ILLUSORY REMEDIES: WHY LACKING OVERSIGHT AND PENALTIES LEAVE HALF THE COUNTRY WITH ONLY A SHADOW OF HEALTHCARE

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INTRODUCTION

Dawn Smith suffered for years from debilitating brain cancer, starting as her twenties ended.[1] One of the hardest parts of her war was the never-ending battle with her insurer, Cigna Health.[2] Procedures and tests prescribed by her doctors were routinely denied; her appeals were met with lacking justifications or silence.[3] These denials often came for preauthorization requests for critical care.[4] Cigna's denials blocked her from treatment regularly, including treatments that prevented her suffering from debilitating pain.[5] She recounted lying on the floor wailing in pain for hours because she could no longer afford medication for her extreme migraines after a 10,000% price hike.[6] It was not until she took her complaints to public forums in 2009 that Cigna started approving procedures and treatments that had previously been denied all the way to the final appeal.[7]

If Dawn received her insurance through an employer–sponsored plan, her legal fight for medical coverage with Cigna would proceed unlike any other litigation over contract for care.[8] If Dawn's prognosis worsened because of her denials, and even if those denials were made in bad faith, there

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[1] Mike Bryant, *The Real Story of Healthcare Denial,* ST. CLOUD INJURY LAW NEWS, LEGAL EXAMINER (Oct. 11, 2009), https://stcloud.legalexaminer.com/health/medical-malpractice/real-story-of-health-care-denial/ [https://perma.cc/MYQ5-6AUT]; *see also* Sam Stein, *Dawn Smith, Brain Tumor Victim: How Her Story Became Rallying Cry For Health Care Reform Supporters*, HUFFPOST (May 25, 2011), https://www.huffpost.com/entry/dawn-smith-brain-tumor-vi_n_309797 [https://perma.cc/JM27-3DTA].

[2] Mike Bryant, *supra* note 1.

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] *Id.*

[8] Peter K. Stris, *ERISA Remedies, Welfare Benefits, And Bad Faith: Losing Sight of The Cathedral*, 26 HOFSTRA LAB. & EMP. L.J. 387, 396–98 (2009).

are few repercussions her insurer would face.[9] If Dawn sought a remedy for her wrongful denials, she would have to go through the insurer's internal appeal process, like she did, before she could bring a claim against her them.[10] Then she would have to go through an external review process.[11] Since that did not work, if she took Cigna to court, assuming she received her Cigna care through her or a family member's employer, she would be able to recover, with near certainty, zero dollars outside the cost of the originally denied care.[12]

The confounding lack of remedy is due to a three-part wall.[13] Each layer interlocks, reinforcing the others:[14] (1) damages immunities—insurers of employer-sponsored plans are generally only subject to equitable remedies and are not exposed to consequential or punitive damages;[15] (2) consulting physician malpractice immunity—the doctors that insurers hire to determine if a claim is medically necessary are treated solely as fiduciaries to the plan, avoiding a meaningful duty of care as a medical doctor to the patient-claimant;[16] (3) and, finally, a complex system of express, reverse, and implied preemption, where states are charged with creating insurance regulations and monitoring mechanisms but have no enforcement powers—resulting in a bizarre, rigid regulatory terrain.[17]

Dawn's story begs the questions: How often are claims denied? What happens when they are? How have things changed since her case? Lastly, what can be done to keep her story from repeating today?

Over 178,000,000 Americans received healthcare plans through employers in 2021.[18] This means over one-half of Americans receive

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[9] *See id.; see* Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004).

[10] *See* Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083, 1088 (9th Cir. 2012) ("As a general rule, an ERISA claimant must exhaust available administrative remedies before bringing a claim in federal court.")(citation omitted); 29 U.S.C. § 1133 (2022); *see also* 1 WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 8.04(e)(i) (Matthew Bender, ed., 2d ed. 2022).

[11] *See Bilyeu,* 683 F.3d at 1088; *see* BARKER & KENT, *supra* note 10.

[12] *See* Peter K. Stris, *supra* note 8, at 396–98.

[13] *See Aetna Health Inc.,* 542 U.S. at 208–09; *see* Skelcy v. United Health Grp., Inc., 620 F. App'x 136, 143–44 (3d Cir. 2015); *see* CIGNA Corp. v. Amara*,* 563 U.S. 421 (2011).

[14] *See Aetna Health Inc.* 542 U.S.; *see* Skelcy v. United Health Grp., Inc., 620 F. App'x 136 (3d Cir. 2015); *see* CIGNA Corp. v. Amara*,* 563 U.S. 421 (2011).

[15] *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 53–54 (1987)

[16] *See* Pegram v. Herdrich, 530 U.S. 211, 222–25 (2000); *Skelcy*, 620 F. App'x at 140, 143–44.

[17] *See* Peter K. Stris, *supra* note 8*; see generally* Terry L. Corbett, *Operationalizing the Healthcare Benefit Corporation,* 24 J. HEALTHCARE L. & POL'Y 267 (2021) (describing the issues treating doctors as fiduciaries raises regarding insureds' access to care).

[18] *See* KATHERINE KEISLER-STARKEY & LISA N. BUNCH, U.S. CENSUS BUREAU, HEALTH INS. COVERAGE IN THE UNITED STATES: 2021 3–4 (2022). The term *employer* does not include all governmental employers, but excludes TRICARE recipients and generally other government employees who receive their health insurance from a direct government fund. *Id.* Additionally, the term may still cover government contractors who are subcontracted or where a government entity outsources their funding for care to an insurance company. *Id.*

healthcare through an Employee Retirement Income Security Act (ERISA) of 1974 protected plan.[19] *Protected* is misleading because it implies employee benefits are being protected; however, ERISA primarily ensures that benefit sources, insurers, and employers are secure.[20] Proponents of ERISA argue that it protects employee–consumers and their dependents by ensuring access to their benefits.[21] ERISA guarantees access through essentially two mechanisms: solvency and standardization.[22] The Act is meant to ensure the institution that provides benefits does not go bankrupt, whether that be a pension fund or a healthcare plan, and to reduce multi-state employers' administrative burdens.[23] With protecting benefactor stability as a guiding principal, a half-century long train of legislation and litigation has made ERISA a safe haven for the largest insurance companies, employers, and unions to provide insurance beneficiaries a fraction of what they are owed.[24]

Cloaked in the safety of legislation and precedent, insurers can avoid covering claims because the penalties for breaching their duties are far cheaper than performing them.[25] But there is an additional major barrier to resolution for wrongfully denied beneficiaries besides the three layer system of immunities and preemption that is responsible for the perverse incentive insurers have to wrongfully deny claims:[26] no entity tracks the prevalence of ERISA health plan claims denial.[27] The lack of monitoring makes the prevalence of wrongful claim denial impossible to know with certainty. Worse, the selective reporting that is available is voluntary, making it high risk for cherry-picked data that masks issues.[28]

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[19] *Id.* (2021 Census Bureau report on health insurance coverage, estimating 54.3% of the country receives health insurance from an employer).

[20] *See* Sharon J. Arkin, *Tort Actions Against Health Maintenance Organizations and Their Doctors*, 23 WHITTIER L. REV. 609, 609–12 (2002); Matthew G. Vansuch, *Not Just Old Wine in New Bottles: Kentucky Ass'n of Health Plans, Inc. v. Miller Bottles a New Test for State Regulation of Insurance*, 38 AKRON L. REV. 253, 267–68 (2005).

[21] Sharon J. Arkin, *supra* note 20; Matthew G. Vansuch, *supra* note 20.

[22] Lee Black, *ERISA: A Close Look at Misguided Legislation*, 10 J. OF ETHICS AMA 307, 307 (2008); *see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001 (1974).

[23] *See* Peter K. Stris, *supra* note 8, at 387.

[24] See Sharon J. Arkin, *supra* note 20 (the primary statutory complaints raised by this article pertaining to accessible tort actions remain essentially untouched); *see also* 29 U.S.C. §§ 1001–1461 (1974); *see* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016) (one of the most recent landmark ERISA cases pertaining to health insurance reporting and describing the judicial lack of interest or ability to change ERISA policy).

[25] *See infra* discussion section (II)(A).

[26] *See* Aetna Health Inc. v. Davila, 542 U.S. 200, 208–09 (2004); *see* Skelcy v. United Health Grp., Inc., 620 F. App'x 136, 143–44 (3d Cir. 2015); *see* CIGNA Corp. v. Amara*,* 563 U.S. 421, 439–40 (2011).

[27] *See generally* EMP. BENEFITS SEC. ADMIN.(EBSA), REPORTING AND DISCLOSURE GUIDE FOR EMPLOYEE BENEFIT PLANS (2017), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/reporting-and-disclosure-guide-for-employee-benefit-plans.pdf [https://perma.cc/DRT2-U35Z] [hereinafter EBSA REPORTING GUIDE]; see *infra* discussion section (II)(C).

[28] EBSA REPORTING GUIDE *supra* note 27; *see* U.S. GOV'T ACCOUNTABILITY OFF., GAO-11-268, PRIVATE HEALTH INSURANCE DATA ON APPLICATION AND COVERAGE DENIALS 10 (2011) ("In overseeing insurer activity, states vary in the data they require insurers to submit on denials and internal appeals of denials.").

Many regulated markets are largely untracked by the government; where the general principal is injured parties are best situated, with the help of plaintiffs' attorneys, to police tortious actors.[29] Private actions in for torts ranging from products liability to malpractice also can provide gauge of the general health of a given industry.[30] Using private court actions as an unofficial tracking mechanism for ERISA health insurance claims is severely inhibited for a number of reasons, including the traditional barriers to initiating a lawsuit.[31] ERISA health insurance claims, leave individuals to fend for themselves, but limited remedies and party asymmetry make it much different.[32] ERISA provides a statutory scheme of enforcement to ensure certainty and standardization; but it appears, instead, to have stripped over half the health insurance market of meaningful accountability.[33] Ultimately, in exchange for insurer financial protection, over one hundred seventy eight million Americans are granted only as much healthcare certainty as they can afford out of pocket. For many insureds, this means paying for the privilege of extremely limited access to healthcare, despite consumer protection efforts.[34]

Consumer protection aspects of ERISA have accumulated over the years, especially in the last twelve years since Dawn's story.[35] But as this Note will show, protections, old or new, are undercut by shifted terms, special immunities, institutionalized opacity, and a strict scheme of preemption.[36] It boils down to this: you can make all the rules in the world, but if there are no punishments, or, if punishments are never enforced, then those rules really have no legal effect—they are mere formalities.[37]

The level of immunity from harm enjoyed by insurers results in an economic terrain where bad faith denials of health insurance claims do not only occur but appear to be the standard.[38] There may even be a conflict of responsibilities for insurance company leadership between providing care as

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[29] *See generally* VICTOR E. SCHWARTZ ET AL., POSER, WADE, AND SCHWARTZ'S TORTS (14th ed. 2020); *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[30] VICTOR E. SCHWARTZ ET AL, *supra* note 29.

