

HEALTH CARE BENEFIT AVAILABILITY FOR EMPLOYEES: THE ERISA FRAMEWORK AFTER 25 YEARS

TESTIMONY OF FRANK CUMMINGS

prepared for delivery at a hearing before the **Subcommittee on Employer-Employee Relations of the Committee on Education and the Workforce, U.S. House of Representative**, 1:30 p.m., Wednesday, February 24, 1999, in Room 2175, Rayburn House Office Building.

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Congress's 1999 agenda targets a health care system that is the envy of the world. Make it better and more responsive, yes. Expand coverage, yes. But as Hippocrates told doctors 2400 years ago -- first, do no harm.¹

There *are* good things Congress can do about health care, without doing harm,

! *if* Congress proceeds carefully,

! *if* Congress listens to what the market tells you,

! *if* Congress does not try to swallow too much in a single gulp, and then choke on it, as in 1994,

! *and if* Congress learns from the past.

There are good lessons to be found in ERISA's 25 years of experience, and painful lessons in the burgeoning and destructive tort-litigation system.

What can be done? How do you do the right thing?

First (as Congress did for pension plans when designing ERISA 25 years ago), find out what the very best plans are already doing -- look there for your standards. That is what Congress did in

¹Epidemics, Bk. I, ch. 11.

designing ERISA's pension standards -- pick from among the best of what was already happening. At least then, you will know what does work -- because it is already being done.

And second, identify what does not work -- what is counter-productive -- and don't do that. And that would include injecting the state model of torts/jury trials/punitive damages into the employee benefit system.

You do not need and should not want a federal Aoverkill statute. After all, employee health benefit plans, like pension plans, are *voluntary*: they can be terminated if they become unduly burdensome. And there is no need or reason to drive employer-sponsored plans into termination, any more than it is a reason to ignore the problems that generate the impulse to turn this over to the State tort-litigation system. There *is* a reason to take problems seriously, and then to enact, cautiously, reasonable standards without being unduly burdensome. That means

! keeping federal preemption;

! assuring quick and fair claims handling;

! and keeping the remedies

-- *federal* -- and under ERISA

(Improve them, but why trash 25 years of precedents, rulings, regulations and interpretations?)

-- *equitable*

(After all, the Courts are already expanding the scope of available Aequitable remedies under ERISA. *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1966). Equitable remedies should be sufficient to achieve the desired result, but without imposing an undue burden on the employer or, ultimately, on the other participants)

-- *non-jury*

(Leave it to judges, and keep the scope of review -- after a required exhaustion of administrative appeals -- limited to Aabuse of discretion as the Court decided in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989))

-- *non-punitive*

(Who, after all, will *really* suffer the consequences of a multimillion dollar punitive damage award? The employer who merely adopted the plan and cannot afford increased coverage costs? The insurance company who then must raise rates? The HMO, which must increase its liability insurance, and its

rates? Or the employees, whose co-payments rise, whose coverage is restricted, and whose employer may decide to drop the plan altogether? Is all of that really required to make improvements in health benefit plans?)

**THE MOST CENTRAL DIFFERENCE BETWEEN PENDING BILLS --
STATE PUNITIVE DAMAGE ACTIONS**

All these bills are long and complex, but a central point of disagreement between the Republican and Democratic proposals relates to enforcement and penalties.

The Republican proposals (last year=s H.R.4250, and this year=s H.R.448, and S.300) would also set fairly extensive and complex procedural requirements for claims handling, impose federal statutory penalties for bad faith claims handling, but keep federal preemption and would not include the threat of damage awards.

The Democratic proposals (H.R.358 and S.6) would lift federal preemption to allow state damage awards. See, for example H.R.358, § 302(a), amending ERISA § 514(e) (Apreemption not to apply to certain actions arising out of provision of health benefits≡). In contrast, see H.R.448, § 1201, amending ERISA § 502 (AExpedited Court Review≡, AStandard of Review Unaffected≡), and enforcement provisions relating to the bill=s small-group-market reform amendments (§ 1305).

