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
(1) No contributions are made by an employer or employee organization;
(2) Participation in the program is completely voluntary for employees or members;
(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.
necessarily precluded by the language of the regulation either. However, ... Fifth Circuit precedent precludes any interpretation of the regulation that leads to the conclusion that the employer's contribution of premiums alone is sufficient to create a group health plan.142

Thus, not only did the Kidder court display a peculiar ambivalence toward its own reasoning, but it seemed determined to preserve the Taggart principle that ERISA does not regulate "bare purchases of health insurance ...."143 Although the court fell far short of requiring the existence of plan assets as a prerequisite to ERISA coverage, it nevertheless revealed doubts regarding Donovan's implication that virtually all employee group health programs, whether self-insured or insured, are ERISA plans. Most importantly, Kidder apparently refused to slam the door on the possibility that future courts may seek an interpretation of ERISA which is more consistent with its "history, structure and purposes. . . ."144

IV. Analysis

Taggart and Donovan and their respective progeny represent two extreme interpretations of ERISA's definition of "employee welfare benefit plan."145 On the one hand, the Taggart court liberally construed the statute to accomplish ERISA's goal of protecting plan assets. Under the Taggart interpretation, a plan with no assets, such as an insured plan, lies outside the scope of ERISA's coverage because "[t]here simply exist no assets for ERISA's statutory safeguards to protect."146 The Donovan court, on the other hand, strictly construed the statute without considering whether its interpretation promoted or defeated the specific goals Congress sought to achieve. Whereas the Taggart court noted that "Congress has . . . chosen to treat ['health plans' and 'health insurance'] separately,"147 the Donovan court merely pointed out that according to the statute an ERISA plan may be established "through the purchase of insurance or otherwise . . . ."148 As a consequence, the Donovan

143. Taggart, 617 F.2d at 1211.
144. Id.
146. Taggart, 617 F.2d at 1211.
147. Id., referring to I.R.C. §§ 105(a), 105(e).
interpretation permits no distinctions between insured and self-insured plans, resulting in the virtual inability of courts "to declare any policy anything other than an ERISA plan..."149

While the Taggart court, unlike the Donovan court, at least considered ERISA's goal of protecting workers from abuse of plan assets by plan administrators, neither court considered ERISA as a whole in interpreting the definition of "employee welfare benefit plan."150 Since an adequate interpretation of the provision must take into account all goals and policies Congress sought to promote in enacting ERISA, neither court's interpretation is satisfactory. In addition to the goal of protecting workers from abuse of plan assets, a competing goal of ERISA is to encourage the formation of employee benefit plans.151 Thus, in determining whether an employer has established an ERISA plan, a court should consider the degree to which its decision will accommodate each of these goals. Furthermore, the court's analysis should necessarily involve an evaluation of the impact of ERISA's preemption and civil enforcement provisions in light of the facts of each case.

Such an analysis will show that any interpretation of ERISA which includes insurance policies purchased by small employers fails to promote ERISA's goals. As applied to insured plans, ERISA fails to adequately protect workers' benefits from abuses by insurers because of the limited remedies available to claimants under ERISA's civil enforcement provisions. As applied to small employers, ERISA fails to encourage the formation of employee benefit plans because the need for small employers to be protected from multiple and conflicting state laws is minimal. In short, where a case involves both a small employer and an insured plan, application of ERISA promotes neither of ERISA's goals and actually serves to defeat those goals.