[31] *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[32] EBSA REPORTING GUIDE, *supra* note 27; *see* Lee Black, *supra* note 22.

[33] Lee Black, *supra* note 22; Sharon J. Arkin *supra* note 20*; see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1131-1136 (1974) (detailing civil and criminal penalties available, who can enforce them, and when they can be enforced).

[34] *See* KATHERINE KEISLER-STARKEY & LISA N. BUNCH, *supra* note 18; Peter K. Stris, *supra* note 8.

[35] *See generally* 29 U.S.C. §§ 1001–1461 (2022). *See also* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, § 1, 110 Stat. 1936 (codified at 42 U.S.C. § 210 (2003)); *see also* The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718 (2010).

[36] *See* Aetna Health Inc. v. Davila, 542 U.S. 200, 208–09 (2004); *see* Skelcy v. United Health Grp., Inc., 620 F. App'x 136, 143–44 (3d Cir. 2015); *see* CIGNA Corp. v. Amara*,* 563 U.S. 421, 439–40 (2011).

[37] *Contra* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 323 (2016) ("These various requirements are not mere formalities.").

[38] Peter K. Stris, *supra* note 8, at 396–98.

their plans describe and engaging in shareholder primacy.[39] When fines are significantly less costly than the bad behavior is profitable, which obligation controls behavior?

After decades of litigation and legislation, the insurers' position has mostly improved, while patients find dwindling avenues for meaningful redress.[40] The United States Supreme Court has heard cases challenging every one of ERISA's prongs described here, and without fail, have upheld the insurers' interests typically in near unanimous decisions.[41] Individual states have little they can affect. The only avenue for long-term, system-wide correction for this issue, is through federal legislation. That legislation must remove immunity from penalties and get doctors back into the business of considering patients first.

In addition to legislation, a more readily achieved resolution, would require no additional legislation. ERISA gives the federal government the ability to request information from insurers.[42] The Department of Labor—the federal agency delegated with enforcing employee benefits—could enact a claim denial reporting system, as is done for Medicare,[43] for ERISA plans immediately.[44] That information would make obfuscating insurance malpractice much more difficult and would illuminate the severity of the issue. Currently, without meaningful remedies, ERISA's hulking patchwork of regulation will remain mere suggestions, and insureds will continue to rely on a massive illusion.[45]

This Note will argue that, outside of sweeping reform or an exodus from ERISA markets, the best solutions to these issues would be through modifications to the Department of Labor's denial reporting requirements, as well as surgical repeals and modifications to existing sections of the Act, removing the cancerous lines that have metastasized throughout the American healthcare system.[46]

Part I of this Note will describe the history and rationale behind ERISA health insurance and where it is today in a post-Affordable Care Act

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[39] *Id.*

[40] *See Id.* at 396–98; *see* BARKER & KENT, *supra* note 10, § 8.04(b)(ii).

[41] See *Pegram*, 530 U.S. 211 (2000); *Gobeille*, 577 U.S. at 312; *Aetna Health Inc.*, 542 U.S. at 200; *CIGNA Corp.*, 563 U.S. at 421; *Humana Inc.*, 525 U.S. at 299; *PacifiCare Health Sys.*, 538 U.S. at 401; *Metro. Life Ins. Co.*, 554 U.S. at 105.

[42] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1027 (2024).

[43] Karen Pollitz et al., *Claims Denials and Appeals in ACA Marketplace Plans in 2020*, KAISER. FAM. FOUND. (Jul. 5, 2022), https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans [https://perma.cc/7JJC-89DE].

[44] *Id.*

[45] U.S. DEP'T OF LAB. & U.S. DEP'T OF HEALTH AND HUM. SERV., REPORT TO CONGRESS ON A STUDY OF THE LARGE GROUP MARKET 5 (2011).

[46] *Id.*

(ACA) world.[47] It will also discuss basic economic theory necessary to contextualize the effects of ERISA regulation. Part II will detail each layer of the underlying problem—including immunities, physician fiduciaries, lacking transparency, and preemption. Part III will analyze the impact of the of the issues within the contextual framework outlined in Part I. Part IV will propose legislative and administrative solutions to correct the issues, with feasibility and efficacy as guiding principles. Finally, Part V will summarize and conclude by describing the state of negligence within the health insurance market and for action in its opposition.

I. BACKGROUND

A. Overview of ERISA

ERISA is highly technical and vast.[48] It covers all forms of employee benefits and has been added to for decades.[49] Major bills like the Affordable Care Act (ACA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) extensively modified and added to ERISA.[50] The issues raised in this Note mostly live in the high limbs of ERISA's giant tree of legislation. To understand the relevant issues, therefore, a cursory understanding of the roots and trunk of ERISA—in other words, its conceptual foundation—is necessary.

Congress established ERISA in 1974 to cure legal constraints arising from the growing number of companies that had offices and employees spanning numerous states. [51] Thanks to advances in communications and travel, like the interstate highway system, rail, and telecommunications, the world had become much smaller.[52] However, expanding businesses also increased employers' legal landscape creating difficulties; each state had its own standards for many forms of employee benefit plans—including pension funds, stock options, termination benefits, health insurance, disability, and

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[47] *See generally* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001; *see generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[48] *See* Lee Black, *supra* note 22 ("ERISA is a complex law that uses somewhat ambiguous language to set up what is, essentially, a skeletal regulatory system for employer-sponsored health plans.").

[49] *See History of EBSA and ERISA*, EMP. BENEFITS SEC. ADMIN., https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/history-of-ebsa-and-erisa [https://perma.cc/DG4G-LHHJ] (last visited Feb. 8, 2024).

[50] *See also* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, § 1, 110 Stat. 1936 (codified at 42 U.S.C. § 210 (2003)); *see* The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718 (2010).

[51] 29 U.S.C. § 1001(a) (1974). ("The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate . . . .")

[52] *Id.* at § 1001; *See* M. Ayhan Kose & Ezgi O. Ozturk, *A World of Change*, 51 INT'L MONETARY FUND FIN. & DEV. 6, 7 (2014).

life insurance.[53] ERISA was, therefore, meant to consolidate employee benefit requirements under a uniform code, encouraging interstate commerce.[54]

Understanding ERISA's broad scope is important because, in many cases, legislation or rulings in one covered area have unintended consequences on the other areas. It helps explain some of the thought processes behind seemingly irrational points of law. Even at its origin, ERISA showed irrational consequences by broadly interpreting "employee benefits."[55] Pension plans were the primary mode of retirement saving in the 1970's when the bill was enacted.[56] The concept of a pension plan is simple: employees make contributions over their tenure.[57] The plan is managed like a hedge fund, accruing interest overtime; and once a person retires, they receive regular payments, typically, until they die.[58] If a plan were mismanaged, even fraudulently, and an injured party sued and won, a large award may bankrupt the plan.[59] That effect could be catastrophic for the rest of the plan beneficiaries. To balance justice for aggrieved beneficiaries and the threat of a pension fund's solvency, ERISA set out strict reporting systems and statutory penalties for wrongful behavior.[60]

The same concept of balancing interests of aggrieved beneficiaries and other beneficiaries was applied to welfare benefits plans, which include health, disability, and life insurance.[61] There are a few key differences between retirement savings and welfare benefits plans, namely health insurance. Pension funds are significantly more straightforward than health insurance.[62] Pension plan participants make contributions, which then must be invested by in specified, sufficiently safe categories of holdings; retirees then pull prescribed amounts of benefits based on their previous contributions.[63] If employer plans fail to report, or show errors, they are

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[53] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001(a); *see* Lee Black, *supra* note 22.

[54] 29 U.S.C. § 1001(a).

[55] Matthew G. Vansuch, *supra* note 20.

[56] *See* Regina T. Jefferson, *Rethinking the Risk of Defined Contribution Plans*, 4 FLA. TAX REV. 607, 612 (2000) ("When ERISA was enacted, defined benefit [one type of pension plan] was the predominant [retirement] plan type.").

[57] *Id.*

[58] Eric Whiteside, *How Do Pension Funds Work?,* INVESTOPEDIA (Apr. 29, 2022) https://www.investopedia.com/articles/investing-strategy/090916/how-do-pension-funds-work.asp [https://perma.cc/D62M-F6BG].

[59] *Id.*

[60] 29 U.S.C. § 1001 (b); KATHRYN MOORE, UNDERSTANDING EMPLOYEE BENEFITS 6 (2nd ed., 2020); see Peter K. Stris, *supra* note 8.

[61] 29 U.S.C. § 1001 (1974); see MOORE, *supra* note 60; see Peter K. Stris, *supra* note 8.

[62] *See* Eric Whiteside, *supra* note 58.

[63] *Id.*

exposed to fines.[64]

Health insurance, on the other hand, is anything but simple. For a claim to be covered, the insurer must determine if the procedure or medical device is medically necessary, which requires the opinion of medical professionals;[65] when they disagree, who determines which opinion controls what an insurance company must pay for? Additionally, ERISA welfare benefits fines are restricted to much smaller sums than those available for other benefit plans.[66] Typically, fines are no more than $100 a day for failing to furnish plan information for more than thirty days after a proper request.[67] The fairly insignificant amount of these fines for not sending plan information also raises the fair question: *so what*? In essence, the civil enforcement structure through fines does little more than push insurers to give someone the contractual language letting them know if they are being wrongfully denied but does little once they are equipped with that knowledge.[68]

Speaking on ERISA fines, in *Gobeille v. Liberty Mut. Ins. Co.*, Justice Kennedy, writing for the majority, noted the mandates are serious and implied there was a steep price for noncompliance: "These various requirements are not mere formalities. Violation of any one of them may result in both civil and criminal liability."[69] What he failed to mention, however, is that the standard for criminal action requires a willful state of mind, the most difficult *mens rea* to prove, and that civil risks were few, as this Note will demonstrate.[70]

B. Plan Types

Health insurance plans in the U.S. break down into three main categories: public, private individual, and group.[71]

Public plans are sponsored by either the local or the federal government.[72] They can be further broken down into entitlements like Medicaid and government-as-employer programs like TRICARE.[73] Although TRICARE, personal private, ACA market plans, religious

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[64] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1131-1136 (detailing civil and criminal penalties available and their enforcement mechanisms).

