A ROSE BY ANY OTHER NAME: HIDING BEHIND THE "SELF-FUNDED" LABEL, STOP-LOSS INSURED ERISA PLANS ESCAPE STATE ANTI-SUBROGATION REGULATION

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ABSTRACT

Prior to the 1980s, health insurers were prohibited—uniformly in all jurisdictions—from seeking reimbursement or subrogation from personal injury recoveries. Today, health benefit providers collect over $1 billion dollars annually through seizures of personal injury recoveries meant for victims. These subrogation and reimbursement claims functionally transform tort victims into collection agents for their insurers. Unfortunately, states' common law and statutory plaintiff protections are largely preempted by federal legislation.

This note discusses the history of this policy shift over the past four decades and how common law principles and legislative intent have been largely ignored. In addition, this note examines how health insurance reimbursement and subrogation negatively impact victims of catastrophic injuries, who are never made whole, even before losing portions of their recovery to their insurer. Finally, this note proposes a practical solution for state regulators to enforce anti-subrogation policies; states should use their authority to regulate stop-loss insurers to limit a benefit plan's ability to sidestep anti-subrogation regulations.

I. INTRODUCTION

Seventeen-year-old Allison Barman was seriously injured as a passenger in an automobile accident.[1] Allison sustained severe injuries and permanent disabilities, including: extensive brain damage, short and long-term memory loss, substantial reduction in IQ, paralysis of the right hand, extreme difficulty in using her right leg, and spleen removal.[2] Allison was a beneficiary of an employee health benefit plan, functionally a health insurance

1. Sealy, Inc. v. Nationwide Mut. Ins. Co., 286 F. Supp. 2d 625, 627 (M.D.N.C. 2003).

2. *Id.*

plan, provided by her father's employer, Sealy, Inc.[3] Allison incurred over $300,000 in medical expenses immediately following the accident.[4] The Sealy employee health benefit plan paid over $225,000 towards Allison's medical bills, and additional portions were paid by a third party stop-loss insurance company insuring the Sealy plan from catastrophic losses.[5]

Subsequently, an additional recovery of $93,366.39 was available through two automobile insurance policies: the policy of the tortfeasor and her own policy.[6] Unfortunately for Allison, the Sealy employee health benefit plan included a subrogation provision.[7] This provision stipulated any funds Allison would otherwise recover for herself, such as a settlement or judgment from a tortfeasor, must first be used to reimburse the plan for medical benefit payments it already paid.[8] Notwithstanding an express recognition of the "tremendous financial, emotional, and physical losses" caused by this accident, and ignoring the reality that Allison would never be made financially whole, the court held that Sealy, not Allison, was entitled to Allison's tort recovery.[9]

While few policy holders are familiar with the concepts of subrogation and reimbursement,[10] the consequences can be shocking and devastating, particularly to the victims of catastrophic tort injuries.[11] Tort subrogation is the practice of one's health insurer taking all, or a portion of, a tort victim's recovery from a third-party, typically the tortfeasor or the

3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.* at 628.
7. *Id.*
8. *Id.*
9. *Id.* at 634.
10. The terms subrogation and reimbursement are distinct remedies but are often used interchangeably in practice. Subrogation refers to the ability of an insurer to assert a claim against a tortfeasor on behalf of the victim, while reimbursement refers to the right of an insurer to be reimbursed from a recovery. For purposes of this note, the term "subrogation" will be used to collectively refer to both strict subrogation and reimbursement. *See* Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 278 (1st Cir. 2000).
11. Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 LOY. U. CHI. L.J. 49, 49 (2008).

tortfeasor's insurer.[12] During most of the twentieth century, this practice was uniformly prohibited by every U.S. jurisdiction.[13] However, starting in the 1980s, subrogation became more routine and today is a massive profit source for health insurance providers.[14]

Despite states' attempts to regulate, many health benefit plans escape state insurance regulations—regulations which would otherwise limit or prohibit this unjust practice.[15] With the passage of the Employee Retirement Income Security Act (ERISA) and its broad preemptive powers, employer-established employee health benefit plans evade state regulations by electing to "self-fund" the plan.[16] Due to an elaborate and often confusing web of Supreme Court jurisprudence[17], employee health benefit plans are deemed self-funded, rather than insured, if the plan pays for participant benefits directly, as opposed to purchasing insurance for participants.[18] However, the distinction is misleading because most "self-funded" plans are functionally insured by purchasing "stop-loss" insurance policies—policies which protect the plan from catastrophic losses by insuring the plan itself, rather than the individual beneficiaries.[19] Because self-funded plans are not directly subject to state insurance regulations, health benefit providers exploit this illusory

12. *Id.*

13. Jonathan P. Connery, Note, *Personal Injury Victims as Insurance Collection Agents: ERISA Preemption of State Antisubrogation Laws*, 24 J.L. & POL'Y 131, 134 (2015).

14. *Id.* at 134–35.

15. *Id.* at 136–37.

16. FMC Corp. v. Holliday, 498 U.S. 52, 71 (1990).

17. *See* Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., 519 U.S. 316, 334-35 (1997) (Scalia, J. concurring) ("Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law. The rate of acceptance, moreover, has not diminished (we have taken two more ERISA pre-emption cases so far this Term), suggesting that our prior decisions have not succeeded in bringing clarity to the law.").

18. *See FMC Corp.*, 498 U.S. at 61 ("[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans.").

19. Jeffrey G. Lenhart, Article, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX REV. 615, 616 (1995).

distinction to sidestep state anti-subrogation policies.[20] The practical effect: Allison Barman's tort recovery—which would have assisted her family in providing necessary lifelong care—went instead to her employer because it had established a "self-funded" employee health benefit plan.[21]

Part II of this note explores the origins of health insurance subrogation, the effect of ERISA's preemption scheme on state anti-subrogation policies, and the regulatory vacuum created by this scheme. Part III describes how employers are structuring health benefit plans, using stop-loss insurance, to eliminate their own risks of self-funding but still exploiting federal preemption of state insurance regulation. Part IV proposes a solution for states attempting to curtail unjust subrogation by directly regulating under what circumstances stop-loss insurers can sell policies. Part V concludes this note by insisting that because the legislative intent of ERISA has been ignored, harming the individuals the legislation was intended to protect, curbing subrogation is a worthy policy interest.

II. EVOLUTION OF HEALTH BENEFIT PLAN SUBROGATION OF TORT RECOVERIES: FROM COMMON LAW PROHIBITION TO PROLIFERATION UNDER ERISA

Four decades ago, a health insurance provider seeking reimbursement from a tort victim for healthcare expenses already paid would have confounded courts, attorneys, and tort victims alike.[22] Today, health insurance subrogation is big business, providing a windfall to insurance companies in excess of $1.1 billion annually.[23] At common law, subrogation was an equitable doctrine, focused on balancing and fairly evaluating the

20. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985) ("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.").