**THE DIMENSIONS OF THE PROBLEM:
WHY REEXAMINE THE MEDICAL ASPECT OF ERISA, AFTER 25 YEARS?**

Though it strains credulity, once upon a time medical treatment was not very expensive, and it was a relatively minor component of employment costs. Consider the following data showing how the relative employer-paid costs (excluding employee contributions) of private pensions and private health insurance have changed, radically, since ERISA=s enactment. According to the Employee Benefit Research Institute:

Employer Outlays for Selected Employee Benefits by Function, Selected Years 1960-1994
(\$ billions)

	<u>1970</u>	<u>1994</u>
Private Employer Pension and Profit Sharing	13.1	87.7
Group Health Insurance	12.1	263.0

(Source: EBRI Databook on Employee Benefits, p. 12, Table 2.2 (4th Ed. 1997))

According to the same chart, in 1970 employer outlays for *Aall benefits*≡ in 1970 (\$65.9 billion), when compared with *Atotal compensation*≡ in 1970 (\$618 billion), were **11%** of total compensation. But employer outlays for *Aall benefits*≡ in 1994 (\$746.5 billion), when compared with *Atotal compensation*≡ in 1994 (\$4,002.4 billion), had risen to **19%** of total compensation.

Comparing employer spending (excluding employee contributions, co-payments, deductibles) on Group Health Insurance before ERISA and in recent years, Employee Benefit Research Institute data show the following:

**Total Employer Outlays for Group Health Insurance . . .
as a Percentage of Total Compensation . . . 1948-1994**

	<u>1970</u>	<u>1994</u>
Health Care as a Percentage of Total Compensation	2.3%	7.6%

(Source: EBRI Databook on Employee Benefits, p. 293, Table 34.1 (4th Ed. 1997))

In short, employee benefits are in a squeeze, and we can see which benefit is squeezing the hardest: **HEALTH**

**STRUCTURAL CHANGES IN THE SYSTEM:
THE RELATION OF DECISIONS ON TREATMENT AND DECISIONS ON COVERAGE**

It is not just costs that have changed. In 1974, decision-making on *coverage* was much more remote from decision-making on *treatment*. Today, the decision on coverage is often, de facto, the decision on treatment. It is a nice legal distinction (and indeed it may have legal consequences) between saying that treatment is not covered by the plan and saying that treatment is denied. From the patient's perspective, however, it may not make much difference.

That blurring of the line between coverage decisions and treatment decisions puts a much greater emphasis on the integrity and competence of the decision-maker.

But that emphasis does not require putting the coverage decision-maker on trial before a jury on a claim of punitive damages. And certainly not enacting that sort of blunderbuss without first trying something much more sensible and much less dangerous:

- (i) find out which providers are doing the best job with claims-handling procedures under ERISA's federal statutory (equitable) enforcement
- (ii) find out what those procedures are, and enact the procedural requirements deemed appropriate,
- (iii) enforce them using federal (ERISA) equitable legal mechanisms, without juries and punitive damages, and
- (iv) let it run a while and see how it works.

THE CORE APROBLEM SITUATION@

The Ordinary Context of Medical Care

Keep in mind that, with all the hue and cry about some aspects of managed care, the dimensions of problem -- which clearly is a real problem -- are fairly limited:

! Most employees don't suffer serious illness or injury.

! Most employees get good responses as to coverage questions.

! Most ill or injured employees get good treatment.

! If there is a controversy, most employees get adequate and reasonably fast claims appeals, reviewed by doctors where appropriate.

The Problem Case (The AHard Case@that AMakes Bad Law@)

The context of the Ahard case≡ now arises because:

- The Afee for service model≡ is being supplanted by the managed care model.²
- Nonetheless, the patient ordinarily believes that he/she Ahas≡ a doctor. The doctor is Amy doctor.≡
- But Amy doctor≡ -- acting for the HMO or managed care organization -- can only provide what the HMO provides, unless the patient wants to go outside the plan=s coverage (ordinarily not realistic economically).
- There are increasing complaints against *some* HMOs= institutional coverage decisions and coverage decision-making.
- In any particular case, the plaintiff may seek to hold the HMO liable for making an objectionable decision.

The Ahard case≡ itself -- the tail that threatens to wag the dog -- comes up this way:

²Employee Benefits Research Institute [EBRI] Issue Brief No. 201, Sept. 1998 (AIn 1997, 15 percent of employees participating in a health plan were enrolled in an indemnity plan, compared with 52 percent in 1992").