[65] *See* 29 C.F.R. §§ 2590.715-2719 (2022); *see also* Karen Pollitz et al., *supra* note 43.

[66] 29 U.S.C. §§ 1131-1136.

[67] *Id.*

[68] *See* EBSA REPORTING GUIDE, *supra* note 27.

[69] Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 323 (2016).

[70] *See id.*; *see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1131–1136.

[71] *See* KEISLER-STARKEY & LISA N. BUNCH, *supra* note 18.

[72] *Id.* at 3.

[73] *Id.*

organization insurance, and Veterans Affairs may be offered as an employee benefit, they do not fall under ERISA.[74] However, some government employee healthcare plans do fall under ERISA.[75] But, determining if a government employee plan qualifies for ERISA requires more facts than private sector employee plans.[76] For this Note, it is important to understand is that a portion of government employees and contractors have ERISA healthcare, contributing to the total usage.[77]

Plans bought by individuals on the private market tend to be more expensive than group plans that are typically offered by associations like a chamber of commerce or an employer—a distinction that encompasses unions for the purposes of ERISA.[78] Employer group plans typically have the lowest private market premiums because employers provide human resources efficiencies, saving insurers considerable cost.[79] Those savings, along with tax credits, are efficiencies employers can leverage to functionally pay their employees more at a lower cost to the company.[80] These savings are one reason for ERISA health plan prevalence.[81]

Employer sponsored plans branch into two categories: fully-funded and self-funded.[82] Fully-funded plans are the more typically thought of version of a group health insurance plan.[83] In a fully-funded plan, an employer contracts with an insurer to provide their staff insurance.[84] The

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[74] *See* Alan M. Levine, *ERISA Title I Fundamentals*, LEXISNEXIS, https://www.morrisoncohen.com/siteFiles/files/ERISA%20Title%20I%20Fundamentals.pdf [https://perma.cc/773Q-REU8] (last visited Apr. 10, 2024).

[75] BARKER & KENT, *supra* note 10, § 8.04(b)(ii).

[76] *Id.* It must be determined if the instrumentality of employment pulls more into the private or public sector, through a six factor test: (1) whether the instrument is for a government purpose; (2) whether performance is on behalf of multiple political subdivision; (3) whether private, state, or political subdivisions have ownership interests or powers; (4) whether control and supervision is under a public authority; (5) whether express or implied statutory authority is necessary for creation and use; and (6) the degree of financial autonomy and source of operating expenses. *Id.*

[77] *See Id.*

[78] See Corbett, *supra* note 17. Unions are a special case because unions do not *employ* all their members. *Id.* But unlike a normal association, they are considered an employer, larger unions may self-insure or seek a fully-funded plan option for their members. *Id.* The union intersection with ERISA provides a considerable wrinkle, in the ERISA landscape. *Id.* What is important to understand for this Note, is how it impacts ERISA prevalence. *Id.* Unions hold a major share of the U.S. labor market and the related health insurance market share. *Id; see* Luke Petach & David K. Wyant, *The Union Advantage: Union Membership, Access to Care, and the Affordable Care Act*, 23 INT'L J. HEALTH ECON. & MGMT. 1, 2 (2023).

[79] Corbett, *supra* note 17.

[80] *See* GARY CLAXTON ET AL., EMPLOYER HEALTH BENEFITS: 2022 ANNUAL SURVEY KEISER FAM. FOUND, 30 (2022).

[81] KEISLER-STARKEY & LISA N. BUNCH, *supra* note 18, at 3, 4; *see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1181–1191(d). 26 I.R.C. § 5000 (2022)

[82] CLAXTON ET AL., *supra* note 80, at 163. For the purposes of this Note, fully-funded plans are also known as *insured or fully-insured* plans. To reduce confusion between insured, and insureds or the state of being insured this paper uses the fully-funded terminology.

[83] KEISLER-STARKEY & LISA N. BUNCH, *supra* note 18, at 3–4

[84] CLAXTON ET AL., *supra* note 80, at 9.

advantages the insurer receives from having a captive client base, that is at least healthy enough to work, and from having certain administrative functions performed by the employer's internal human resource departments, are traded back in part to the employer and the employees through reduced rates.[85]

Self-funded or self-insured plans are those where the employer will foot the bill for any covered medical expenses, but employers typically use a health insurance company to perform the administrative duties required to manage an ERISA plan.[86] Self-funded companies present many of their own problems for employees, because they are not subject to nearly any state law governing insurance.[87] Rather, they are completely covered by ERISA, giving them an extreme amount of leeway in determining acceptable coverage.[88] Self-funded plans have few bounds other than those written into the terms of their plans,[89] whereas when an insurance company is the actual insurer, a fully-insured plan, they are bound by some state laws that may mandate certain minimum standards.[90]

This Note will predominantly address issues arising from fully-funded plans. While all the issues discussed apply to self-funded plans, it is important to distinguish between the incentive structures for self-funded firms, and insurance companies.[91] In a self-funded plan, the claim administrators, which are typically actual insurance companies, are compensated through a fee system instead of a premium structure.[92] It is not clear if this actually has a large impact on claims outcomes.[93] To draw a connection between claim denials and the compensation structure for claim administrators requires consideration of many more market incentive, which is a task beyond the scope of this Note.[94] Accordingly, this Note narrows its focus on fully-funded plans, where the incentives are much more bare.[95]

C. Claims and Denials

Essential to this Note are the basic concepts of claims for coverage and their subsequent denials. Unlike most other forms of insurance,

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[85] KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 383–84 (7th ed. 2020).

[86] *Id.; see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1181–1191(d).

[87] ABRAHAM & SCHWARCZ, *supra* note 85; *see* 29 U.S.C. §§ 1181-1191(d).

[88] ABRAHAM & SCHWARCZ, *supra* note 85, at 400.

[89] *Id.*

[90] *Id.*

[91] *Id.*

[92] *Id.*

[93] Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 114 (2008).

[94] ABRAHAM & SCHWARCZ, *supra* note 85, at 400.

[95] *Id.*

healthcare coverage includes the function of access to routine and preventative care.[96] This quality creates a strange adjustment to the concept of a claim. Normally, in the insurance context, a claim is a reactive measure.[97] For example, in the context of homeowners or automobile owners insurance, when calamity strikes and a new roof or bumper is needed, the insured files a claim outlining what happened that an adjuster reviews to determine if the claim has merit under the terms of the relevant policy.[98] Health insurance claims, however, include, *inter alia*, regular doctor checkups and medical testing, which do not occur sporadically but are considered a routine aspect of health care.[99]

Claims for medical coverage can be described under two general categories: post care and prior-authorization .[100] Post care refers to any care that is written in the plan as approved or that is approved by law and a claim for it is filed after the care or product is provided.[101] This may cover routine care like an annual check-up, limited discretionary coverage (i.e., care assumed covered up to X amount during a Y period), and emergency services.[102] For more expensive, elective, or repeat care within a certain time frame, plans require prior-authorization.[103] Prior-authorization is coverage that requires the insurer to approve coverage before the insured receives care.[104] When prior-authorization is denied, patients must choose between paying out of pocket, assuming they even can, for care like medical tests that may bring positive or negative results, or they can save their money and hope for the best.[105] A tendency to avoid care is not entirely irrational if the potential debt from that care would jeopardize a person's food or shelter security, putting them in the "*what will kill me faster"* dilemma.[106]

Unfortunately, there is not currently a reliable source for national claim denial prevalence in ERISA markets.[107] While the Centers for

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[96] *Id.* at 383.

[97] *Id.*

[98] *Id.*

[99] *Id.*

[100] *See Preauthorization,* HEALTHCARE.GOV, https://www.healthcare.gov/glossary/preauthorization/ [https://perma.cc/3N4S-RJCD] (last visited Apr. 10, 2024).

[101] *See* Haley Sweetland Edwards, *How You Could Get Hit With a Surprise Medical Bill,* N.Y. TIMES (Mar. 7, 2016, 2:38 PM EST) https://time.com/4246845/health-care-insurance-suprise-medical-bill/ [https://perma.cc/QV9Y-TSLC].

[102] *Id.*

[103] See EBSA REPORTING GUIDE, *supra* note 27.

[104] *See* HEALTHCARE.GOV, *supra* note 100.

[105] *See* Karen Pollitz et al., *supra* note 43 (analyzing CMS data on Healthcare.gov market plans' claim denial data and finding less than one percent of claims were appealed).

[106] *See* Mark Henricks & Kim Porter, *Medical Bankruptcies: Can You File for Bankruptcy Over Medical Bills?* FORBES (Aug. 11, 2022, 4:00 PM), https://www.forbes.com/advisor/debt-relief/medical-bankruptcies/ [https://perma.cc/R4Y4-X79S].

[107] *See Infra* discussion section (II)(C).