21. Sealy, Inc. v. Nationwide Mut. Ins. Co., 286 F. Supp. 2d 625, 634 (M.D.N.C. 2003).

22. Roger M. Baron & Anthony P. Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 CREIGHTON L. REV. 325, 330 (2011).

23. *Id.* at 325.

interests of competing parties.[24] Due to the equitable, common law nature of subrogation, two common law principles thwarted initial attempts to expand subrogation to the territory of personal injury claims: the prohibition on assignment of personal injury claims and the prohibition of dividing a cause of action.[25] Furthermore, the equitable nature of subrogation significantly limited an insurer's ability to prioritize its recoupment over the rights of a tort victim.[26] However, these equitable principles quickly gave way to insurers' attempts to bypass common law prohibitions.[27]

A. Contractual Subrogation Rights and State Imposed Limitations

Insurers found in contract what was prohibited by common law—a nearly unfettered ability to create and enforce subrogation rights against their insureds.[28] Insurers began including contractual provisions in their policies expressly granting themselves subrogation rights.[29] Although subrogation by insurance companies was historically limited to property insurance, automobile insurers entered the subrogation realm in the 1960s and began inserting subrogation clauses into automobile insurance policies.[30] Even then, health insurers were hesitant to seek recovery from tort judgments.[31] This hesitation was short lived, and in 1982 the Supreme Judicial Court of Massachusetts decided the first reported case of a health insurer seeking reimbursement from a tort judgment.[32]

While the Massachusetts court, in *Frost v. Porter Leasing Corp.*, denied an insurer's subrogation rights, it nevertheless

24. Maher & Pathak, *supra* note 11, at 51.
25. Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. REV. 237, 239 (1996).
26. Maher & Pathak, *supra* note 11, at 72.
27. Baron & Lamb, *supra* note 22, at 329.
28. Maher & Pathak, *supra* note 11, at 72.
29. *Id.*
30. Baron & Lamb, *supra* note 22, at 329.
31. *Id.* at 330.
32. *Id.*

made clear this right could be created contractually.[33] Mr. Frost's health insurer paid over $20,000 in medical benefits after he was injured in a motor vehicle accident.[34] Despite claiming $600,000 in damages for him and his wife, Mr. Frost settled with the defendant for $250,000, the limit of the defendant's liability insurance policy.[35] A subsequent dispute arose when Mr. Frost's insurance company intervened and asserted a subrogation right against the judgment for benefits it already paid.[36] The court denied the insurer's claim, recognizing that "courts have not recognized implied rights of subrogation" in the area of medical insurance.[37] However, the court balked at the opportunity to issue a comprehensive denial of health insurer subrogation rights, stating: "*[I]n the absence of a subrogation agreement* between the insurer and the insured, an insurer that has paid medical or hospital expense benefits has no right to share in the proceeds of the insured's recovery against a tortfeasor."[38] Today, the type of "subrogation agreement" alluded to in the *Frost* holding is regularly included in health insurance policies.[39]

States were not, however, powerless to reign in health insurance subrogation via the traditional role of states as insurance regulators.[40] States were responsible for regulating insurance since at least 1869, when the Supreme Court held, in *Paul v. Virginia*, insurance contracts were not articles of commerce and, therefore, not subject to federal regulation.[41] Although the Supreme Court overturned its *Paul* decision in 1944, granting Congress the *authority* to regulate insurance,[42] Congress promptly elected not to assume this regulatory role.[43]

33. Frost v. Porter Leasing Corp., 386 Mass. 425, 425 (1982).

34. *Id.* at 426.

35. *Id.*

36. *Id.*

37. *Id.* at 429.

38. *Id.* at 431–32 (emphasis added).

39. Baron & Lamb, *supra* note 22, at 326.

40. JOHN G. DOBBYN & CHRISTOPHER C. FRENCH, INSURANCE LAW IN A NUTSHELL, 501 (5th ed. 2016).

41. *See* Paul v. Virginia, 75 U.S. (8 Wall.) 168, 183 (1869).

42. *See* United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 553 (1944).

43. Baron & Lamb, *supra* note 22, at 328.

Congress enacted the McCarran-Ferguson Act, clearly delegating the power to regulate insurance to the "several States"[44] and declaring "that the continued regulation and taxation by the several States of the business of insurance is in the public interest[.]"[45]

Consistent with their authority to regulate the business of insurance, many states adopted anti-subrogation policies.[46] A minority of states have wholesale prohibitions on health insurance subrogation of tort recoveries.[47] Many others have policies, either judicially or legislatively created, to mitigate subrogation's harsh effects.[48] The make-whole doctrine and the common-fund doctrine are common examples of limitations on subrogation rights.[49]

The make-whole doctrine, a common law doctrine codified by statute in many jurisdictions, is a middle of the road approach to subrogation claims.[50] The make-whole doctrine prevents an insurer from asserting its subrogation rights if the tort victim has not been "made whole."[51] Commonly, especially in cases involving catastrophic injuries, plaintiffs are never fully compensated for their losses.[52] Either the tortfeasor lacks the assets to compensate the tort victim, the tortfeasor is underinsured, or uncertainties of litigation compelled the tort victim to settle outside of court for less than full damages.[53] Subrogation in these instances is particularly unjust, causing a tort victim to be in a similar or worse financial situation after a recovery is awarded.[54] The make-whole doctrine alleviates this

44. 15 U.S.C. § 1012(a).

45. 15 U.S.C. § 1011.

46. Baron & Lamb, *supra* note 22, at 329.

47. Baron, *supra* note 25, at 237.

48. *Id.* at 238.

49. *Id.* at 249, 255.

50. *Id.* at 249.

51. Grp. Health Coop. v. Coon, 193 Wash. 2d 841, 850 (2019).

52. Baron, *supra* note 25, at 250–51.

53. *See generally* Admin. Comm. of the Wal-Mart Stores, Inc. v. Shank, 500 F.3d 834 (8th Cir. 2007); US Airways, Inc. v. McCutchen, 569 U.S. 88, 133 S. Ct. 1537 (2013); Sealy, Inc. v. Nationwide Mut. Ins. Co., 286 F. Supp. 2d 625 (M.D.N.C. 2003).

54. *See generally Admin. Comm. of the Wal-Mart Stores, Inc.*, 500 F.3d 834;

possibility by ensuring the tort victim's recovery is prioritized over reimbursing the health insurer.[55]

Similarly, the common-fund doctrine is an equitable attempt to lessen the harsh effects of subrogation of tort recoveries.[56] Under the common-fund doctrine, "a litigant or a lawyer who recovers a common fund for the benefit of persons other than himself or his clients is entitled to a reasonable attorney's fee from the fund as a whole."[57] This doctrine prevents insurers from benefiting from policyholders' tort judgments without contributing to court costs and attorney's fees, functionally avoiding "freeloading" by insurers.[58] Equity dictates insurers would be unjustly enriched collecting a tort recovery via subrogation but leaving the insured to pay the litigation bill.[59] While the common-fund doctrine essentially allows for subrogation, it requires the subrogated insurer to at least pay its fair share toward acquiring a recovery.[60]

Unfortunately, the greatest stumbling block to states' attempts at preventing unjust subrogation outcomes is a law, enacted in 1974, intended to protect employee benefit recipients.[61]

B. Legislative History of ERISA and the Unintended Consequence of a Regulatory Vacuum

When the Employee Retirement Income Security Act became law in 1974, it was championed as a win for employee benefit protections.[62] As outlined in the law itself, the legislative intent was, "in the interest of employees and their beneficiaries, . . . minimum standards be provided assuring the equitable character

US Airways, Inc., 569 U.S. 88, 133 S. Ct. 1537; *Sealy, Inc.*, 286 F. Supp. 2d 625.

55. Baron, *supra* note 25, at 252.

56. *US Airways, Inc. v. McCutchen*, 569 U.S. at 99, 133 S. Ct. at 1547.

57. *Id.* at 96, 133 S. Ct. at 1545 (internal quotation omitted).