A. ERISA Applied to Insured Plans

Unlike employers who establish and maintain self-insured employee benefit plans, employers who merely purchase insurance for their employees have little, if any, opportunity to abuse plan assets. The Taggart court relied on this distinction in declaring that ERISA does not regulate "bare purchases of health insurance where . . . the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits."152 The Taggart reasoning

149. Brady v. Empire Blue Cross/Blue Shield, 732 F. Supp. 678, 680 n.1 (W.D. La.), rev'd without opinion, 915 F.2d 692 (5th Cir. 1990); see supra note 6.
151. See supra notes 26-37 and accompanying text.
implies that Congress designed ERISA to protect workers’ benefits from abuses by employers who actually own all or part of the insurance funds and act as administrators, managers, or trustees of those funds, who decide how to invest the funds and whether or not to grant claims, and who are subject to suit by employees whose claims are denied. Employers who establish and maintain self-insured plans fit that description, so they should fall within the scope of ERISA’s coverage.

In contrast, employers who merely purchase insurance receive no funds to abuse; rather, they receive insurance policies and usually some enrollment forms or claim forms to distribute to their employees. Although such employers may collect premiums through payroll deductions and may contribute a portion of each employee’s premium, they have no discretion over how to invest the premiums—they must forward the premiums to insurance companies either directly or through METs. The insurance funds remain in the hands of insurance companies and are not subject to employer abuse. Therefore, as Taggart recognized, employers who establish insured plans are not within the purview of ERISA’s primary goal—i.e., the protection of workers from “abuses occurring in respect of private pension [and health insurance] assets.”

It may be argued that, as applied to insured plans, ERISA protects workers’ benefits from insurer abuse rather than employer abuse. After all, insurers define the terms of insurance contracts and determine whether or not to grant claims for benefits. Additionally, insurers operate under an inherent conflict of interest which is absent where employers administer self-insured plans. One court explained as follows:

Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business. That is, when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company, it is exercising discretion over a situation for which it incurs “direct, immediate expense as a result of benefit determinations favorable to [plan participants.”

The argument that ERISA protects workers from insurer abuse is weak, however, for at least two reasons. First, ERISA does not regulate the substantive terms of insurance contracts. Only state laws protect

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153. See supra note 6 and note 126 and accompanying text.
154. Taggart, 617 F.2d at 1211.
156. See supra text accompanying notes 58-63.
workers from inequitable provisions in insurance policies. Such laws "regulate insurance" within the meaning of the savings clause and the McCarran-Ferguson Act, and therefore they are saved from preemption. At the same time, those laws are preempted when applied to self-insured plans because of the deemer clause. As noted in Metropolitan, the distinction between insured and self insured plans is one "Congress is aware of and one it has chosen not to alter."

The second weakness in the argument that ERISA protects workers from abuses by insurers stems from the fact that even though ERISA provides a cause of action to recover benefits due, it does not adequately protect workers from insurers who wrongfully deny claims. As the Court explained in Pilot Life, ERISA's civil enforcement scheme is exclusive; therefore, the Act preempts all state remedies for bad faith or breach of contract. Consequently, workers under insured as well as self-insured plans remain uncompensated for damages resulting from improper claims processing by insurers or, in the case of self-insured plans, plan administrators. Yet, because of the inherent conflict of interest under which insurance companies operate, the potential for insurer misconduct in insured plans is even greater than the potential for employer misconduct in self-insured plans. ERISA, nonetheless, permits no remedies for damages caused by an insurer's wrongful denial of claims.

Thus, courts which interpret ERISA to include insured plans do not promote ERISA's goal of protecting workers' benefits from abuse.
Courts would better serve that goal by following Taggart's lead in excluding insured plans from ERISA coverage, thereby freeing workers to choose from among the wide array of state causes of action available in most cases. Furthermore, permitting states to regulate claims processing should result in greater deterrence of insurer misconduct simply because state laws provide claimants with more causes of action and remedies than ERISA. The Taggart reasoning is also more consistent with the deference shown by Congress toward state regulation of insurance as evidenced by the savings clause and the McCarran-Ferguson Act.