Medicare and Medicaid Services (CMS) have instituted denial reporting in a systematic manner, it does not include private markets.[108] Thirty states have all payer reporting programs, but the data they capture is not consistent state-to-state.[109] Additionally, in 2016, the United States Supreme Court held in *Gobeille v. Liberty Mut. Ins. Co.* that states could ask for reporting information, but they could impose no penalties on ERISA plans for non-compliance.[110] Loose reporting requirements have also led to difficulty for private sector research groups struggling to provide consistent denial information in such a fragmented market.[111] Various research group estimates range from as low as four percent to thirty percent being denied in employer–sponsored markets.[112] These numbers can be even worse when inclusive of ignored, delayed, or lost claims.[113]

A Kaiser Foundation report from 2022 analyzed transparency data released by the CMS on claims denials and appeals for non-group qualified health plans offered on HealthCare.gov.[114] While this data is not from the employer–sponsored market, it is the most reliable data available to provide a clearer, albeit still incomplete, snapshot of the denial landscape.[115] HealthCare.gov insurers denied over eighteen percent of in-network claims.[116] The reasons for denials were broken into the following categories:

a. Denials due to lack of prior authorization or referral,
b. Denials due to an out-of-network provider,
c. Denials due to an exclusion of a service,
d. Denials based on medical necessity (reported separately for behavioral health and other services), or
e. Denials for All Other Reasons.[117]

By far the most common reason for denials was "all other reasons."[118] These denial reason categories are applicable to group plan denials, and the companies that administer Medicare and Medicaid plans are companies that

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[108] *See* EBSA REPORTING GUIDE, *supra* note 27; *see also infra* discussion section (II)(C).

[109] KATHERINE GRACE CARMAN ET AL., THE HISTORY, PROMISE AND CHALLENGES OF STATE ALL PAYER CLAIMS DATABASES: BACKGROUND MEMO FOR THE STATE ALL PAYER CLAIMS DATABASE ADVISORY COMMITTEE TO THE DEPARTMENT OF LABOR 1 (Jun. 2, 2021), https://home.treasury.gov/policy-issues/financial-markets-financial-institutions-and-fiscal-service/federal-insurance-office/about-fio [https://perma.cc/9NKS-U82U].

[110] *See* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 323 (2016).

[111] U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[112] *Id.*

[113] *Id.*

[114] Karen Pollitz et al., *supra* note 43.

[115] *Id.*

[116] *See id.*

[117] *Id.*

[118] *Id.*

also manage large group plans, like Blue Cross Blue Shield and Cigna. The necessary elements for a denial tracking system to function are already in place, showing that denial tracking could be readily incorporated for ERISA plans. [119]

Following the CMS data, seventy percent of internal claim appeals were completely successful, but less than one percent of denials were appealed.[120] It is possible that the reason for appeal success prevalence is that unreasonable denials are so rare that the small percentage of wrongful denials are easy to catch; however, more likely, the rarity of appeals themselves points to issues of inertia and completely asymmetrical competition between insurers and insureds.[121]

D. Economics and Incentives

Basic economic doctrine has held for centuries that firms and individuals act in their interest.[122] While the more recent field of behavioral economics has cast some doubt on the uniformity of firms' and individuals' ability to act rationally, the basic concept still holds.[123] Firms and individuals take actions because they feel that the value or utility of the outcome will outweigh the cost or opportunity cost expenditure of the act.[124] In other words, people do not cheat on their taxes or steal because the penalties and social costs, multiplied by a probability of being caught, outweigh the perceived benefits—at least for some. And people do things like purchase cars because the utility they bring outweighs the cost.[125]

The larger a group is, the more interests that become relevant.[126] This is especially true in policymaking.[127] The increasingly peripheral interests are referred to as externalities.[128] Classic examples of weighing externalities are

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[119] *Id.*

[120] *Id.*

[121] Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Healthcare: The Case for Managed Federalism*, 23 AM. J. L. AND MED. 251, 265-266 (1997); *See generally* Katherine T. Vukadin, *Unfinished Business: The Affordable Care Act and The Problem of Delayed And Denied Erisa Healthcare Claims*, 47 J. MARSHALL L. REV. 1 (2014); *See* Ivan Major, *Two-Sided Information Asymmetry in the Healthcare Industry*, 25 INT'L ADVANCES IN ECON. RSCH., 177 (2019).

[122] See generally RICHARD H. THALER, MISBEHAVING: THE MAKING OF BEHAVIORAL ECONOMICS (Jun. 14, 2016).

[123] *Id.*

[124] JACK P. FRIEDMAN ET AL., BARRON'S DICTIONARY OF BUSINESS AND ECONOMICS TERMS (5th ed. 2012). In economics, *utility* is catchall term to describe the more subjective forms from which entities derive value and is the quantifying of qualitative values like taste, smell, or status; and non-monetary quantitative values like calories or dosage. *See id.*

[125] *Id. See generally* RICHARD H. THALER, *supra* note 122.

[126] JACK P. FRIEDMAN ET AL., *supra* note 124.

[127] *See* RICHARD H. THALER *supra* note 122.

[128] *Id.*

seen in health and welfare.[129] For example, economists weigh the loss in tax income from burdening a power plant with expensive air filtration machinery against the cost of having a population riddled with lung diseases from pollution.[130] The diseases are negative externalities of the pollution, and avoiding lost work and medical expenses are positive externalities of the regulatory requirements.[131] When given a large-scale problem, like pollution control or health insurance policy, the sum of all externalities, original costs, and benefits equal what is termed as the "social cost" or "social benefit," depending on whether the externality is a net loss or gain.[132] In sum, so long as the social benefit of an action continues to outweigh the social cost of that action, a course of action is likely advisable.

1. Perverse Incentives.

When narrow interests create a social cost, this is often the result or cause of a perverse incentive.[133] The cobra effect describes this concept's origin in economics.[134] The British Empire, concerned about cobras in Deli, put a bounty on their heads; but this led to the breeding of cobras, and increased their overall population.[135]

A perverse incentive scenario more like the one at play in ERISA healthcare markets.[136] In this context, there is a student who parks in an area near enough to the Brandeis School of Law, that is functionally equidistant to the paid-for parking lots. Unfortunately, it is metered. But, after deducing they would only receive–on average–one fifteen-dollar ticket a semester, they weighed the cost of being a scofflaw against the utility of essentially free parking. It would cost them at least $300-$330 to pay for parking for the school year; they could also park for free around a twenty-minute walk from

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[129] *See generally* Bruce C. Greenwald & Joseph E. Stiglitz, *Externalities in Economies with Imperfect Information and Incomplete Markets*, 101 Q. J. OF ECON. 229 (1986).

[130] *See id.* at 230.

[131] Çağatay Koç, *The Productivity of Healthcare and Health Production Functions*, 13 HEALTH ECON. 739, 741–43 (2004).

[132] JACK P. FRIEDMAN ET AL., *supra* note 124.

[133] *Perverse Incentives*, FORBES (Feb. 20, 2009), https://www.forbes.com/2009/02/19/incentives-compensation-bonuses-leadership_perverted_incentives.html?sh=6c7515745b3b [https://perma.cc/79L2-6P3E]; Patrick Warczak Jr., *The Cobra Effect: Kisor Roberts, and the Law of Unintended Consequences*, 54 AKRON L. REV. 111, 112 (2020).

[134] Patrick Warczak Jr., *supra* note 133.

[135] *Id.*

[136] *See* David McAdams & Michael Schwarz, *Perverse Incentives*

in the Medicare Prescription Drug Benefit: 44 INQUIRY: J. HEALTH CARE ORG., PROVISION, & FIN.157, 158 (2007) ("Since insurers prefer to attract less costly patients, each insurer has an incentive to offer *less* generous coverage than its competitors (at a lower price). In some situations, this can create a 'race to the bottom' in which a competitive insurance market fails to offer any insurance product providing meaningful coverage.").

the school every day. The solution is obvious, roll the dice on the metered area.[137] A student dodging parking tickets because the incentives line up is hardly a major issue, maybe even whimsical. But, when gatekeepers of access apply that logic healthcare, the social cost is catastrophic. [138] Consider the analog of theft. Imagine the only punishments for theft were having to return what was stolen and paying legal defense fees. There would be an incentive to steal anything more valuable than cost of associated legal fees.[139] The cost incurred socially would include massively increased retail security; depressed sales and income tax revenue; and the cascading effects of the ensuing vigilantism, as the legitimacy of the justice system waned.[140] In the healthcare context, when firms find the rate of denying claims is more profitable than approving them, including factors like marketability, they reach market equilibrium.[141] As in the theft analogy, if the regulatory solution is ineffective, and other market factors do not reign in a market with perverse incentives the social cost will spiral.[142]

2. Inelastic Demand.

Inelastic demand and market choice are two more central factors in market equilibrium deranging outcomes in ERISA healthcare.[143] Demand is a primary market mover; it is how much something is wanted or needed.[144] Elasticity is how much the price can fluctuate without effecting demand.[145] The more necessary something is for survival or the more coerced into its use, the more inelastic its demand becomes.[146] Insulin has an inelastic demand curve for diabetics, EpiPens for people with severe allergies, oil for shippers, and so on.[147]

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[137] JACK P. FRIEDMAN ET AL., *supra* note 124. over the course of two years of this parking experiment the students has paid $45 in tickets, or only 14% of the price to pay for parking).

[138] *See* Lee Black, *supra* note 22.

[139] *See* Patrick Warczak Jr., *supra* note 133.

[140] *See* Lee Black, *supra* note 22; *see also* Bruce C. Greenwald & Joseph E. Stiglitz, *supra* note 129.

[141] JACK P. FRIEDMAN ET AL. *supra* note 124. Market equilibrium is where the price for something meets the demand for it. *Id.* Markets will fluctuate, events like Market equilibrium occurs when the price and quantity of an item are aligned with an equal market demand and market supply. *Id.* Markets will fluctuate; for instance, events like supply shortages may drive the cost of something up beyond demand, and there may be a mismatch where firms work to adjust their model to return their supply and demand to equal at a desired profit margin. *Id.* There are an almost incalculable number of factors affecting price for any good or service, which is why price stability is often treated as dispositive as to whether a market is stable instead rather than other concepts like supply, demand elasticity, and speculated security. *See id.*

[142] *See* Patrick Warczak Jr., *supra* note 133.

[143] Çağatay Koç, *supra* note 131, at 741.

[144] JACK P. FRIEDMAN ET AL., *supra* note 124.

[145] Çağatay Koç, *supra* note 131, at 741.