1. The employer pays premiums to an HMO (or other managed care organization) for coverage of employees and covered dependants.
2. The employer delivers the plan (and a summary plan description), but the plan is designed by, and run by, the HMO itself.
3. The HMO lists primary care physicians.
4. The employee or other participant selects a primary care physician from the list.
5. The plan states what is covered and what is excluded from coverage (e.g., what is necessary and what is experimental).
6. The employee or dependant becomes ill or is injured.
7. The employee or dependant visits the primary care physician. The primary care physician orders tests (or indicates that the matter should be referred to a specialist), subject to HMO approval.
8. The HMO disapproves, acting on behalf of the Plan. (That is, the act of disapproval is a *coverage determination under the terms of the Plan*).
9. The participant appeals, and the HMO denies the appeal, again holding that the proposed treatment is not necessary and therefore not covered.
10. The primary care physician advises the patient that the treatment is not available under the terms of the plan.³
11. The employee either cannot afford the treatment on a non-insured basis or decides not to proceed.
12. The patient suffers other substantial injury or dies. He/she claims the injury would have been avoided if the treatment had not been denied.

³The possible themes and variations include: (i) the doctor tells the patient the treatment is not necessary (acting in his capacity as physician), or (ii) the doctor tells the patient that the AHMO doesn't cover it (acting in his capacity as messenger for the HMO or for the Plan). *Either way*, the employee now finds that the treatment is not covered by the Plan.

13. The patient claims that the conduct of the HMO was the practice of medicine, and was medical malpractice. The HMO argues that this was simply a coverage determination, interpreting the terms of the employee benefit plan, and deciding that the plan did not cover the proposed treatment.

The Aproblem case@is the exception. But it is real, and it is important, and as we all know, *Ahard cases make bad law.*⁴

The Ahard cases \equiv in ERISA health plans are those where the courts treat the HMO=s act of interpreting the plan and denying coverage as if it were Amedical malpractice, \equiv not preempted, and subject to state law trial of a damage action.⁵ The trend they set threatens to make bad law unless

⁴*Northern Securities Co. v. United States*, 193 U.S. 197, 400-01 (1904) (Holmes, J.) (AGreat cases like hard cases make bad law. For great cases are called great, not by reason of their real importance in shaping the law of the future, but because of some accident of immediate overwhelming interest which appeals to the feelings and distorts the judgment. These immediate interests exercise a kind of hydraulic pressure which makes what previously was clear seem doubtful, and before which even well settled principles of law will bend.@)

⁵In New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, 115 S. Ct. 1671 (1995), the Supreme Court held that medical quality standards, even though they indirectly affect the choice of benefits under the Plan, nonetheless are traditionally left to the states, and therefore are not

Congress steps in and supplants these non-preemption interpretations with substantive and procedural ERISA standards. In other words, the current status quo will change even if Congress does nothing. **The courts are already doing it.** The question is whether ERISA preemption will continue to crumble by judicial erosion of it, or whether something better can be designed.

Hard cases, in my view, are not a reason to turn the entire system of ERISA health claims over to state juries awarding punitive damages. **And keep in mind that the much more complex pension requirements of ERISA have been on the books for 25 years and have achieved overwhelming compliance without a single jury trial, and without a single punitive damage award.**

preempted by ERISA. In Dukes v. US Healthcare, 57 F.3d 350, 19 E.B.C. 1473 (3d Cir. 1995), cert. denied, 516 U.S. 1009 (1995), the Court of Appeals held that a malpractice claim against an HMO, for failure perform (cover) necessary blood tests, was not preempted. This was the first such malpractice case after Travelers. In Pacificare, Inc. v. Burrage, 59 F.3d 151, 19 E.B.C. 1572 (10th Cir. 1995), the Court of Appeals denied a motion to mandamus and restrain the district court, thereby holding that (a) although a state law claim against an HMO for wrongful plan administration is preempted by ERISA, (b) the HMO may be liable vicariously for the doctor=s malpractice, and such potential vicarious liable, though it may affect the Plan, presents a connection to the Plan that is too tenuous to warrant preemption. And in Texas, a new state law makes the HMO directly liable for failure to exercise ordinary care when making treatment decisions. In Corporate Health Ins., Inc. v. Texas Department of Insurance, 12 F. Supp. 2d 597, 22 E.B.C. 1973 (1998) (appeal pending, settlement pending), the District Court held that the Texas law is not preempted (although another part of the law, dealing with the Areview process,≡ was preempted).