58. *Id.*

59. *Id.* at 100, 133 S. Ct. at 1547–48

60. Baron, *supra* note 25, at 255.

61. Connery, *supra* note 13, at 166.

62. Pension Benefit Guaranty Corporation, *History of PBGC*, PBGC.GOV, https://www.pbgc.gov/about/who-we-are/pg/history-of-pbgc (last updated Aug. 17, 2020).

of such plans and their financial soundness."[63] Unfortunately, the broad preemptive language in ERISA has, at least in the health benefit plan context, caused a great deal of harm to the very employees the Act was intended to protect.[64]

ERISA's legislative history began a decade prior to the passage of the law.[65] In 1963, a Studebaker plant in South Bend, Indiana closed its doors, leaving many jobless and terminating the employee pension plans of over 4,000 workers.[66] Concerned with citizens innocently losing their retirement, Congress began an investigation into the regulation and administration of employee pension plans, culminating in the passage of ERISA.[67] Appropriately named the Employee *Retirement Income* Security Act, the primary catalyst for the Act's passage was pension plan protection.[68] Upon signing the Act into law, President Ford remarked, "[T]he men and women of our labor force will have much more clearly defined rights to pension funds and greater assurances that retirement dollars will be there when they are needed."[69]

Despite Congress's stated purpose in passing ERISA, the Act has far broader implications. ERISA applies to "any employee benefit plan if it is established or maintained by an employer."[70] This definition includes not just pension plans, but employee "welfare plans" providing medical benefits—essentially, any employee provided health insurance.[71] Unfortunately, ERISA's substantive regulations are almost entirely aimed at employee pension plans.[72] Health benefit plan regulation accounts for less than one-half of Title I's provisions, none of Title II or Title IV's provisions, while Title III focuses on jurisdiction and

63. 29 U.S.C. § 1001(a)
64. Connery, *supra* note 13, at 133–34.
65. Pension Benefit Guaranty Corporation, *supra* note 62.
66. *Id.*
67. Connery, *supra* note 13, at 133.
68. Connery, *supra* note 13, at 133–34.
69. Pension Benefit Guaranty Corporation, *supra* note 62.
70. 29 U.S.C. § 1003(a).
71. 29 U.S.C. § 1002(1).
72. Lenhart, *supra* note 19, at 618.

enforcement.[73] Scholars and courts alike acknowledge the problematic regulatory vacuum created by the combination of ERISA's broad preemption scheme and its limited health benefit regulatory framework.[74] Unfortunately, "[ERISA preemption] has unfolded in a line of Supreme Court cases that have created a 'regulatory vacuum' in which virtually all state law remedies are preempted but very few federal substitutes are provided."[75]

C. The Tangled Web of ERISA Preemption and its Impact on Health Benefit Plan Tort Subrogation

In practice, ERISA preemption is problematic because of both its expansive authority and the complex interplay between statutory clauses.[76] ERISA preemption is the most expansive preemption scheme enacted by Congress, leading to questions about its overall constitutionality.[77] Justice Thomas stated, "Until we confront whether Congress had the constitutional authority to pre-empt such a wide array of state laws in the first place, the Court—and lower courts—will continue to struggle to apply §1144."[78] In addition to being unmanageably expansive, Congress achieved ERISA preemption through three statutory clauses—clauses which seemingly contradict one another.[79] This scheme has led the Supreme Court to note, on several occasions, the preemptive provisions of ERISA are "perhaps not a model of

73. *Id.* at 618 n.15.

74. *See* Baron & Lamb, *supra* note 22, at 327 ("Notwithstanding this background, the health insurance industry has been able to seize upon the vacuum created by ERISA's preemptive effect to create the reimbursement mechanism that has the effect of crushing personal injury victims who are victimized twice—initially by a tortfeasor and then again by their own health insurer."); *see also* Aetna Health Inc. v. Davila, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring) ("Because the Court has coupled an encompassing interpretation of ERISA's preemptive force with a cramped construction of the 'equitable relief' allowable under § 502(a)(3), a 'regulatory vacuum' exists.").

75. DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 456 (3d Cir. 2003).

76. *See* Gobeille v. Liberty Mutual Insurance Company, 577 U.S. 312, 329, 136 S. Ct. 936, 948–49 (2016); *see also* GARY L. WICKERT, ERISA AND HEALTH INSURANCE SUBROGATION IN ALL 50 STATES, 5-10 (6th ed. 2017).

77. *Gobeille*, 577 U.S. at 329, 136 S. Ct. at 949.

78. *Id.*

79. GARY L. WICKERT, ERISA AND HEALTH INSURANCE SUBROGATION IN ALL 50 STATES, 5-11, 5-10 (6th ed. 2017).

legislative drafting."[80] The preemption scheme established by Congress is a legal tug of war, where Congress initially took power from the states in one clause, gave power back in another, and then retook much of what it had given back.[81]

The breadth of ERISA's preemptive power is initially established in the preemption clause.[82] The preemption clause, 29 U.S.C. § 1144(a), states: "Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a)[.]"[83] The Supreme Court has characterized the preemption clause as "deliberately expansive."[84] Although ERISA never mentions subrogation, this clause has been interpreted by courts to include the preemption of state anti-subrogation statutory and common law rules when these laws "relate to" an employee benefit plan.[85] In the legal tug of war created by ERISA's drafters, the preemption clause seemingly takes the whole rope, characterizing the regulation of employee health benefit plans as "exclusively a federal concern."[86]

With the savings clause, the drafters of ERISA next attempt to return to the states some of what was taken away in in the preemption clause.[87] The savings clause, 29 U.S.C. § 1144(b)(2)(A), states: "Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."[88] Recall when Congress enacted the McCarran-Ferguson Act, it unambiguously assigned the duty and

80. Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 67 n.* (1987) (quoting Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985)).

81. WICKERT, *supra* note 76, at 5-11, 5-10.

82. *See* 29 U.S.C. § 1144(a).

83. 29 U.S.C. § 1144(a).

84. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45-46 (1987).

85. FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990).

86. *Pilot Life Ins. Co.*, 481 U.S. at 46 (citing Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981)).

87. GARY L. WICKERT, ERISA AND HEALTH INSURANCE SUBROGATION IN ALL 50 STATES, 5-11 (6th ed. 2017).

88. 29 U.S.C. § 1144(b)(2)(A).

power to regulate insurance to the "several States"[89] and declared "that the continued regulation and taxation by the several States of the business of insurance is in the public interest[.]"[90] The McCarran-Ferguson Act and the notion that states should regulate insurance still exist today and appear to be in harmony with the ERISA savings clause.[91] Subject to the deemer clause (discussed in the following paragraph), the savings clause saves anti-subrogation laws from preemption.[92] The Supreme Court has held the savings clause to encompass anti-subrogation laws because these laws "directly control[] the terms of insurance contracts" by invalidating or limiting the effect of contractual subrogation provisions.[93] Were the legal tug of war to stop at the savings clause, the matter of subrogation regulations would fully reside with the states.[94]

Much of the confusion and litigation regarding ERISA preemption focuses on the final clause, the deemer clause, and its interplay with the savings clause.[95] The deemer clause, 29 U.S.C. § 1144(b)(2)(B) states:

> Neither an employee benefit plan . . . nor any trust established under such a plan shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.[96]

While the preemption clause is relatively easy to decipher, courts have struggled more to determine the legislative intent of Congress in enacting the savings and deemer clauses.[97] It would appear Congress intended—all within the same statute—to first take away via the preemption clause, return via the savings

89. 15 U.S.C. § 1012(a).
90. 15 U.S.C. § 1011.
91. Baron & Lamb, *supra* note 22, at 329.
92. FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990).
93. *Id.*
94. *Id.*
95. *See generally FMC Corp.*, 498 U.S. 52.
96. 29 U.S.C. § 1144(b)(2)(B).
97. *See generally FMC Corp.*, 498 U.S. 52.