[146] *Id.*

[147] *Id.*

Coercion can come from regulatory or unofficial channels.[148] Regulatory coercion would be requiring a specific inspection or service to perform a central function of one's life, more formally known as standards compliance.[149] Health insurance may present like this for employers large enough to trigger ACA and ERISA mandates to provide coverage for employees.[150] Coercion in this context is not necessarily bad. But, it does put employers in a position where they must provide health insurance.[151] Savings per-person increase with participation, and plans may require certain participation minimums.[152] This puts employers in a position where they may mandate participation in their company healthcare plan.[153] It is also generally much more affordable to be on an ERISA plan than on a private plan, and employee compensation is often designed with the understanding that a significant portion of what would be wages will be diverted to pay for health insurance.[154] This means participants on ERISA plans have little to no actual choice in how they participate in the market.[155] They may complain in mass to their employers who have a choice, but only once a year; and changing insurance providers is a costly exercise.[156] This combination of coercion and necessity creates a highly bizarre market, not subject to the kind of pressures normally present in other markets, despite directed legislative efforts to fix ERISA shortfalls.[157]

E. Movements to Cure Deficiencies in ERISA Healthcare

Landmark legislation affecting ERISA over the past three decades, from least recent to most recent, includes: HIPPA, the ACA, and The Mental Health Parity and Addiction Equity Act (MHPAEA).[158] MHPAEA compels

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[148] *Coercion,* FREE LEGAL DICTIONARY, https://legal-dictionary.thefreedictionary.com/coercion [https://perma.cc/2MC6-W63B] (last visited Nov. 7, 2022).

[149] *See generally* Ekow N. Yankah, *The Force of Law: The Role of Coercion in Legal Norms*, 42 U. RICH. L. REV. 1195 (May, 2008).

[150] *Id,; see also* ABRAHAM & SCHWARCZ, *supra* note 85*,* at 383–84.

[151] ABRAHAM & SCHWARCZ, *supra* note 85*,* at 383–84; Yankah, *supra* note 149.

[152] ABRAHAM & SCHWARCZ, *supra* note 85, at 383-84; Yankah*, supra* note 149.

[153] Çağatay Koç, *supra* note 131, at 741 (describing how demand can be artificially created in large work forces, given appropriate incentive structures).

[154] ABRAHAM & SCHWARCZ, *supra* note 85*,* at 383–84; *see* G. EDWARD MILLER ET AL., AGENCY FOR HEALTHCARE RSCH. & QUALITY, MEPS INSURANCE COMPONENT CHARTBOOK 2022 114–15 (2022); *and see* AGENCY FOR HEALTHCARE RSCH. & QUALITY, *Medical Expenditure Panel Survey (MEPS) Insurance Component (IC)* https://datatools.ahrq.gov/meps-ic [https://perma.cc/E5BW-SQM2] (last visited Feb. 28, 2023).

[155] *See generally* David Horton, *Infinite Arbitration Clauses*, 168 U. PA. L. REV. 633 (2020).

[156] *See* Sam Hughes et al., *Federal Solutions to Address Rising Costs of Employer-Sponsored Insurance*, CNTR. FOR AM. PROGRESS (Feb. 2024), https://www.americanprogress.org/article/federal-solutions-to-address-rising-costs-of-employer-sponsored-insurance/ [https://perma.cc/U9KV-LBF9]; *see also* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1181–1191(d).

[157] See Yankah, *supra* note 149; *see also* Çağatay Koç, *supra* note 131.

[158] Health Insurance Portability and Accountability (HIPAA) Act of 1996, Pub. L. No. 104-191, 100

insurance providers to treat mental healthcare on more equal footing with physical healthcare; it is of some interest to this Note because it is a source of emerging ERISA litigation.[159] Congress has enacted smaller adjustments in regular intervals over the years, even as recently as 2022, with emphasis on consumer protection—like the No Surprise Act.[160] Additions include measures to curb out-of-network price difference, conflicting and confusing language in plans and their summaries, and language used by representatives of insurers.[161] Congress over the years has also mandated coverage for items including air ambulance transportation gynecological exams, and neonatal care, as well as requiring external reviews as a final step when insurance companies deny claim appeals.[162] Possibly the most consequential reform was the ACA's mandate against denying coverage based on preexisting conditions.[163]

On the surface, these new regulations are excellent from a consumer viewpoint because they are steps toward patient access to care and they signal growing political will to make systemic changes in healthcare.[164] However, the political viability of a universal care solution is extremely low in the near future.[165] A hybrid model that expands the ACA and creates a viable public option is more likely to pass, but that still could easily take a few electoral cycles to institute.[166]

How will the most recent consumer protection bills affect ERISA

Stat. 2548; Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010); Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, 122 Stat. 3881 (2018).

[159] *See* Jason Grant, *UnitedHealth to Pay $14.3M in 'Landmark' Settlement Over Mental Health Parity Law,* ALM BENEFITS PRO, (Aug. 19, 2021), https://www.benefitspro.com/2021/08/19/in-first-joint-state-fed-enforcement-of-mental-health-insurance-coverage-parity-laws-ag-james-announces-14-3m-settlement-412-120152/?slreturn=20221007193928 [https://perma.cc/3LM7-HMNB].

[160] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1885–1885(n); *see* 26 I.R.C. § 9816 (2022).

[161] 29 U.S.C. §§ 1885-1885(n); 26 I.R.C. § 9816.

[162] 29 U.S.C. §§ 1885-1885(n); 26 I.R.C. § 9816.

[163] *Pre-Existing Conditions*, U.S. DEP'T OF HEALTH AND HUMAN SERV. https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html [https://perma.cc/8FFZ-3FCY] (last visited Feb. 17, 2024). *See also* Vukadin, *supra* note 121.

[164] *See* Vukadin, *supra* note 121.

[165] *Tracking Public Opinion on National Health Plan*: Interactive, KAISER FAM. FOUND. (Oct. 16, 2020), https://www.kff.org/interactive/tracking-public-opinion-on-national-health-plan-interactive/ [https://perma.cc/5GSZ-S4RM]; *Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage,* KAISER FAM. FOUND. (Oct. 16, 2020), https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/ [https://perma.cc/R63C-DXCV]. Though these studies are a couple years old, they show a contentious field where there is intense dissent over whether there should be a universal healthcare plan or not. There is growing popular support for a Medicare-for-all solution, but it is not great enough to reasonably overcome legislative opposition. However, there is much greater popular support for making healthcare availability fairer, and some level of governmental increase to availability. *See id.*

[166] *Id.*

healthcare markets?[167] Such bills will likely not impact ERISA healthcare markets as much as reformers hope.[168] Recall the parking scenario, like paying for infrequent inexpensive tickets being cheaper than paying for parking, if the cost of penalties for wrongfully denying claims is cheaper than paying for them, then the math becomes simple, and the incentives perverse.[169]

II. ANALYSIS OF THE INDIVIDUAL ISSUES

This section will discuss ERISA's elements of law and administration, which create the resulting perverse incentive for insurers to deny health insurance claims.[170] Section (A) will discuss statutory immunities for insurers from various damages. Section (B) will discuss insurers' consulting physician-fiduciary immunities and their consequences. Section (C) will list and discuss stakeholders, who would be expected to track claim denials but do not, and the resulting lack of reliable market data. Section (D) will discuss preemption and how it has and still makes solving the other listed issues nearly impossible.

A. Wrongful Denial Damages Immunities

1. Source of Authority for Recoverability and Standing

The first layer and the most formidable protection for ERISA insurers comes from 29 U.S.C. § 1132.[171] This section exempts ERISA healthcare plans from some of the fines other ERISA financial benefits are subject to.[172] It also declares that the Secretary of State, beneficiaries, and participants can recover by injunctive action, or equitable remedies for coverage that was denied.[173]

Under an ERISA plan, there are several entities that can bring a claim for any given denial: a plan participant (generally the employee), a

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[167] *See* 29 U.S.C. §§ 1885–1885(n); *see also* 26 I.R.C. § 9816.

[168] Lee Black, *supra* note 22.

[169] See Yankah, *supra* note 149; see *infra* pp. 18-19*; see also* Çağatay Koç,, *supra* note 131, at 741.

[170] *See* David McAdams & Michael Schwarz, *supra* note 136; *see* Lee Black, *supra* note 22.

[171] *See* 29 U.S.C. § 1132.

[172] *Id.* ("A civil action may be brought— . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.")

[173] *Id.* (Injunctive relief can be in the form of an order for an insurer to approve coverage for something they refuse to cover; this would address a situation where a healthcare provider will not perform a treatment without prior authorization—so no money has been spent, and an exact cost may be unknown. Equitable relief is more ambiguous, but it generally refers to costs incurred in reliance or by dues owed by performance. If an insured has incurred costs from treatments that should have been covered but were denied, the insurer may have to pay those costs. This is similar to expectancy damages, but it is limited to actual costs or dues.).

beneficiary (generally the employee's dependent), a Secretary of State, the Department of Labor, an employer, and the denied medical provider.[174]

A second source of authority is from 29 U.S.C. § 1131, which provides a criminal statute for violating ERISA statutes "willfully."[175] Willfully typically means that someone intentionally violates a law which they know of, making it the highest bar for intentionality.[176] Willfully in § 1131 is modified by 29 U.S.C. § 1028, which defines the standard making the element for intentionality only *knowing*, but it gives a secondary defense based on a good faith interpretation of statements from sufficiently authoritative bodies.[177] Section 1131 could produce restitution funds for affected claimants, but, to date there appears to have been—*five*—cases in the past fifty years which garnered a § 1131 conviction by plea or trial, all of which were, raised over retirement fund fraud.[178] No criminal cases arising from § 1131 pertaining to welfare benefits plans were found.

2. Barriers to Recovery and Limitations on Awards

ERISA-backed plan insurers are immune from consequential and punitive damages for negligence regarding their actual plan.[179] Their immunity includes bad faith, so even if they know they are being negligent, the cost of that negligence is capped very low.[180] The rationale is that, if they were to suffer major awards against them, the plan could be at risk for insolvency, jeopardizing their ability to provide benefits for everyone else who relies on them.[181] The method used to protect against insurer abuse is a

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[174] BARKER & KENT, *supra* note 10, § 8.04(c)(iii).

[175] 29 U.S.C. § 1131.

[176] *Id.*

[177] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1132; *see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1028; *see also* United States v. Phillips, 19 F.3d 1565, 1584 (11th Cir. 1994) ("The only logical interpretation of Part 1 of ERISA is that the term 'willfully' in section 1131 requires a finding of only general intent and that section 1028 provides additional statutory defenses not otherwise present for general intent crimes. Under this interpretation, sections 1131 and 1028 serve distinct purposes; the term 'willfully' as used in section 1131 ensures that the act was done voluntarily and not by accident or mistake; and section 1028 provides the proper scope of defenses in accordance with the codified 'prudent man' standard as determined by Congress.).