Nevertheless, despite ERISA's failure to adequately protect participants and beneficiaries of insured plans, exclusion of insured plans from ERISA coverage in all cases may not be prudent. Courts also should take into account ERISA's second major goal—i.e., encouraging the formation of employee benefit plans. By establishing uniform laws regulating employee benefit plans, ERISA protects employers from multiple and conflicting state laws and facilitates the administration of plans covering employees in more than one state, thereby encouraging the formation of such plans. As suggested in Pilot Life, the restricted choice of causes of action and attendant remedies available to claimants under ERISA's civil enforcement scheme represents a balancing of the individual's need to settle claims against the public need to encourage the formation of employee benefit plans. Therefore, where the public need to encourage the formation of employee benefit plans outweighs the employees' need for the greater protection of state laws, inclusion of insured plans within the scope of ERISA is justified.

Such a case exists where an employer seeks to purchase group health insurance for employees in more than one state. Absent ERISA's uniform standards to guide processing of claims, the insurer and possibly the employer would be subject to differing regulatory requirements in different states. The result would be increased administrative costs and ultimately higher premiums and fewer benefits for workers. Arguably, the public need to reduce this administrative burden on insurers, em-
ployers, and employees outweighs the need of employees for the added protection of state laws. In such cases, ERISA's uniform regulations may indeed serve to encourage employers to purchase group health insurance for their employees.

Thus, to the extent ERISA is necessary to encourage employers to provide group health insurance for their employees, insured plans as well as self-insured plans should fall within the scope of ERISA. As the next section of this comment will show, however, small-employer plans fail to meet this test.

B. ERISA Applied to Small Employers

Since small employers rarely, if ever, have the resources to establish self-insured plans, they must purchase insurance if they want to provide health benefits for their employees. Consequently, all of the shortcomings discussed in the previous section concerning ERISA as applied to insured plans are also relevant to an analysis of ERISA as applied to small employers. In other words, ERISA fails to protect employees of small employers from abuse of plan assets because there are no assets to protect. Nor does ERISA, as opposed to state law, offer these employees adequate remedies for wrongful denial of claims by insurers. Finally, ERISA coverage of small-employer plans is justified only when the public need to encourage small employers to purchase employee group health insurance outweighs the employees' need for the added protection of state laws.

It follows that where a small employer is involved, the inquiry must focus on whether ERISA is necessary to encourage the employer to provide group health insurance for its employees. In the vast majority of cases, ERISA is unnecessary to achieve that goal.

First of all, small employers typically do not conduct business across state lines. Unlike large interstate employers, they are not subject to the administrative burdens caused by multiple and conflicting state laws. Therefore, ERISA's uniform regulations, which Congress designed to relieve those burdens, are not a significant inducement to small employers to provide group health insurance for their employees.

Furthermore, ERISA does not substantially reduce the administrative costs of insurers of small-employer plans. Although insurers may do business among many states, the savings clause nevertheless renders them subject to multiple and conflicting state laws which regulate the substantive content of insurance contracts. This means that the substantive terms of all policies issued in a particular state must conform with that

174. See supra note 23 and accompanying text.
175. See supra text accompanying notes 58-63.
state’s insurance laws. Thus, insurers should encounter no great obstacles in also adapting their administrative practices to conform with laws regulating the processing of claims (laws which otherwise are preempted by ERISA) in the state where the employer does business. Also, most insurers customarily issue non-employee group health policies and individual policies not covered by ERISA. Since these types of policies are subject to all the laws of particular states, the insurers should already be familiar with and have mechanisms for complying with those laws. In short, ERISA is unnecessary to control the administrative costs of insurers of small-employer plans.

Whether one looks at the effects of ERISA on small employers themselves or on the insurers of small-employer plans, it becomes clear that ERISA offers little to encourage small employers to provide group health insurance for their employees. ERISA’s uniform regulations do not reduce any existing administrative burdens on small employers, nor do those regulations substantially reduce the administrative costs of insurers of small-employer plans.

As applied to small employers, then, ERISA fails to meet the public need to encourage the formation of employee benefit plans. Consequently, this public need is outweighed by the need of individual claimants to have access to the wide array of state causes of action and remedies. ERISA coverage of small employers therefore cannot be justified.