ERISA=S ORIGINAL INTENT COVERED
BOTH PENSIONS AND EMPLOYEE WELFARE PLANS
AND PREEMPTED STATE LAW AS TO BOTH

Pensions: A AKeep Your Promises@Law

The original context of ERISA was a series of "hard luck stories" -- stories in which a worker or group of workers worked long and hard and then did not get the pension they were promised. They *did not get what they were promised* either because there was insufficient vesting, or insufficient funding, or a dishonest or incompetent person misapplied the funds, or the employer "walked away" from the plan. Those were the pension problems that ERISA solved -- by setting standards for funding, vesting, accrual, anti-discrimination, PBGC guarantees, and so on. Those pension standards that are now universal, and universally observed and followed -- without imposing damage actions, jury trials or punitive damages.

Most people obey the law, if you make it clear. You don=t need to terrorize them.

As to pensions, ERISA was a Akeep-your-promises law.≡ When it came to pensions, ERISA *did not mandate benefits*. It did not tell a sponsor how Arich≡ a plan to have, nor even whether to have a plan, or any particular type of plan. ERISA said to employers, instead:

If you decide to have a plan, and after you decide what plan to have and what benefits to give, you must deliver on your promises:

You must disclose your promised benefits (reporting and disclosure, with a Summary Plan Description);

You must pre-fund your benefits;

You may not unreasonably forfeit those benefits (vesting);

And you must run the plan honestly and with due care (fiduciary standards).

But the substance of the pension plan -- the choice of the benefits themselves -- is still for the parties themselves to decide -- collectively bargained or otherwise established by the employer.

Those were the standards, and they have been accepted and implemented and followed -- all without jury trials, without punitive damages, without anything but the equitable remedies allowed by ERISA.

Welfare Plans - Differences and Similarities

Congress went further in 1974 and covered employee welfare benefits plans as well -- intentionally, deliberately.

Congress did not set welfare plan funding standards -- possibly because health insurance is ordinarily an annual purchase, not a 30 year accumulation. Congress did not require 5-year-vesting for health insurance either -- obviously for the same reason.

But Congress did many of the same things for welfare plans as for pension plans. Congress set disclosure standards, fiduciary standards and enforcement mechanisms for all employee benefit plans, not just pension plans.

DELIBERATE PREEMPTION OF STATE LAWS FOR BOTH PENSION AND WELFARE PLANS

There is not the slightest doubt that the statute was intended to cover, and did cover, welfare plans, including health and medical plans, as well as pension plans, and intended to *preempt state laws as to both*.

Just look at the plain meaning of the words in ERISA. The statute preempts all state laws that relate to any *employee benefit plan*.[≡] ERISA § 514. Section 514 could have said, but did not say, *Any employee pension plan*.[≡] The statute defines *employee benefit plan*[≡] to include both pension plans and *any employee welfare benefit plan*.[≡] ERISA § 3(3). And the term *employee welfare benefit plan*[≡] is defined -- in the very first definition in ERISA -- to mean any plan established by an employer or union or both for the purpose of providing

A . . . for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits[≡] [ERISA § 3(1), 29 U.S.C. § 1002(1)].

There is no basis for the slightest doubt about Congress's intent, in the end, to preempt the law of welfare plans as well as pension plans. Earlier versions of the bill were limited to specific pension subjects, but not the final version. And that was no accident or oversight. A Missouri court in 1973 had held that Monsanto violated state insurance laws by maintaining a self-insured health plan. (See Butters, *State Regulation of Noninsured Employee Welfare Benefit Plans*, 62 Georgetown L.J. 340 (1973)), and the state law floodgates were in danger of opening. Of more direct concern to the labor movement was the burgeoning of pre-paid legal service plans (which were *welfare plans*,[≡] not pension plans), after the Taft-Hartley Act (§ 302(c)(8), 29 U.S.C. § 186(c)(8)) was amended in 1973 to allow them as joint labor-management trusts. (P.L. 93-95). The National Association of Insurance Commissioners was developing a state law on the subject. And the American Bar Association came out in favor of compulsory open-panel plans. (ABA Ann., Rep., vol 99, at 166-174 (1974)). John Dent, the Subcommittee's then-Chairman and the principal House ERISA sponsor and conferee, then amended his bill to preempt as to welfare plans, and to add the deemer clause. See Daily Labor

Report Feb. 14, 1974, Supp., p. 54. Why? To make sure that the NAIC, the ABA, and the States left these welfare plans alone. It made sense then, and it makes sense now.