clause, and again take away from the states via the deemer clause.[98]

The Supreme Court has interpreted the deemer clause as establishing a distinction between self-funded and insured employee health benefit plans.[99] An employee benefit plan which purchases insurance for its participants is an insured plan, while a plan that is fully funded by the employer is "self-insured" or "self-funded."[100] While this distinction may not be apparent to a plan participant (particularly because most self-funded plans are managed by insurance companies acting as third-party administrators) the consequences can be drastic.[101]

In *Metropolitan Life Insurance Co. v. Massachusetts*, the Supreme Court was tasked with determining if ERISA preempted a Massachusetts' minimum benefits regulations.[102] The ERISA plan at issue was an insured plan; it purchased insurance from Metropolitan Life Insurance Company for its employees.[103] The court explicitly stated that the deemer clause prohibited the commonwealth from directly regulating the plan itself.[104] The deemer clause prevents the employee health benefit plan from being "deemed" an insurance company for state regulatory purposes.[105] However, ERISA's preemption scheme prohibited direct regulation of the employee health benefit plan, not the insurance company from which the plan purchased policies for employees.[106] The commonwealth was not preempted from regulating the insurance company, Metropolitan Life, and the substance of its contracts with participants.[107] The Court recognized the creation of a distinction, stating:

98. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985).

99. *Id.* at 747.

100. *Id.* at 732.

101. Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another"*, 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 95 (2005).

102. *Metro. Life Ins. Co.*, 471 U.S. at 727.

103. *Id.* at 734.

104. *Id.* at 735 n.14.

105. *Id.*

106. *Id.* at 746.

107. *Id.*

> 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.[108]

In a subsequent decision, *FMC Corp. v. Holliday*, the Supreme Court applied this same distinction to a state anti-subrogation regulation.[109] Pennsylvania enacted an anti-subrogation statute prohibiting subrogation by health insurers of car accident victims' tort recoveries.[110] The Court, performing a preemption analysis, first reasoned that the anti-subrogation law falls under the preemption clause because it "relate[s] to" an employee benefit plan.[111] Next, the Court reasoned "[t]here is no dispute that the Pennsylvania law falls within ERISA's insurance saving clause" because it "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain."[112] However, due to the deemer clause, the statute was preempted.[113] The plan was self-funded, and therefore Pennsylvania was prohibited from deeming the plan an insurance company.[114] Since self-funded plans are not "insurance companies" under the Court's reasoning, the regulation is not saved from preemption.[115]

While the distinction between self-funded and insured plans, and its impact on anti-subrogation policies, seems settled under *Metropolitan Life* and *FMC Corp.*, the existence of "self-funded" plans, which are nevertheless insured by stop-loss policies, has created an additional layer of complexity and uncertainty.[116]

108. *Id.* at 747.
109. FMC Corp. v. Holliday, 498 U.S. 52, 56 (1990).
110. *Id.* at 55.
111. *Id.* at 58.
112. *Id.* at 60–61.
113. *Id.* at 65.
114. *Id.* at 61.
115. *Id.*
116. Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 248 (1997).

III. EMPLOYER EXPLOITATION OF STOP-LOSS INSURANCE TO SIMULTANEOUSLY AVOID RISK AND EVADE ANTI-SUBROGATION LEGISLATION

Employers are increasingly choosing to structure health benefit plans to simultaneously eliminate their risk of catastrophic losses while also evading state insurance regulations through ERISA preemption.[117] Recall, an employer can establish an "insured" health benefit plan by purchasing health insurance through a third-party insurer for their employees, or an employer can self-fund the plan by setting aside funds to directly pay employee healthcare claims.[118] The advantage of an insured plan, from the employers prospective, is the third-party insurer is liable to pay health benefits.[119] The disadvantage is the insurer is subject to state insurance regulations, which indirectly imposes regulations on the plan.[120] Conversely, self-funded plans escape state insurance regulations but disadvantage employers in that the employer bears the risk of a catastrophic injury or illness of a participant—resulting in substantial claims.[121] Employers have found a way to have their cake and eat it too by creating plans that evade regulation *and* limit their risk of loss: the stop-loss plan.[122]

A. Avoiding Risk, Avoiding Regulation, All While Ignoring Supreme Court ERISA Preemption Reasoning

An employer can elect to self-fund a health benefit plan, by directly paying claims for its employees, but avoid the inherent risks of self-funding by purchasing insurance to protect itself from liability for large claims.[123] These insurance policies, known as stop-loss policies, insure the benefit plan, rather than

117. Paredes, *supra* note 116, at 249.

118. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985).

119. WICKERT, *supra* note 76, at 4-17.

120. *Id.*

121. *See* FMC Corp. v. Holliday, 498 U.S. 52 (1990); Paredes, *supra* note 116, at 234.

122. Paredes, *supra* note 116, at 234.

123. Lenhart, *supra* note 19, at 626.

individual plan participants.[124] The amount when the stop-loss insurer indemnifies is called the attachment point.[125] Stop-loss policies can have either a specific attachment point, where the stop-loss insurer reimburses the plan when an individual participant's claims reach a certain amount, or an aggregate attachment point, where the stop-loss insurer reimburses if the total of all participants' claims reach a specified amount.[126] Many plans have both a specific and an aggregate attachment point.[127] For example, a stop-loss insurer could cover claims for any individual participant over $10,000 per year (the specific attachment point) and will indemnify if the plan's total claims are beyond $250,000 per year (the aggregate attachment point).[128] Functionally, an employer is self-funding the benefit plan up to the attachment point, and because the stop-loss insurer indemnifies the employer, the plan is insured for claims beyond the attachment point.[129]

The Supreme Court has not yet granted certiorari to hear a case regarding a stop-loss policy's effect on ERISA preemption.[130] While courts vary on how they treat stop-loss insured benefit plans,[131] with the exception of some early cases from the 1980s and early 1990s, courts uniformly agree a plan insured with stop-loss coverage is self-funded and exempt from direct state insurance regulations.[132] However, the degree in which state laws can impose indirect regulation on a self-funded plan, through regulation of the stop-loss provider, is less clear.[133]

In labeling ERISA plans that are partially funded with stop-loss policies as "self-funded," most courts have similar reasoning; unless a benefit plan purchases health insurance for

124. Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991).

125. WICKERT, *supra* note 76, at 4-22.

126. *Id.* at 4-22–4-23.

127. *Id.* at 4-23.

128. *See* Paredes, *supra* note 116, at 249.

129. *Id.*

130. *Id.* at 259.

131. *Id.* at 251.

132. *Id.*; *see* Korobkin, *supra* note 101, at 112.

133. *See* Korobkin, *supra* note 101, at 115.

participants, it is self-funded because the plan is ultimately liable to participants.[134] In other words, because the stop-loss policy insures the plan rather than plan participants, and no privity exists between the participants and the stop-loss insurer, the plan is self-funded.[135] However, even these courts have carved out hypothetical distinctions which could render a stop-loss covered plan insured.[136] In *Brown v. Granatelli*, the Fifth Circuit Court of Appeals, in dictum, noted: "If, for example, a plan paid only the first $500 of a beneficiaries' health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastrophic coverage would not mask the reality that it is close to a simple purchase of group accident and sickness coverage."[137] However, the dissent contended this distinction generates even more uncertainty by creating a sliding scale which is "unworkable as a standard for future cases."[138]

Using the binary labels "self-funded" and "insured" to categorize health benefit plans, while seemingly consistent with a cursory glance at the holdings in *Metropolitan Life* and *FMC Corp.*, ignores the Court's ERISA preemption reasoning and does not adequately apply to stop-loss insured, self-funded plans.[139] The court in *Brown*, and others that have followed, seek to characterize a plan as self-funded or insured based on the stop-loss attachment point.[140] These courts reason the status of a plan depends on the level of risk borne by the plan versus the risk that falls on the stop-loss insurer.[141] This reasoning, however, is absent from *Metropolitan Life* and *FMC Corp.*[142] In addition to

134. *See generally* Am. Med. Sec. v. Bartlett, 111 F.3d 358 (4th Cir. 1997); *see also* United Food & Commercial Workers & Emp'rs Ariz. Health & Welfare Tr. v. Pacyga, 801 F.2d 1157 (9th Cir. 1986); Bill Gray Enters. v. Gourley, 248 F.3d 206 (3d Cir. 2001).