[178] *Phillips*, 19 F.3d at 1565; United States v. Gray-Burriss, 920 F.3d 61 (D.C. Cir. 2019); Sealed Order, United States v. Lontine, No. 3:02-cr-00365 (D. Or. Jul. 15, 2004); Sealed Order, United States v. Mayhew, No. 3:02-cr-00364 (D. Or. Jul. 15, 2004); Plea Agreement, United States v. Higgs et al, No. 4:05-cr-00239 (W.D. Mo. Feb. 8, 2006) (please entered for two defendants). Author performed exhaustive searches using Lexis+, Westlaw, Bloomberg Law, with no jurisdictional limitations. Author also searched through Federal Department of Justice databases. Author holds that it is likely his search has not found cases which were brought. But, the scarcity of caselaw, dockets, and legal news, indicate a clear lack of either prosecutorial interest, or efficacy of the statute. Compare this statute, to similarly situated white collar criminal statutes like those which apply to securities, and the void of indictments is unsettling.

[179] *See generally* Lee Black, *supra* note 22.

[180] *Id.; see also* 29 U.S.C. §§ 1131–1136.

[181] *See* Peter K. Stris, *supra* note 8.

system of semi-mandatory reporting to the Department of Labor (DOL), which channels through their relatively new sub-agency the Employee Benefits Security Agency (EBSA); state Departments of Insurance, and the Department of Treasury.[182] But the statutory enforcement scheme and schedule of fines takes negligent behaviors that would normally create millions of dollars in liability exposure—per-incident—and reduces them to mere hundreds of dollars in exposure.[183]

In Dawn's case, she would be able to seek reimbursement or coverage for the medication she needed, but she would receive nothing for the months of needless pain and suffering.[184] If that pain and suffering forced her to hire home care that was not covered under the plan, she would be out that money as well. Dawn would get nothing to cover the costs incurred from her insurer's negligence.[185]

Insurers are further insolated by institutionalized difficulty in recovery.[186] Before a person can recover, they must go through a multi-step internal appeal process.[187] ERISA mandates that insurers develop a system for appeal, but those systems are only checked if an investigation is started.[188] Before that point, insurers may be granted multiple warnings to change course.[189] This is a slow process for someone who needs care. Once the EBSA or another agency gets involved, insurers still have at least thirty days to respond, by sending the plan language.[190] While an appeal can be lodged immediately, without plan language, the appellee may be swinging in the dark.[191]

If appeal efforts are exhausted, and it is a beneficiary or participant who is seeking redress, they will likely be forced to arbitrate.[192] Because of the extreme damages immunities, there is a narrow window of cases that most attorneys in this area of law will take on contingency,[193] making it a daunting

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[182] *See* EBSA REPORTING GUIDE, *supra* note 27.

[183] 29 U.S.C. §§ 1131–1136(2024); *see also* Peter K. Stris, *supra* note 8.

[184] *See* Bryant, *supra* note 1; *see also* Arkin, *supra* note 20, at 667–69.

[185] Arkin, *supra* note 20, at 667–69.

[186] *See* 29 U.S.C. § 1133; *see also* 29 C.F.R. § 2590.715-2719 (2022).

[187] BARKER & KENT, *supra* note 10, § 8.04(c)(iii); 29 U.S.C. § 1133; 29 C.F.R. §§ 2590.715-2719 (2022). There are exceptions for going through the internal processes: if it can be shown that the insurer is not responsive, or their internal review processes does not comply with statute. *Id.*

[188] 29 C.F.R. § 2560.503-1 (2023) (explaining claims procedures for health insurance in general, including appeals for group plans under ERISA).

[189] *Id.*

[190] U.S.C. § 1132(c)(1). Plan language, also referred to as detailed plan language, is essentially the contract the insurer must honor; ERISA cases often turn on whether there is a reasonable interpretation of the language within the plan which the insurer is contradicting. *Id.*

[191] *See generally* HEALTH INFO. CTR. ERISA CLAIMS AND APPEALS PROCEDURES, PACER CTR. (2016), https://www.pacer.org/health/pdfs/HIAC-h15.pdf [https://perma.cc/D58A-5F5E].

[192] *See* PacifiCare Health Sys. v. Book, 538 U.S. 401, 406–07 (2003); *see also* Horton, *supra* note 155.

[193] MARY FRANCES DERFNER & ARTHUR D. WOLF, COURT AWARDED ATTORNEY FEES ¶ 16.63 (2022) ("Dague was decided under a pair of 'prevailing party' fee-shifting statutes requiring use of the lodestar

task to find representation.

3. Costs of Seeking Care and Redress

If claimants make it to a court room or win at arbitration and they can only receive injunctive or equitable relief, their hard fight may still be worth their efforts, considering 8% of Americans file bankruptcy over medical debt.[194] Unlike most other claims that have a tortious element, the legal fight runs the risk of bankrupting plaintiffs as well.[195] This is because the damages available are generally preclusive of attorneys' fees, and considering punitive and consequential damages are disallowed, there is no room for attorneys to work on contingency.[196] A win means medical bills are paid or a procedure is now pre-approved.[197] There are exceptions to this rule, but they usually arise from ERISA claims outside the scope of this Note, like disability, life, or when a health care provider has had enough of an insurer's denials and files a mass tort on behalf of a series of their patients.[198] For the average patient though, the choice to pay out of pocket for legal aid to ensure their access to medical care may be preferable to fighting with an insurance company pro se, but for most it is unattainable.[199]

4. Blocking and Cost-Effective Medical Malpractice

A hidden figure in the wrongful denial picture are subsequent claims derived from gatekeeper claims.[200] Making it difficult to get a blood test more than once a year, or an MRI ever, is not only incentivized by the cost of the

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methodology. Because the statutes providing for fees in favor of a 'prevailing party' are given a uniform interpretation, the courts of appeals have applied the reasoning of Dague to preclude contingency enhancements under a variety of other federal fee-shifting statutes that employ the 'prevailing party' language. A non-exhaustive list of "prevailing party" statutes under which contingency enhancements are prohibited include: . . . ERISA.").

[194] *See* Lina Velikova, *The Truths & Myths Behind Medical Bankruptcies,* MEDALERTHELP (Jan. 14, 2022). https://medalerthelp.org/blog/medical-bankruptcies/ [https://perma.cc/5GJ8-W8TE].

[195] *Id.*; *see also* DERFNER & WOLF, *supra* note 193.

[196] *See* DERFNER & WOLF, *supra* note 193.

[197] *Id.*; *see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1132; *see also* BARKER & KENT, *supra* note 10, § at 8.04(c)(i); *and see PacifiCare Health Sys*., 538 U.S. at 406–07 (2003).

[198] Complaint at 1, Popovchak et al. v. UnitedHealth Grp. Inc. et al., (S.D.N.Y. Dec 21, 2022) (No. 1:22-cv-10756). This case is a mass tort, being spearheaded by a healthcare provider. It exemplifies the scenario where an interest is large enough for equitable remedies to justify litigation intervention. This case also pulls in several other federal statutory violations, and it may show a viable legal strategy to for Plaintiffs' attorneys to follow in the future because the additional causes of action may allow them to bypass the strict preclusion of punitive and consequential damages.

[199] DERFNER & WOLF, *supra* note 193.

[200] *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28, at 25. While the data from this report is more than twelve years old, it does state that diagnostic treatment appeals are more likely to result in a reversal—which suggests there is a higher prevalence of frivolous denial of diagnostic care, although it is inconclusive as to the degree. *Id.*

testing, but also by the extreme cost of chronic illness.[201] Pain management is far cheaper.[202] From the perspective of an insurer, it is also far cheaper to have a chronically ill person move to public care through Medicaid or Medicare.[203]

With a young cancer patient like Dawn Smith, when comparing the costs of receiving treatments resulting in remission—*or*—being slowed from receiving diagnostic care, until her tumor is inoperable the second option is a fraction of the cost.[204] The American Cancer Society published a study in 2017, providing three case studies that were descriptive of a typical cancer patient's cost profile, which ranged from over $123,000 to $201,000 in treatment costs over a single year.[205] Especially considering the high rate of cancer patients who suffer return bouts after remission,[206] there is a clear perverse incentive to move chronically or severely ill patients as quickly and quietly toward long term government care as possible.[207]

B. Doctors as Fiduciaries

1. Basic Concept and Functionality

When a claim for care is sent to an insurer, it is almost always done by the claimant's medical provider.[208] These claims are reviewed by insurers for a number of factors, including whether the procedure is covered, or if a treatment is medically necessary.[209] The only people generally qualified to make these determinations are medical professionals, so insurers retain consulting physicians to make those determinations, qualification standards

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[201] *See* AM. CANCER SOC'Y, THE COST OF CANCER 9–12 (2017), https://www.fightcancer.org/sites/default/files/Costs%20of%20Cancer%20-%20Final%20Web.pdf [https://perma.cc/X9XX-D7BZ].

[202] *See generally* McAdams & Schwarz, *supra* note 136.

[203] *See* AM. CANCER SOC'Y, *supra* note 201 (If someone paid $1,000 a month for their health insurance premiums, it would take 124 months to pay in the cost of a twelve-month period of cancer treatment for the least expensive case study. That calculation excludes the cost of plan administration and the value of interest from investing premiums over time, so the total calculation is, of course, more involved. Regardless of how the other factors impact overall cost, shifting these kind of losses to a public system as fast as possible is clearly preferred because the chance that the account of a chronically ill person proving a net positive is very low.).

[204] *Id.*

[205] *Id.*

[206] Andrea S. Blevins Primeau, *Cancer Recurrence Statistics*, CANCER THERAPY ADVISOR (Nov. 30, 2018), https://www.cancertherapyadvisor.com/home/tools/fact-sheets/cancer-recurrence-statistics/ [https://perma.cc/A8MY-VNRG].

[207] *Id.; see also* AM. CANCER SOC'Y, *supra* note 201.