V. Recommendations

In order to achieve the goals of ERISA as intended by Congress, courts must interpret ERISA’s definition of “employee welfare benefit plan”76 in light of the Act as a whole. The problem is that courts are faced with the strict construction advanced in Donovan77 in the Eleventh Circuit and adopted by the Fifth Circuit in Memorial Hospital.78 As a result, the law as it now stands represents an interpretation of ERISA which, when applied to small-employer plans, fails to promote the Act’s dual goals of protecting employee benefits from abuse and encouraging the formation of employee benefit plans. Therefore, in the absence of congressional amendment of ERISA to correct the problem, courts should adapt this jurisprudence to effect the purposes of ERISA and to avoid the injustice of needlessly restricting the remedies available to employees.

In the Fifth Circuit, the present test for determining whether an employer has “established or maintained”79 an employee welfare benefit

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177. Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982).
plan was expressed most clearly in Gahn v. Allstate Life Insurance Co.\textsuperscript{180} According to Gahn, a court must conduct two inquiries.\textsuperscript{181} First, the court must apply the Secretary of Labor's safe-harbor provision.\textsuperscript{182} According to that provision, ERISA does not cover a plan if (1) the employer makes no contributions, (2) employee participation is completely voluntary, (3) the employer's sole functions are to advertise the availability of the plan, and (4) the employer receives no consideration.\textsuperscript{183} Usually, in small-employer plans, employee participation is voluntary and the employer receives no consideration; therefore, small employers escape factors (2) and (4). However, insurers often require employers to contribute a percentage of employee premiums as a prerequisite to obtaining group rates, and many courts have found such "contributions" by employers to meet the first factor of the safe-harbor provision.\textsuperscript{184} Kidder strongly rejected the notion "that the employer's contribution of premiums alone is sufficient to create a group health plan,"\textsuperscript{185} but concluded that an employer's "payment of premiums on behalf of its employees is "substantial evidence that a plan, fund, or program [was] established."\textsuperscript{186} Courts also have found the third factor to be satisfied where employers distribute application and claim forms, make payroll deductions for premiums, and update enrollment information.\textsuperscript{187}

If the court finds that any of the above factors has been met, then the plan does not qualify for exemption from ERISA coverage under the safe-harbor provision, and the court must proceed to the second inquiry.\textsuperscript{188} This inquiry is the Donovan test of "whether, "from the surrounding circumstances[,] a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and

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\item[180.] 926 F.2d 1449, 1452 (5th Cir. 1991). Gahn was decided less than three weeks before Kidder v. H & B Marine, Inc., 932 F.2d 347 (5th Cir. 1991) (Thornberry, J.), see supra text accompanying notes 136-44, but was not cited in the latter opinion. After stating the test for deciding whether an employer has established or maintained an ERISA plan, the Gahn court remanded the case to the district court for further factual findings relevant to the determination.
\item[181.] Gahn, 926 F.2d at 1452.
\item[182.] 29 C.F.R. § 2510.3-1(j) (1991). See supra note 141 and accompanying text.
\item[183.] 29 C.F.R. § 2510.3-1(j) (1991).
\item[185.] Kidder v. H & B Marine, 932 F.2d 347, 352 (5th Cir. 1991).
\item[186.] Id., quoting Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982).
\item[188.] Gahn v. Allstate Life Ins. Co., 926 F.2d 1449, 1452 (5th Cir. 1991).
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procedures for receiving benefits. Of course, as seen in the cases, an ERISA plan has been found in almost every instance where the Donovan test has been applied, whether the plan at issue was insured, self-insured, large, or small.

The analysis in Part IV revealed that Donovan's strict construction of ERISA fails to promote ERISA's goals when applied to small-employer plans. Thus, if courts are to interpret ERISA in a way which avoids injustice and which effects the goals Congress intended to achieve, the Donovan test cannot be the final inquiry in the determination of whether an ERISA plan exists in a particular case.