135. *See generally Bartlett*, 111 F.3d 358; *see also United Food & Commercial Workers & Emp'rs Ariz. Health & Welfare Tr.*, 801 F.2d 1157; *Bill Gray Enters.*, 248 F.3d 206.

136. *See* Brown v. Granatelli, 897 F.2d 1351, 1355 (5th Cir. 1990).

137. *Id.*

138. *Id.* at 1356.

139. *See* Korobkin, *supra* note 101, at 115.

140. *See Brown*, 897 F.2d at 1355.

141. *See id.*

142. *See generally* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724

creating an "unworkable . . . standard for future cases," the dissent in *Brown* correctly points out the "*plan* and the *policy* may be treated differently."[143]

The Court in *Metropolitan Life* held the savings clause saved an insurance regulation (a minimum benefits law) from preemption because the law did not regulate the plan itself, but instead applied to an insurance company.[144] The deemer clause prohibits states from deeming an employer provided benefit plan as an insurer, and therefore, state regulations are preempted as applied to the plan itself.[145] However, laws regulating insurance bought by the plan are saved under the savings clause.[146] While courts and scholars have mistakenly promulgated that states have the ability to regulate insured ERISA plans, this is a misnomer.[147] The regulation of insured employee health benefit plans does not arise from a rigid self-funded plan versus insured plan dichotomy.[148] Rather, this authority is achieved indirectly through regulation of insurers providing coverage to plan participants.[149] This reasoning should be applied to stop-loss policies.[150]

B. The Open Question—To What Extent are States Permitted to Regulate Stop-Loss Insurers?

States are already regulating stop-loss insurers.[151] The most prevalent example of state stop-loss regulation is the Stop Loss Insurance Model Act created by the National Association of Insurance Commissioners (NAIC Model Act) and adopted, either

(1985); FMC Corp. v. Holliday, 498 U.S. 52 (1990).

143. *Brown*, 897 F.2d at 1357 (emphasis in original).

144. *Metro. Life Ins. Co.*, 471 U.S. at 746.

145. *Id.* at 740.

146. *Id.* at 746.

147. *See* La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys., 461 F.3d 529, 546 (5th Cir. 2006) (incorrectly citing the Supreme Courts holding in *FMC Corp*. to be: "[A state] statute would be saved from preemption to the extent that it applied to insured ERISA employee benefit plans[.]").

148. *Metro. Life Ins. Co.*, 471 U.S. at 746.

149. *Id.* at 747.

150. *See generally* Korobkin, *supra* note 101, at 115.

151. *See* STOP LOSS INSURANCE MODEL ACT (NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, 2002).

entirely or partly, in several states.[152] The substantive provisions of the NAIC Model Act limit the terms a stop-loss insurer can include in its policies. Specifically, the Act sets minimum attachment points—a $20,000 minimum specific attachment point and a minimum aggregate attachment point calculable using a set of factors, including the number of members and expected claims.[153] The purpose of the NAIC Model Act is to prevent self-funded health benefit plans from using stop-loss policies with such low attachment points that they function as direct insurance.[154] The Act survives a savings clause analysis because the law clearly regulates the business of insurance by mandating the types of policies that can be sold.[155] In fact, no state regulation based on the NAIC Model Act has been challenged in court.[156]

In addition to minimum attachment point laws, states have also enacted statutes prohibiting stop-loss insurers from selling policies to certain types of employers.[157] Statues in New York, Delaware, and Oregon prohibit the sale of stop-loss policies to health benefit plans established by small employers.[158] Self-

152. The NAIC Model Act has been adopted in a "substantially similar manner" in five states and twenty-three states have either adopted older versions of the law, similar laws, or provided other related administrative guidance. NAIC MODEL LAWS, REGULATIONS, GUIDELINES AND OTHER RESOURCES—SUMMER 2020 (NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, 2002).

153. *See* STOP LOSS INSURANCE MODEL ACT (NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, 2002).

154. While minimum attachment point regulations may deter some employers from establishing self-funded plans, and instead opt to fully insure their health benefit plan, the current levels set by the NAIC Model Act have not been adjusted for inflation or rising health care costs since its creation in 1995. Furthermore, some states have enacted similar regulations with minimum specific attachment points as low as $10,000. *See* Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539, 556–57 (2013).

155. Jost & Hall, *supra* note 154, at 562.

156. *Id.*

157. Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 27, 81 (2011).

158. Jost, *supra* note 157, at 81.

funded plans established by small employers are particularly problematic because a large number of participants are required to properly pool risk.[159] If, for example, an employer with under fifty employees establishes a self-funded plan, the employer is likely relying on stop-loss insurance to bear a majority of the risk while still evading state insurance regulations.[160] These laws, like minimum attachment point laws, function to prevent employers from benefitting from a self-funded status while transferring most or all of the risk to an insurance company.[161] The preemption analysis of these prohibition-type laws is similar to the analysis regarding the proposed regulation of this note.[162]

Until and unless Congress decides to amend its ERISA preemption scheme or the Supreme Court decides to revisit its prior holdings (either of which would be appropriate),[163] one method legislatures could utilize to reduce the practice of unjust subrogation should focus on the regulation of stop-loss insurance companies.[164] Instead of asking whether an employee health benefit plan is self-funded or insured, states should focus their attempts to limit the practice of subrogation within their jurisdictions on the following question: How can state legislatures maximize their authority to directly regulate stop-loss insurers to accomplish anti-subrogation goals?[165] Until states address this issue, employers will continue to exploit the ERISA preemption scheme—to the detriment of employees—by avoiding both state anti-subrogation policies as well as the true risks of fully self-funding health benefit plans.

159. *See* Jost & Hall, *supra* note 154, at 561–62.

160. *Id.* at 556.

161. Jost, *supra* note 157, at 81.

162. *See infra* Part IV, Section A.

163. Aetna Health Inc. v. Davila, 542 U.S. 200, 222 (2004) (Ginsburg, J. dissenting) ("I also join the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.") (internal quotes omitted).

164. *See generally* Korobkin, *supra* note 101, at 115.

165. *See* Jost, *supra* note 157, at 81.

IV. USING STOP-LOSS INSURANCE REGULATION TO REIN IN TORT-RECOVERY SUBROGATION

Because states have both the authority to regulate insurers and a public policy interest in curbing subrogation of tort recoveries, states can and should prohibit stop-loss carriers from selling policies to health benefit plans if those plans include subrogation clauses in underlying contracts. State anti-subrogation regulation of insured employee health benefit plans is already common practice, sanctioned by the Supreme Court, because states can regulate third-party insurers insuring plan participants.[166] Similarly, direct regulation of stop-loss insurers would survive a proper preemption analysis, even if the regulation indirectly impacts ERISA plans.[167] In fact, states are already regulating stop-loss carriers, however, not to the maximum permitted extent.[168] This proposed regulation would discourage subrogation by prohibiting employers from enjoying the benefit of subrogation while simultaneously avoiding the risks of self-funding.