[208] *Everything You Need to Get Started In Medical Billing & Coding: 3.04: More About Insurance & the Insurance Claims Process,* MED. BILLING & CODING CERTIFICATION, https://www.medicalbillingandcoding.org/insurance-claims-process/ [https://perma.cc/P5C4-HEM8] (last checked, Jan. 22, 2023).

[209] *See* 29 C.F.R. §§ 2590.715-2719 (2022); *see also* Karen Pollitz et al., *supra* note 43.

for these consulting physicians vary by state.[210]

Physicians making these determinations for insurers are not considered as making medical determinations for care when assessing claims.[211] They are instead considered to be making descriptive determinations as plan fiduciaries.[212] ERISA defines who is a fiduciary in 29 U.S.C. § 1002(21)(A):

> [A] person is a fiduciary with respect to a plan to the extent[:]
> (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets,
> (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or
> (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.[213]

By this rule, physicians consulting on behalf of welfare benefits plans are treated under the law as fiduciaries because of their discretionary authority, while they make qualitative determination regarding administration of the plan.[214] However, this does not mean they must meet the standard of care required by a treating physician.[215] In *Pegram v. Herdrich*, the Court determined this to mean, unless the physician fiduciary is actually treating the patient, as they had under certain the Health Maintenance Organization (HMO) plans, they are not exposed to medical malpractice.[216] Despite the

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[210] AM. MED. ASS'N, 2021 PRIOR AUTHORIZATION STATE LAW CHART (2021), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/pa-state-chart.pdf [https://perma.cc/J7R9-B2KJ] (explaining how the state where the plan is issued controls what the specific review standards are, and how the state of issuance is typically the determined by the employer and not the beneficiary).

[211] *See generally* Skelcy v. United Health Grp., Inc., 620 F. App'x 136 (3d Cir. 2015); *and see* Corbett, *supra* note 17, at 296–98.

[212] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1109(a); *see* Aetna Health Inc. v. Davila, 542 U.S. 200, 220 (2004); *see also* Pegram v. Herdrich, 530 U.S. 211, 220–22 (2000) (The Health Maintenance Organization (HMO) in Pegram was a hybrid system where patients were treated by the same organization that acted as the insurer in a pre-paid arrangement. The doctors who saw patients were directly incentivized not to treat patients through an associated bonus structure. *Id.*); *and see* Corbett, *supra* note 17, at 296–98.

[213] 29 U.S.C. § 1002(21)(A).

[214] *See Pegram*, 530 U.S. at 227–28.

[215] *Id.* at 229; *see also* Wit v. United Behav. Health, 79 F.4th 1068, 1082–83 (9th Cir. 2023).

[216] *Pegram*, 530 U.S. at 229.

Court's acknowledgement that decisions of treatment and eligibility are "*inextricably mixed*" *defacto* medical determinations,[217] insurance companies have another layer of credibility protection that immunizes them from any *respondeat superior* claims.[218] Insulation from medical malpractice claims incentivizes doctors to act against the interest of patients, while creating a terrain of medical shadow governance.[219] Unaccountable physicians who never see or even speak with the patients override the determinations of treating physicians who engage with patients.[220]

In Dawn's case, despite a diagnosis of brain cancer, if the insurer's consulting doctor, without even once seeing her, decided that requested care was not medically necessary, the consulting doctor would have no medical malpractice exposure.[221] It would not matter that the doctor had not met a physician's standard of care by any assessment, because they would be acting only as a plan fiduciary; they may, however, have liability exposure for approving treatment that is not medically necessary for the same reason.[222] The second form of liability however, would most likely be to the insurer.[223]

2. Controlling Opinion and Valid Roles in Medical Consultation

Of course, there are legitimate differences in opinion on appropriate treatments between medical professionals.[224] Though this is not a controversial claim, the practitioner with the most information is usually best situated to make determinations for a given patient.[225] This is especially true if differences in levels of qualification are considered.[226] It is also not a controversial claim that some doctors over-prescribe treatments because they are unscrupulous.[227] However, the number of doctors who operate actively in bad faith are few.[228]

It is fair for insurers to protect against abuse of their obligations by mistake or fraud; however, it is divorced from reality to deny that insurers' consulting physicians are not making medical determinations of consequence

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[217] *Id.*; *see also* Corbett, *supra* note 17, at 296–98.
[218] *Pegram*, 530 U.S. at 211.
[219] *See id.;* Corbett, *supra* note 17, at 296–98.
[220] *See Pegram*, 530 U.S. at 229.
[221] *See id.*; *and see* Sam Stein, *supra* note 1.
[222] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1109.
[223] 29 U.S.C. § 1109.
[224] Kathy Katella, *Can a Second Opinion Make a Difference?*, YALE MED. (Jan. 15, 2020) https://www.yalemedicine.org/news/second-opinions [https://perma.cc/AKA2-YX3Z].
[225] *See generally* Major, *supra* note 121.
[226] *Id.*
[227] *See* Lauren Rousseau and I. Eric Nordan, *Tug v. Mingo: Let the Plaintiffs Sue – Opioid Addiction, The Wrongful Conduct Rule, and the Culpability Exception*, 34 W. Mich. U.T.M. Cooley L. Rev. 33, 73 (2017).
[228] *Corbett, supra* note 17, at 298–99.

to patients' health outcomes.[229] It is a baffling determination, then, that a consulting physician is immune from medical malpractice especially because, unlike with an attending physician, a patient cannot get a second opinion.[230] Patients can appeal, but their appeal will go to the same company and, with a relatively high probability, the same physician.[231] After that appeal, they can then go for an external review, but this process can delay treatment for months.[232]

Consider Dawn's denial of coverage for her migraine medication after the price hike.[233] Her claim would have supposedly gone in front of the doctor who denied the claim originally.[234] In so doing, the doctor determined either Dawn did not need the medicine, or there was a qualifying substitute.[235] Those are both medical determinations: The doctor would have to read her medical record, determine what treatments were viable, and filter out normally viable options based on her medical history.[236] Since insurer determinations are made internally, consulting physicians performing medical services and guarding the interests of their employers cannot be separated.[237]

3. Consequences of Doctors Acting Only as Fiduciaries

Treating consulting physicians only as fiduciaries is flawed for two reasons of practice and one of rationale. First, this system gives consultants with no interest in patient wellbeing veto power over their treatment.[238] Care providers who deal directly with patients, when given the choice between risking patient default and providing care without prior-authorization, sensibly must often choose to delay treatment, especially if their employer does not allow them to treat patients without prior-authorization.[239]

Second, this system necessarily indemnifies insurers from

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[229] *See* Pegram v. Herdrich, 530 U.S. 211, 229 (2000).

[230] *See* Aetna Health Inc. v. Davila, 542 U.S. 200, 220 (2004) ("This strongly suggests that the ultimate decisionmaker in a plan regarding an award of benefits must be a fiduciary and must be acting as a fiduciary when determining a participant's or beneficiary's claim.").

[231] *See generally* HEALTH INFO. CTR., *supra* note 191.

[232] *Id.*

[233] *See* Bryant, *supra* note 1; *see also infra* discussion in Introduction.

[234] Bryant, *supra* note 1. *see* Am. Med. Ass'n, *supra* note 210.

[235] *Id.*; *see, e.g.,* Skelcy v. United Health Grp., Inc., 620 F. App'x 136, 143–44 (3d Cir. 2015).

[236] RESTATEMENT (THIRD) OF TORTS: CONCLUDING PROVISIONS, Duties to Patients & Others § 3I (Am. L. Inst. 2022).

[237] *See* Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 127–28 (2008) (Scalia, J. dissenting) ("A third-party insurance company that administers an ERISA-governed disability plan and that pays for benefits out of its own coffers profits with each benefits claim it rejects. I see no reason why the Court must volunteer, however, that an employer who administers its own ERISA-governed plan 'clear[ly]' has a conflict of interest.").

[238] *Id.*

[239] *Id.*

malpractice done by their employees, making it especially pernicious.[240] As a general rule, employers are responsible for the actions of their employees, and to a lesser extent contractors, so long as their employees are acting in the scope of their employment and in furtherance of the employer's interest.[241] It would be paradoxical for these physicians to not act within the furtherance of their employer's interest while assessing claims.[242] In a typical medical malpractice case, hospitals and practices are liable for the malpractice of their associates.[243] But because of this special role, insurers bear none of that risk.[244] Insurers cannot be liable for medical malpractice that their consulting physicians have not committed by operation of law, even if in fact they have.[245]

Finally, the rationale for the deference given to physician gate keepers, presumes an abundance of hypochondriacs and unqualified or predatory treating physicians. It juxtaposes medical doctors into the adversarial system of law, and medicine should be anything but adversarial.[246] When disagreements arise between physicians over a patient, the Hippocratic Oath and human decency demand physicians do no harm.[247] Their goal must be to reach the best outcome for the patient in question practicable, not play a game of semantic gotcha[248]

C. Prevalence and Transparency

1. The Existing CMS Data System

As stated, the only reliable data on claim denial comes from CMS.[249] But that data only tracks the CMS plans of Medicare and Medicaid.[250] A Kaiser Family Foundation report on recent CMS data found less than one percent of claim denials were appealed by insureds, and of the appeals, over seventy percent were reversed.[251] From this CMS data, it may be extrapolated that probable only a tiny percentage of denials are appealed.[252] It can also be

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[240] *See* Skelcy v. United Health Grp., Inc., 620 F. 'pp'x 136, 143–44 (3d Cir. 2015).
[241] JOSEPH D. ZAMORE ET AL., BUSINESS TORTS § 5.03 (2022).
[242] *See id.* § 22.02.
[243] *Id.* § 5.03.
[244] *See* LOUIS R. FRUMER & MELVIN I. FRIEDMAN, PERSONAL INJURY: ACTIONS, DEFENSES, DAMAGES § 77.03 (2023).
[245] *Id.*
[246] *See AMA Principles of Medical Ethics*, AM. MED. ASS'N, https://code-medical-ethics.ama-assn.org/principles [https://perma.cc/8J22-ATDA] (last visited Feb. 13, 2023).
[247] *Id.*
[248] *Id.*
[249] *See infra* discussion section I.
[250] Karen Pollitz et al., *supra* note 43.
[251] *Id.*
[252] *Id.*

extrapolated from the data that a denied claim's merit and appellate status are not correlated in a way that predicts merit of non-appealed claims because there is no control group studied here.[253] To determine how many valid claims are being denied, a random sampling or complete review would need to be taken.[254] The void of information begs the question: Who should be collecting and aggregating claim denial data for ERISA plans?