THE LIMITS OF THE INSURANCE EXCEPTION TO ERISA PREEMPTION

When it comes to ERISA preemption of remedies -- particularly remedies under insured plans, the Abible up to now has been the Supreme Court's ruling in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). In *Pilot Life* the Supreme Court held preempted a state law claim of Wrongful claims denial because, even though Wrongful claims denial was a state tort applicable to insurers, nonetheless the Court held that this sort of thing is *not what Congress had in mind in the insurance law exception to ERISA ' 514 preemption*. Why? For three reasons given by the Court:

(1) Using a "common-sense view" of the language of the savings clause itself (ERISA § 514(b)(2)(A), 29 USC § 1144(b)(2)(A)), the state common law does not regulate insurance. To survive preemption, a law must not just have an impact on the insurance industry, but must be specifically directed toward regulating that industry.

(2) The state common law does not meet the criteria specified in the McCarran-Ferguson Act (15 USC § 1011 et seq.) defining the meaning of the phrase "business of insurance." The McCarran-Ferguson criteria require an examination of whether the practice in question (a) has the effect of transferring or spreading a policyholder's risk, (b) is an integral part of the policy relationship between the insurer and the insured, and (c) is limited to entities within the insurance industry, the state common law having only an attenuated connection to the policy relationship between the insurer and the insured, thus meeting only one of the factors under the McCarran-Ferguson Act criteria. And --

(3) The role of the savings clause in ERISA as a whole indicates that Congress intended ERISA to be the exclusive vehicle for actions asserting improper processing of ERISA-plan benefits.

It is *Pilot Life*'s third reason, of course, which has been the guiding principle of ERISA preemption ever since -- at least until now.

The Department of Labor and the Solicitor General, however, now seem to take a very different approach, seeking to put *Pilot Life* on the endangered list. In *Ward v. Management Analysis Co. Empl. Disability Benefits Plan*, 135 F.3d 1276 (9th Cir. 1998), *cert. granted sub nom. UNUM Life Ins. Co. v. Ward*, 142 L. Ed. 2d 275 (U.S. 1998) (an appeal that was argued today in the Supreme Court [No. 97-1868]), the Ninth Circuit held that California's Notice-prejudice rule was not preempted, treating it as a law governing the business of insurance, even though it had the effect of overriding the claims provisions of the Plan setting time limits for the filing of claims. In an amicus brief filed in the Supreme Court by the Solicitor General, the Government has taken the position that, although the Supreme Court's rule set forth in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S.

41, 50 (1987) should not be directly attacked *As a general matter*≡ (Brief, p. 27), nonetheless, A the insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated-benefits laws and other prescriptive measures that do so.≡ (Brief, pp. 29-30).

That interpretation of Pilot Life, in my view, is wrong, and it is counterproductive and dangerous. Here we have the Government issuing wide-ranging and tough new proposed ERISA rules⁶ governing claims procedures, basing those proposed rules on DOL=s express statutory authority to issue claims-handling standards, and at the same time they are suggesting to the Supreme Court that ERISA leaves claims handling requirements to the states!

If this Committee -- this Congress -- is now to revise and improve ERISA=s treatment of health benefit claims, surely it is no time to turn this subject over to 50 state legislatures, 50 state health commissioners, 50 state insurance commissioners, 50 state common law court systems, with 50 state standards for punitive damages. On the contrary, it is time to nail down the vitality of Pilot Life. Whatever health claims ERISA amendment this Committee may report, the accompanying Committee Report could and should state that the bill is reported based on the assumption that Pilot Life is A good law,≡ and stating a broad interpretation of that preemption ruling.

RETAINING FLEXIBILITY **FOR THE SMALL EMPLOYER**

One of the ironies of the insurance exception to ERISA preemption is that it gives the large self-insured employer the flexibility to design and re-design the scope of coverage, free of the cross-currents of state insurance laws.

The small employer -- who *needs* the flexibility all the more -- finds it more difficult to self-insure, and thus falls out of ERISA=s preemption and into the clutches of state law, juries, damages and the trial of state tort actions.

One way out, among others, would be expanded use of combined self-insurance and stop-loss coverage.

⁶Nature abhors a vacuum, and a power vacuum seems to attract just about everyone with an urge to tell others what=s right. The Department of Labor, which actually has regulatory jurisdiction under ERISA   503, has issued new proposed claims regulations in a what appears to be a case of overkill. 63 Fed. Reg. 48390, 29 CFR Part 2560 (September 9, 1989) (reconsideration reportedly pending, after public hearings in early 1999).