As an aid to formulating yet a third inquiry, Taggart offers a reliable guide insofar as it implies that courts should consider the "history, structure and purposes of ERISA" in making their determinations. The means of implementing such a consideration of ERISA's "history, structure and purposes" can be derived from the Supreme Court's opinion in Pilot Life. According to the Pilot Life Court, ERISA's civil enforcement scheme "represents a careful balancing of the need for prompt and fair claims settlement procedures against public interest in encouraging the formation of employee benefit plans." From this statement emerges a useful measure of whether application of ERISA in a particular case promotes the goals of the Act. If the careful balance of individual needs against the public interest is upset by the application of ERISA, then application of ERISA in such a case does not promote the Act's goals.

Thus, even if a plan does not qualify for exemption from ERISA coverage under the Secretary of Labor's safe-harbor provision, and even if a plan satisfies the elements of the Donovan test, the plan still should meet the balancing test derived from Pilot Life in order to qualify as an ERISA plan. Under that balancing test, a health insurance plan is not an ERISA plan unless application of ERISA is necessary to encourage the employer to provide insurance for its employees. When ERISA is not necessary for that purpose, the employees' need for the added protection of state laws outweighs the public interest in encouraging the formation of employee benefit plans. In such a case, the court should

193. Id. at 54, 107 S. Ct. at 1556.
find that the employer did not establish or maintain an employee welfare benefit plan within the meaning of ERISA.

Since ERISA is not necessary to encourage small employers to provide group health insurance to their employees, the need of these employees for the added protection of state laws outweighs the public interest in encouraging small employers to purchase insurance. Thus, the balancing test permits small-employer plans to slip through the wide net of the Donovan test, thereby enabling courts to avoid the injustice resulting from needless preemption of a claimant’s state causes of action and remedies. Another advantage of adding this balancing test to the two-step inquiry enunciated in Gahn is that it will correct the problem created by Donovan and its progeny without overruling any of those cases.

Congressional amendment of ERISA offers an alternative solution to the problems created by application of ERISA to small-employer plans. Such an amendment could simply exclude small employers who conduct business in a single state, or employers with fewer than a certain number of employees, from the definition of “employee welfare benefit plan.”

VI. CONCLUSION

Congress enacted ERISA in order to correct two specific problems: the first problem concerned abuses of assets held in trust by employers for the benefit of employees; the second concerned inconsistent and conflicting state laws which created administrative burdens on employers who chose to establish benefit plans for employees in more than one state. Presumably, Congress intended ERISA to regulate only those types of employee benefit plans susceptible to these problems, such as pension plans and self-insured welfare benefit plans. On the other hand, as Taggart recognized, it is unlikely that Congress intended ERISA’s vesting standards, funding requirements, termination insurance, reporting and disclosure guidelines, and fiduciary obligations to apply to insured

194. 29 U.S.C. § 1002(1) (1988). Congress has already taken a step in this direction by excluding some small employers from the provisions of the Comprehensive Omnibus Budget Reconciliation Act of 1985 (“COBRA”). Id. §§ 1161-68. See supra text accompanying notes 68-70. COBRA requires employers to provide continuation health coverage to employees who leave work under certain circumstances, but employers which “employed fewer than 20 employees on a typical business day during the preceding calendar year” are exempted from this requirement. Id. § 1161(b). Although COBRA’s small-employer exemption is almost certainly too narrow for adoption by ERISA generally, it could serve as a model for a broader provision exempting small employers from ERISA as a whole.

195. See supra text accompanying notes 25-29.

health plans in which "[t]here simply exist no assets for ERISA’s statutory safeguards to protect." It is also unlikely that Congress intended ERISA’s preemption provisions and uniform regulations to reduce administrative burdens on insured plans covering employees in only one state. In fact, Congress had already reserved to the states the power to regulate insurance in the McCarran-Ferguson Act.