An example of such a regulation would, in addition to providing applicable definitions and a private right of action, have language similar to the following:

> No insurer shall provide stop-loss or reinsurance coverage for a health benefit plan if the underlying contracts between the plan and the plan beneficiaries contain: (1) any provision providing for subrogation of any person's right to recovery for personal injuries from a third party or (2) any provision requiring the beneficiaries of the plan to reimburse the plan or otherwise pay back benefits paid pursuant to the plan from any recovery for personal injuries from a third party.[169]

The Proposed Regulation is targeted at stop-loss policies, and

166. *See generally* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

167. *See* Korobkin, *supra* note 101, at 136.

168. *See* STOP LOSS INSURANCE MODEL ACT (NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, 2002) (The NAIC Stop Loss Insurance Model Act has been enacted in several jurisdictions).

169. For purposes of this note, the described regulation will be referred to as the "Proposed Regulation."

it would have the desired effect of reducing subrogation of tort recoveries.

A. Survival of an ERISA Preemption Analysis

The Proposed Regulation would survive an ERISA preemption analysis, consistent with Supreme Court precedent, because it regulates insurance and applies to insurance companies.[170] The Proposed Regulation is certainly within the scope of the preemption clause, the first step of the preemption analysis, because it "relate[s] to" an employee benefit plan.[171] However, the regulation would be saved from preemption by the savings clause, and, because the regulation applies to insurance companies and not the plan itself, the deemer clause does not apply.

Recall, the savings clause saves from preemption any law which "regulates insurance."[172] Early ERISA preemption cases focused on a three-factor test to determine when a law regulates insurance.[173] These factors, which arose from McCarran-Ferguson Act jurisprudence, are: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."[174] However, the Supreme Court stated, in *Kentucky Association of Health Plans v. Miller*, that the "use of the McCarran-Ferguson case law in the ERISA context has misdirected attention [and] failed to provide clear guidance to lower federal courts[.]"[175] Justice Scalia established a clear, two-factor test for determining if a state law "regulates insurance" in the context of the ERISA savings clause; a state law regulates

170. *See generally* Ky. Ass'n of Health Plans v. Miller, 538 U.S. 329 (2003); *see also* Korobkin, *supra* note 101, at 136.

171. *See* 29 U.S.C. § 1144(a).

172. 29 U.S.C. § 1144(b)(2)(A).

173. *Miller*, 538 U.S. at 339.

174. *Id.* at 333 (quoting Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982)).

175. *Id.* at 339–40.

insurance if it is "specifically directed toward entities engaged in insurance" and "substantially affect[s] the risk pooling arrangement between the insurer and the insured."[176]

The Kentucky statute at issue in *Miller* was an "Any Willing Provider" statute, requiring health insurers to allow any health care provider to become a member of their network.[177] Essentially, the regulation prohibited insurers from entering into exclusive network arrangements with providers.[178] The ERISA preemption analysis hinged on whether the statute regulated insurance for savings clause purposes.[179] In analyzing whether the statute met the first element—whether it was specifically directed towards insurers—the opinion differentiated between laws directed towards the insurance industry and "laws of general application that have some bearing on insurers[.]"[180]

The Court rejected the argument that the statute was not specifically directed towards insurers because of the indirect impact the statute had on non-insurers, specifically, health care providers.[181] By preventing insurers from entering into exclusive network agreements with providers, the statute equally prevents providers from entering into limited network contracts with insurers.[182] However, even significant effects on non-insurers are not inconsistent with the requirement that laws saved from preemption must be specifically directed towards the insurance industry.[183] "Regulations 'directed toward' certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such regulation outside the scope of ERISA's savings clause."[184]

The Proposed Regulation would similarly satisfy the first savings-clause element because the regulation is specifically

176. *Id.* at 341–42.
177. *Id.* at 331–32.
178. *Id.* at 332.
179. *Id.* at 334.
180. *Id.*
181. *Id.* at 337.
182. *Id.* at 334.
183. *Id.* at 335.
184. *Id.* at 335–36.

directed towards stop-loss insurers.[185] The regulated entity, stop-loss insurers, would be prevented from selling polices to a non-regulated entity, employee benefit plans with subrogation provisions.[186] Functionally, the regulation would equally prevent the non-regulated entity from entering into agreements with stop-loss insurers.[187] However, the indirect consequence imposed on employee health benefit plans does not alter the regulations savings clause status—the regulated entity is still the stop-loss insurer.[188] As Justice Scalia noted in *Miller*, disabling the non-insurer entity from doing business with the regulated entity does not place the regulations outside the scope of the savings clause.[189]

An apt analogy illustrating the difference between regulation targeting the provider of a commodity and regulation targeting the consumer is state prohibitions regulating sales of tobacco to minors. In South Carolina, it is unlawful for a vendor to sell tobacco products to anyone under the age of eighteen.[190] It is also unlawful for anyone under the age of eighteen to attempt to purchase tobacco products.[191] The former is a regulation on the vendor while the latter is a regulation on consumers. If South Carolina were to eliminate the consumer prohibition, the regulation targeting vendors would still functionally prohibit a minor from purchasing tobacco. The indirect consequence the prohibition has on a minor does not alter the characterization of the regulation as one directed towards vendors. Similarly, the consequence the Proposed Regulation has on employee health benefit plans does not modify the character of the regulation as

185. *See generally id.* at 335.

186. *See generally Miller*, 538 U.S. 329.

187. *Cf. Miller*, 538 U.S. at 334 (upholding statute after acknowledging: "[T]he AWP laws equally prevent providers from entering into limited network contracts with insurers, just as they prevent insurers from creating exclusive networks in the first place.").

188. *Cf. Miller*, 538 U.S. at 335 ("[T]he effects of these laws on noninsurers, significant though they may have been, [are not] inconsistent with the requirement that laws saved from pre-emption by § 1144(b)(2)(A) be 'specifically directed toward' the insurance industry").

189. *Id.* at 335–36.

190. S.C. Code Ann. § 16-17-500(A) (1976).

191. S.C. Code Ann. § 16-17-500(F)(1)(a) (1976).

one targeting insurers.[192] Provided states do not attempt to enact a related purchaser prohibition—prohibiting employee health benefit plans with subrogation clauses from purchasing stop-loss insurance—the regulation passes the savings clause analysis.[193]

The second savings clause element—the law must substantially affect the risk pool arrangement—can be satisfied by showing a law restricts the insurers ability to enter into insurance bargains.[194] In *Miller*, Justice Scalia offered a law requiring insurance companies to pay janitors double the minimum wage as a counter example to a law that affects risk pooling.[195] Although this example is directed towards insurance companies, it is not related to the business of insurance and therefore does not satisfy the second element.[196] Rather, to pass a savings clause analysis, a law must regulate an insurance company "with respect to their insurance practices[.]"[197] The challenged regulation in *Miller*, while it did not alter or control the terms of insurance policies, it did limit with whom an insurance company could conduct business.[198] The second element was satisfied because, "[b]y expanding the number of providers from whom an insured may receive health services, [the regulations] alter the scope of permissible bargains between insurers and insureds[.]"[199]

Similarly, the Proposed Regulation would satisfy the second test as a regulation that substantially affects the risk pool arrangement between the insured and insurer.[200] Clearly, a prohibition on stop-loss insurers offering policies to certain health benefit plans relates to the business of insurance, unlike Justice Scalia's minimum wage for janitors example.[201] By

192. *See generally Miller*, 538 U.S. 329.