Here is how it works: *Uninsured (self-insured) plans* get the benefit of the Supreme Court's ruling in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), where the Court ruled that an *uninsured plan* could not be regulated by state insurance law (because of the *Adeemer* clause in ERISA § 514), even though the very same set of benefits, if covered by an *insured plan*, would be subject to state regulation of insurance (which could impose various state benefit mandates and other requirements).

Large employers may be able to accept the risk of the unanticipated costs of unexpected medical expenses, thereby escaping the reach of state-by-state insurance regulation.⁷

But what of the small employer? The problem of small business' initial inability to accept the risks inherent in *self-insured* health plans may be amenable to stop-loss coverage, because the stop-loss insurer is not insuring the plan or its beneficiaries -- instead, the stop-loss insurer is simply protecting the employer from unanticipated losses. State regulation of insurance, therefore, does not reach -- or at least ought not to reach -- the plan itself. The decided cases, for the most part, have sustained that view -- although not without strenuous efforts to the contrary by various state insurance regulators.⁸

Obviously, availability of self-insured plans is not all that is needed to expand coverage to the presently-uninsured workforce (mainly working for smaller employers), but stop-loss, combined with small-group-market reform, is certainly worth a try.

CONCLUSION

The question facing Congress now is not new. I recall delivering testimony more than 25 years ago, in 1973 Senate hearings, that if the States are to legislate in this field, only chaos can result, in the absence of preemption. . . . [O]ne need only examine a recent New Jersey law on the subject to see a good example. U.S. Senate, Committee on Finance, *Hearings on Private Pension Plan Reform*, 93 Cong., 1st Sess. 1031 (1973).

The New Jersey law to which I then referred, the Private Nonvested Pension Benefits Protection Act, N.J. Laws 1973, Ch. 124, would have imposed a tax on every employer shutting

⁷See Insurance Bd. under Social Ins. of Bethlehem Steel Corp. v. Muir, 819 F.2d 408, 8 E.B.C. 1889 (3d Cir. 1987).

⁸See American Medical Security, Inc. v. Bartlett, 111 F.3d 358, 20 E.B.C. 2761 (4th Cir. 1997) (stop-loss for non-insured plans does not subject self-insured plans to state insurance regulation); Tri-State Machine Inc. V. Nationwide Life Ins. Co., 33 F.3d 309, 18 E.B.C. 1972 (4th Cir. 1994), cert. denied, 513 U.S. 11833 (1995); Safeco Life Ins. Co. V. Musser, 65 F.3d 647 (7th Cir. 1995); compare Lincoln Mut. Casualty Co. v. Lectron Prods., Inc., Employee Health Benefit Plan, 970 F.2d 206, 15 E.B.C. 2130 (6th Cir. 1992); Thompson v. Talquin Bldg. Products Co., 928 F.2d 649 (4th Cir. 1991).

down a New Jersey Plant -- a tax equal to the value of all pension accruals forfeited by employees with 15 years of service or more. Similarly, a year later California had under consideration a bill which would have mandated a cost-of-living adjustment to every pension plan operating in California. *Journal of Commerce*, Dec. 17, 1973, p.9. Minnesota had another state law on the subject, and others were sprouting coast to coast.

Once a problem is identified, an interstate competition seems inevitably to erupt --the object of which always seem to be *Amore*.≡ Many of the States are now seemingly on a rampage. Twenty-eight State legislatures are expected to take up bills this year to extend liability to health plans. *BNA Pension & Benefits Reporter*, v. 26, No. 7, p. 534 (Feb. 15, 1999). Among the states considering bills to extend malpractice liability to health plans are Arizona, California, Florida, Illinois, Maryland, Michigan, New Jersey, New York and Washington. (*Id.*). The New York Legislature has already passed four health care reform bills, including one (A.1400) which would hold health care organizations liable for wrongful denial or delay of care or payment for care which they were contractually or legally obligated to provide or cover. (*Id.* at 535).

Someone in each State legislature always seems to have a least one *Agood*≡ idea which will not work. If you abandon preemption, or simply allow it to shatter, you will see many of them enacted, and you will not like the combined result. Not one bit.

That is not a reason to enact a federal *Aoverkill*≡ statute either, driving employer-sponsored plans into termination. But just as surely it is not a reason to ignore the problems that generate the *impulse* to turn this over to the State tort-litigation system. It is simply a reason to take the problems seriously, and then to enact, cautiously, reasonable standards without being unduly burdensome. That means

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[-end-]