Yet, some courts apparently have interpreted ERISA’s provisions without reference to Congress’s intent. Such an interpretation is most conspicuous in Donovan’s construction of ERISA’s definition of “employee welfare benefit plan.” Under the Donovan “test,” a health insurance policy is an ERISA plan based on the mere fact that an employer has purchased the insurance for the benefit of employees. Taggart and its progeny at least acknowledged that, as applied to insured plans, strict construction of the definition would not promote ERISA’s goal of protecting plan assets from abuse. Nevertheless, when the Fifth Circuit adopted the Donovan test in Memorial Hospital, it effectively abandoned its earlier interpretation of ERISA as expressed in Taggart.

Soon after Memorial Hospital, however, the Fifth Circuit in Kidder revealed doubts regarding Donovan’s implication that virtually all employee group health programs, whether self-insured or insured, are ERISA plans. Although the Kidder court proceeded to apply the Donovan test to the facts before it, the court seemed anxious to preserve the Taggart principle that ERISA does not regulate “bare purchases of health insurance.” In effect, Kidder paves the way for future courts to reconcile the widely divergent approaches to ERISA represented by Taggart and Donovan.

In an effort to assist courts in adapting existing jurisprudence toward the achievement of ERISA’s goals, this comment has proposed an interpretation of ERISA’s definition of “employee welfare benefit plan” which considers the “history, structure and purposes” of the Act as

197. Taggart, 617 F.2d at 1211.
201. Donovan, 688 F.2d at 1373. See supra text accompanying note 118.
206. Taggart, 617 F.2d at 1211.
a whole. Under this interpretation, an employee group health insurance plan should not be characterized as an ERISA plan unless to do so would promote ERISA's dual goals of protecting workers' benefits and encouraging the formation of employee benefit plans. Because these goals are competing, the determination of whether a particular plan is governed by ERISA involves the application of a balancing test in which the public need to encourage the formation of employee benefit plans is weighed against the employees' need for the protection of state law.207 Thus, where ERISA's uniform regulations are necessary to reduce administrative and economic burdens on insurers, employers, and employees, this need can be said to outweigh the employees' need for access to state law remedies. In such cases, ERISA coverage of the plan is consistent with the Act's purposes and is therefore appropriate.

Under this analysis, however, ERISA coverage of small-employer plans is rarely justified. First of all, small employers usually purchase insurance rather than establish self-insured plans, so they receive none of the funds ERISA was designed to protect.208 At the same time, because insurers own the funds out of which claims are paid, they operate under an inherent conflict of interest which increases the potential for misconduct in claims handling.209 Since ERISA provides no remedies for damages caused by an insurer's wrongful denial of claims,210 employees under small-employer plans have a great need for access to the wide array of state law remedies. Meanwhile, under ERISA, the same employees would be left virtually unprotected. In other words, when applied to small-employer plans, ERISA fails to achieve its goal of protecting workers' benefits.

ERISA also fails to encourage small employers to establish employee benefit plans. Since small employers typically do not conduct business across state lines, they are not subject to inconsistent and conflicting state laws. Whether one looks at the effects of ERISA on small employers themselves or on the insurers of small-employer plans, ERISA's uniform regulations do not reduce any existing administrative burdens on small employers, nor do those regulations substantially reduce the administrative costs of insurers of small-employer plans.211 Thus, any need for ERISA to encourage small employers to form employee benefit plans is minimal.

Accordingly, under the proposed balancing test, ERISA should not apply to small-employer group health insurance plans because the min-

207. See supra text accompanying notes 176-94.
208. See supra note 23 and accompanying text.
209. See supra text accompanying notes 12 and 155.
210. See supra text accompanying notes 71-77.
211. See supra text accompanying notes 174-75.
imal need for ERISA to encourage small employers to form employee benefit plans is outweighed in such cases by the great need of employees for the added protection of state law.

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