193. *Cf.* Korobkin, *supra* note 101, at 130–31 (proposing regulation to prohibit stop-loss insurers from selling policies to health benefit plans that do not include state mandated benefits).

194. *Miller*, 538 U.S. at 338–39.

195. *Id.* at 338.

196. *Id.*

197. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 366 (2002).

198. *Miller*, 538 U.S. at 338.

199. *Id.* at 338–39.

200. *See id.*

201. *See id.* at 338.

limiting a stop-loss provider's eligible insureds, the risk pooling arrangement is substantially affected.[202] Furthermore, proponents of subrogation justify the practice by arguing subrogation limits the liabilities of health benefit plans (and thus those savings are passed to participants).[203] A subrogation proponent asserting the elimination of subrogation rights in underlying policies does not alter the risk pooling arrangement between the insured and the insurer would be disingenuous at best.[204]

B. The Faulty Reasoning Used to Oppose Stop-Loss Regulation

The ongoing presence of state stop-loss insurance regulations supports the legitimacy of a state's authority to do so.[205] Although to a lesser extent than proposed by this note, states are already exercising their right to regulate stop-loss insurers.[206] In fact, some of these regulations (particularly those of New York, Delaware and Oregon[207]) resemble the Proposed Regulation,

202. *Cf. id.* at 338–39. (By "altering the scope of permissible bargains between insurers and insureds . . . [an] AWP prohibition substantially affects the type of risk pooling arrangement that insurers may offer. ").

203. *Compare* WICKERT, *supra* note 76, at 1-27 ("Subrogation costs not realized, or eliminated due to the erroneous application of equitable doctrines such as Made Whole or Common Fund Doctrines, are reflected in and spread over future premiums among the issuing insurer and all of the insureds purchasing the same insurance") *with* Connery, *supra* note 13, at 165 ("Any subrogation recovery depends on a number of unpredictable factors such as the provable liability of the tortfeasor, the tortfeasor's insurance policy, and the willingness of the insured to pursue the case. Even if all these factors line up favorably, extended litigation in the tort action can delay a settlement for years. Instead, insurance rates are based on 'actuarial estimates . . . [t]hey are not usually computed with any possible recovery from third-party sources in mind because the mathematical probability of such a recovery is difficult to determine.'").

204. This note does not concede that subrogation successfully reduces premiums. It is nevertheless logically inconsistent to simultaneously assert (1) subrogation is justified because it *does* affect the risk pooling arrangement in a manner that lowers premiums and (2) anti-subrogation policies *do not* affect the risk pooling arrangement and therefore fall outside the scope of the savings clause. *Contra* WICKERT, *supra* note 76, at 1-27.

205. *See* STOP LOSS INSURANCE MODEL ACT (NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, 2002).

206. *See* Korobkin, *supra* note 101, at 129.

207. *See supra* Part III, Section B.

restricting to whom a stop-loss provider can sell a policy.[208] With limited exceptions, state attempts to regulate stop-loss insurers have survived in court and have ample precedent to justify their validity.[209]

However, opponents of state regulation of stop-loss insurance often point to the Fourth Circuit decision in *American Medical Security v. Bartlett* to support the claim that ERISA preempts such regulation.[210] However, this is a poor case on which to base such a precedent because (1) the regulation at issue in this case was poorly drafted and incoherent,[211] (2) the frequently criticized court opinion was equally flawed,[212] and (3) the decision predated the savings clause clarification in *Kentucky Association of Health Plans v. Miller* and likely would have been decided differently with *Miller* as a guide.[213]

The regulation challenged in *Bartlett* was a Maryland Insurance Commissioner regulation which established a minimum attachment point for stop-loss insurers but also attempted to label stop-loss insurance policies with lower attachment points to be health insurance policies, and consequently subject to Maryland minimum coverage regulations.[214] The regulation itself is problematic because it is illogical to suggest a stop-loss policy is capable of providing medical benefits to its insured.[215] The insured of a stop-loss policy is a health benefit plan.[216] One could speculate the regulation is meant to require stop-loss providers to provide minimum benefits directly to participants—despite having no contractual relationship with participants.[217] However, this is mere speculation because the regulation does not specify what it

208. *See* DEL. CODE. ANN. tit. 18, § 7218(e); N.Y. INS. LAW §§ 3231(h), 4317(e); OR. REV. STAT. § 742.065(3)

209. *See* Korobkin, *supra* note 101, at 128.

210. *See id.* at 122–23.

211. *See id.* at 123.

212. *See id.*

213. Jost & Hall, *supra* note 154, at 562–63.

214. Am. Med. Sec. v. Bartlett, 111 F.3d 358, 362 (4th Cir. 1997).

215. Korobkin, *supra* note 101, at 123–24.

216. Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991).

217. *See* Korobkin, *supra* note 101, at 123–24.

means to label a stop-loss policy to be a health insurance policy.[218]

Furthermore, using the *Bartlett* decision to evince a state's lack of authority to regulate stop-loss insurers is unpersuasive because the decision was poorly reasoned.[219] Specifically, the opinion reads non-existent and broad-sweeping rules into ERISA jurisprudence.[220] The court erroneously reads into the holdings of *Metropolitan Life* and *FMC Corp.* a savings clause principle requiring courts to determine what the purpose and effect of a regulation is to determine if it "regulates insurance."[221] However, the Supreme Court's ERISA preemption cases never made proper intent of state regulators an elemental requirement for savings clause purposes.[222] Additionally, the court erroneously claims that "state insurance regulations may not directly or indirectly regulate self-funded ERISA plans."[223] The court should have focused on the problematic drafting of the regulation instead of applying a flawed savings clause analysis.[224]

Lastly, Justice Scalia's savings clause clarification from *Miller*, had it been decided prior to *Bartlett*, could have saved the court from its misinterpretation of what it means to be related to the business of insurance.[225] Justice Scalia made clear in *Miller* that any indirect effect a state regulation has on another entity is irrelevant in deciding which entity a regulation targets.[226] So long as the regulation is aimed towards the proper entity, it will pass a preemption analysis.[227] It is worth noting that, after the *Bartlett* decision, Maryland passed a statute following the NAIC

218. *See generally id.* at 123–25 (discussing possible interpretations of the Maryland regulation and the court's failure to specify which interpretation it adopted and struck down).

219. *See id.* at 123.

220. *See id.* at 126.

221. Am. Med. Sec. v. Bartlett, 111 F.3d 358, 360 (4th Cir. 1997).

222. Korobkin, *supra* note 101, at 125–26.

223. *Bartlett*, 111 F.3d at 361.

224. *See* Korobkin, *supra* note 101, at 125 ("The court's failure to clearly state its interpretation of what the regulation at issue actually requires suggests a lack of understanding on its part[.]").

225. Korobkin, *supra* note 101, at 123.

226. *See Miller*, 538 U.S. at 335.

227. *See id.*

Model Act.[228] The updated statute prohibited insurance companies from selling stop-loss policies with specific attachment points under $10,000 or aggregate attachment points lower than 115% of expected annual claims.[229] This statute, adjusted for inflation, is still good law in Maryland.[230]

States are already regulating stop-loss insurers, including some states limiting to whom they can sell policies.[231] Carefully drafted regulations, purposefully created not to run afoul of the savings clause, can pass a savings clause analysis while simultaneously impacting self-funded employee health benefit plans.[232] The Proposed Regulation meets this standard and would significantly inhibit the prevalence of unjust subrogation of tort recoveries by health benefit plans.

C. Impact of the Proposed Stop-Loss Regulation

Employers self-funding an employee health benefit plan while avoiding risk via stop-loss insurance is pervasive in the United States. A 2020 study found that 67% of covered US workers are enrolled in self-funded employee health benefit plans, including 23% of workers in small firms and 84% of workers in large firms.[233] This increased from only 44% in 1999.[234] Furthermore, of the workers enrolled in self-funded plans, 62% of those plans purchase stop-loss coverage.[235] Predictably, the lowest usage of stop-loss insurance for self-funded plans, 46%, is found in the largest firms, those with 5,000 or more workers.[236]

228. MD. CODE ANN., INS. § 15-129 (1999).

229. *Id.*

230. MD. CODE ANN., INS. § 15-129 (LexisNexis 2021).

231. *See* DEL. CODE. ANN. tit. 18, § 7218(e); N.Y. INS. LAW §§ 3231(h), 4317(e); OR. REV. STAT. § 742.065(3)

232. *See generally* Ky. Ass'n of Health Plans v. Miller, 538 U.S. 329, 335 (2003).

233. Kaiser Family Foundation, *2020 Employer Health Benefit Survey, Section 10: Plan Funding*, KFF.ORG, (Oct. 8, 2020), https://www.kff.org/report-section/ehbs-2020-section-10-plan-funding/.

234. *Id.*

235. *Id.*

236. *Id.*

The Proposed Regulation would function to prevent these plans, plans that are self-funded and purchase stop-loss policies, from successfully asserting subrogation rights. Recall, health benefit plan subrogation rights regarding tort recoveries are based in contract.[237] The common law largely prohibited these right but contractual clauses specifically providing for them became popular in the 1980s.[238] By prohibiting stop-loss insurers from insuring self-funded plans if they include subrogation rights in their policies, employers would have three options: Option one, an employer could elect to fully insure its health benefit plan by purchasing third party health insurance for participants. Option two, an employer could continue to self-fund its employee benefit plan, omit subrogation clauses in its contracts with participants, and continue to purchase stop-loss insurance. Option three, an employer could opt to fully self-fund their employee health benefit plan, thereby avoiding any indirect consequences of stop-loss regulation.[239]

The first option would further the goal of curbing subrogation while also protecting employers from catastrophic claim amounts. Recall, insured employee health benefit plans are indirectly subject to state insurance regulation via regulations of the insurance companies that provide their employees with policies.[240] The insurance policies covering these plan participants would be subject to existing anti-subrogation regulation.[241] Furthermore, employers would still limit their own liability because they would not be directly liable for health benefit coverage.[242] That ultimate liability would fall to the insurer.[243]

Option two, self-funding but omitting subrogation clauses in underlying contracts, would also further the goal of curbing

237. Maher & Pathak, *supra* note 11, at 72.

238. Baron & Lamb, *supra* note 22, at 326.

239. *Cf.* Korobkin, *supra* note 101, at 130 (proposing an "underlying coverage requirement" would leave employee health benefit plans with analogous options).

240. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 746 (1985).

241. *Id.*

242. WICKERT, *supra* note 76, at 4-17.

243. *Id.*

subrogation practices while allowing employers to continue limiting their liability and avoid most state insurance regulations. By continuing to self-fund employee health benefit plans, employers would continue to enjoy the flexibility of self-funding, by avoiding many state insurance regulations.[244] Employers would also still benefit from the liability-avoiding protections of stop-loss regulations.[245] However, employees would be protected from employers asserting subrogation rights while simultaneously avoiding risk.[246]

While the third option, fully self-funding an employee health benefit plan, still permits employers to include subrogation clauses in health benefit plans, the other options would likely be more desirable for many employers.[247] Obviously, any regulation on stop-loss insurers would have no impact, directly or indirectly, on an entity declining to purchase stop-loss insurance. However, many employers would find this option undesirable or lack the resources to utilize it.[248] By fully self-funding, an employer is singularly liable for health benefit claims.[249] Smaller firms lack the number of employees required to adequately pool risk and would therefore be compelled into options one or two.[250] Even amongst the largest firms self-funding their employee health benefit plans, firms that clearly have the capability of pooling risk without a stop-loss insurer, 46% still utilize stop-loss insurance.[251] Many of these firms may choose to fully self-fund; however, many would conceivably value the certainty and limited liability benefits of stop-loss insurance and chose to sacrifice contractual subrogation rights.

While the regulation of stop-loss insurance would not be a

244. *Metro. Life Ins. Co.*, 471 U.S. at 747.

245. Paredes, *supra* note 116, at 234.

246. *See generally* Korobkin, *supra* note 101, at 112 ("By hiring a TPA and purchasing stop-loss coverage with low attachment points (sometimes from the same company), self-insured EHBPs can virtually eliminate all of the costs of self-insurance while taking advantage of the beneficial regulatory treatment provided to them by virtue of ERISA.").

247. *See id.*

248. *See* Jost & Hall, *supra* note 154, at 556.

249. *See id.* at 545–46.

250. *See id.* at 556.

251. Kaiser Family Foundation, *supra* note 233.

catchall in the effort to eliminate subrogation of tort recoveries, it is both feasible from an ERISA preemption standpoint and would allow states to drastically reduce the practice. While the largest firms, firms which could truly self-fund and sufficiently pool risk, could still evade state insurance regulations, these are arguably the firms most likely to have employees in several states and would benefit the most from the uniformity that ERISA was intended to provide.[252] Fully eliminating the practice of subrogation would likely require Congressional action or the Supreme Court to radically recalibrate its ERISA preemption jurisprudence.[253] However, the Proposed Regulation is a tool states could use to curb subrogation and prevent employers from exploiting ERISA, and an arbitrary "self-funded" status, to their employees detriment.[254]

V. CONCLUSION

Lost in the *Metropolitan Life Insurance Co. v. Massachusetts* opinion and its progeny is the primary purpose of the Employee Retirement Income Security Act—the protection of employees' financial well-being. Proponents of subrogation have exploited a poorly drafted preemption scheme to justify a practice antithetical to the concept of employee financial protection. Given the lack of regard for legislative intent, it is hypocritical to assert stop-loss regulation should be preempted based on the intent of the regulator. A systematic application of the savings clause clearly allows states to regulate stop-loss insurers, even if the regulator intends to have an indirect, albeit significant, effect on employee health benefit plans.

Allison Barman, the plaintiff left permanently disabled by a

252. Korobkin, *supra* note 101, at 130.

253. *See* Aetna Health Inc. v. Davila, 542 U.S. 200, 222 (2004) (Ginsburg, J. dissenting) ("I also join the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.") (internal quotes omitted).

254. *See* Paredes, *supra* note 116, at 269 ("[C]ourts presumably promote the rights and interests of plan participants when, instead of promoting uniformity, they hold that states are not preempted from regulating a plan's stop-loss provider."); *see also* Jost & Hall, *supra* note 154, at 556 ("[S]top-loss insurance is subject to state regulation, making it a ready vehicle for policy reforms.").

tragic car accident, was never made whole. Even had she kept her entire recovery, that amount would have almost certainly been surpassed by the true costs of her injuries. But instead of her recovery assisting her and her family left to care for her, it went to reimburse her health benefit provider. Simply because her employee health benefit plan was self-funded, the make-whole doctrine was preempted. But her health benefit plan was not entirely "self-funded" in any commonsense interpretation of that phrase. The plan's liability was limited by an insurance policy. Health benefit plans established by employers should not be permitted to avoid state anti-subrogation policies by hiding behind an illusory "self-funded" status. Reining in the practice of turning tort victims into collection agents for their employers is a worthy public policy and states should enact regulation to that effect.