2. Stake Holding Agencies and The Common Tragedy

The tangled web of preemption and statutory regulation fractures ERISA health insurance plan monitoring into various federal and state agencies, creating a seemingly porous system of accountability.[255] The organizations that are supposed to monitor or regulate insurers providing ERISA-based care include: the EBSA under the Department of Labor (DOL); state and federal Departments of Insurance under their Secretary of State; state All Payer Reporting Systems; the Department of the Treasury; a pseudo private entity, the National Association of Insurance Commissioners (NAIC); and, to a lesser extent, multiple other governmental bodies, like specialized departments under the Department of Justice (DOJ), that deal with healthcare fraud, or other highly specific issues that might run against insurers.[256] Despite this, no agency tracks ERISA claim denials that are not brought to it.[257]

After contacting multiple agencies, including the EBSA and departments of insurance, I found, at least at the consumer-facing level, their representatives tend to think tracking denials is a different agency's function.[258] According to the scant guidance available, there is nothing compelling insurers to report their denials, unless they are specifically asked by a qualified federal agency as part of an open investigation.[259] Moreover, state attempts to monitor claim denials were hamstrung: in 2016, *Gobeille v.*

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[253] *Id.*

[254] *See* Abolfazl Asudeh et al., *On Detecting Cherry-picked Trendlines,* 13 VLDB ENDOWMENT 939–41 (2020).

[255] *See, e.g.,* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016); *see also* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[256] *What We Do,* EMP. BENEFITS SEC. ADMIN., https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/what-we-do [https://perma.cc/L44E-893L] (last visited Jan. 22, 2023); *Industry Directory*, INS. INFO. INST., https://www.iii.org/services/directory/company-categories/state-insurance-departments [https://perma.cc/7JY2-U6TQ] (last visited Feb. 17, 2024); CARMAN ET AL., *supra* note 109; *About FIO*, U.S. DEP'T OF THE TREASURY, https://home.treasury.gov/policy-issues/financial-markets-financial-institutions-and-fiscal-service/federal-insurance-office/about-fio [https://perma.cc/7VZR-3APN] (last visited Jan. 22, 2023).

[257] *See infra* discussion sections (II)(C)(1)-(9).

[258] Telephone Interview with anonymous representatives, Emp. Benefits Sec. Admin. (Dec. 16, 2022, Sept. 28 2022, Sept. 02, 2022, Aug. 30, 2022); E-mail from Francis Beifuss to NAIC representative (Nov. 1, 2022, Nov. 2, 2022); Telephone Interview with anonymous representative, U.S. Department of the Treasury (Nov. 1, 2022).

[259] *See* EBSA REPORTING GUIDE, *supra* note 27, at 2.

Liberty Mut. Ins. determined that state reporting systems usually conducted through All-Payer Claims Databases (APCD) cannot enforce penalties.[260] Vermont had a system where it enacted fines for non-compliance.[261] Insurers were supposed to report data about their insured, specifically cost and demographic data.[262] Liberty Mutual brought suit against the imposition, and in an eight to one split, the Supreme Court upheld that the fines were preempted by ERISA, thus rendering the state's enforcement mechanism useless.[263]

3. The Employee Benefit Security Administration

The Employee Benefit Security Administration (EBSA) is a sub-agency under the DOL, which is mandated with administering ERISA requirements.[264] While the EBSA has a significant role in protecting other critical employee benefits like 401-ks and pension plans, they bare a large portion of the health insurer regulating burden.[265] The EBSA sets mandatory reporting standards for insurers, advocates for employees, has investigative authorities, and conducts various benefits related research.[266]

Although the EBSA is a boon for employees trying to use their owed benefits there are some clear holes in their methodology and implementation.[267] The relationship it polices is the employer-employee relationship.[268] What that process looks like for an employee who is running into a wrongful denial of healthcare is bifurcated depending on the plan type: fully-funded or self-funded plans.[269]

In the self-funded case, where coverage is ultimately paid for by the employer, the EBSA leveraging fines and going directly against the employer makes more sense.[270] Even if a wrongful denial was the claim administrator's fault, a self-funded firm is typically large enough to hire human resources

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[260] *See generally* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016).
[261] *Id.* at 315.
[262] *Id.* at 315–16.
[263] *Id.* at 326–27.
[264] EMP. BENEFITS SEC. ADMIN, *What We Do*, *supra* note 256.
[265] *Id.*; *see also* EMP. BENEFITS SEC. ADMIN., *History supra* note 49.
[266] EMP. BENEFITS SEC. ADMIN., *History, supra* note 256; *and see* EMP. BENEFITS SEC. ADMIN, *What We Do*, *supra* note 49.
[267] EMP. BENEFITS SEC. ADMIN., *History, supra* note 256; *and see* EMP. BENEFITS SEC. ADMIN, *What We Do*, *supra* note 49; *see also* JANET L. YELLEN ET AL., REALIZING PARITY, REDUCING STIGMA, AND RAISING AWARENESS: INCREASING ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE, U.S. DEP'T OF LAB. 3 (2022); *and see* Telephone Interview with anonymous representatives, Emp. Benefits Sec. Admin., *supra* note 258 (An EBSA representative clarified that plans and issuers, referenced in the above report, as meaning the sponsoring employer and the plan they procure. Claim administrators are not considered the issuer.).
[268] *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28, at 5.
[269] *Id.*
[270] *Id.*

staff and other support staff to ensure compliance; and the EBSA countering the incentives they have for negligence is rational.[271] Moreover, the employers have plenty of time to correct the behavior of the claim administrators before any actual penalties are levied; and their account size and the nature of the relationship between a claim administrator as opposed to an insurer, gives self-funded firms significant leverage to control or fire claim administrators.[272]

Conversely, in the case of fully-funded plans, EBSA leveraging fines against the employer directly and immediately makes little to no sense.[273] The rationale is that the employer, once it notices wrongful healthcare claim denials, should fight for their employees and should sue their insurers if they are non-compliant.[274] However, employers with fully-funded plans are often smaller with fewer resources, and they do not have the option to leave a plan the way an administrator can be fired.[275] The plan, therefore, ultimately takes the risk away from the perpetrator and places it on an employer, in hopes that market solutions will prevail in curbing bad insurer behavior.[276]

The problem with that assertion is health insurance in the U.S. does not operate like a normal market.[277] Instead, the health insurance market is insulated from normal remedies and avoids many anti-trust laws through the McCarren Ferguson Act—discussed in more depth in section (II)(D)—allowing the industry to set somewhat uniform standards, even if those standards are sub-optimal.[278] Even if the health insurance market did respond to normal market pressures, the current system would unnecessarily still pit employees against employers. [279]

As an example, imagine an employee in a firm with thirty full-time

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[271] AL STEWART, U.S. DEP'T OF LAB., ANNUAL REPORT ON SELF-INSURED GROUP HEALTH PLANS MARCH 2021 4 (2021), https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2021.pdf.

[272] *See* BARKER & KENT, *supra* note 10; *see also* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1133.

[273] *See* BARKER & KENT, *supra* note 10.

[274] YELLEN ET AL., *supra* note 267, at 39–41.

[275] *See* STEWART *supra* note 271.

[276] *See* Major, *supra* note 121.

[277] *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015; *see also* United States v. Robertson, 158 F.3d 1370, 71–72 (9th Cir. 1998) (clarifying that ". . . Congress enacted the McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015, . . . [to] allow[ ] the states to continue regulating the insurance industry despite its interstate effects."); *contra* Humana Inc. v. Forsyth, 525 U.S. 299, 314 (1999) ("Because RICO [federal law] advances the State's interest in combating insurance fraud, and does not frustrate any articulated Nevada policy, we hold that the McCarran-Ferguson Act does not block the respondent policy beneficiaries' recourse to RICO in this case."); *see* discussion *infra* Section I.(D).

(insurance in general was insulated from federal anti-trust laws because information is necessary for firms to function, and they provide a backstop or safety net. So they are allowed to share information insureds, which normally could amount to price fixing).

[278] United States v. Robertson, 158 F.3d at 1370.

[279] *See* Major, *supra* note 121, at 178–79. *United States v. Robertson*, 158 F.3d 1370.

employees. The employee is denied an MRI, and it is clear from their plan language and personal context that the MRI should be covered. Their employer is a small firm, so they, like most others, outsource health insurance to a fully-funded plan like one through United Health Systems.[280] United denies the claim, while breaking a series of ERISA plan requirements and resulting in confusion, and gives bad advice for how their denial should be resolved, which in turn creates further delays.[281] If requested by the employee, the EBSA will contact the employer and let them know they are violating the terms of their care plan. Because it is the employer's duty to police the insurer,[282] this puts whomever at the small firm is wearing the human resources hat that day against an insurer.[283] They can only really leave once a year.[284] It also likely has an obvious chilling effect—employees accusing their employers and source of healthcare of potentially criminal wrongdoing certainly presents a difficult proposition to the wronged.[285] This is especially so when the wrongdoing is clearly not the fault of the employer, who likely has no idea there is even an issue, because of the reporting requirements set by the EBSA.[286]

In its current Reporting and *Disclosure Guide for Employee Benefits*, the EBSA does not require insurers to notice anyone other than beneficiaries or participants of a denial of a claim for care.[287] In fact, they may be violating privacy act regulations for disclosing the entirety of a claim denial to the employer who is supposedly policing them.[288]

The EBSA provides a necessary function of helping curb issues of lacking accountability; however, their methods are monolithically aimed toward self-funded plans.[289] There is also a major issue creating a conflict between maintaining barriers of privacy between employers and employees when it comes to their healthcare outcomes.[290] There needs to be a

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[280] *See* STEWART *supra* note 271, at 4–5.

[281] HEALTH INFO. CTR., *supra* note 191.

[282] *See* STEWART *supra* note 271.

[283] *Id.*

[284] *See* EBSA REPORTING GUIDE, *supra* note 27, at 5–8.42 U.S.C. §§ 300gg-1(a)-(c) (restrictions on denying insurance coverage for preexisting conditions, can be avoided outside of special enrolment periods, this and contractual obligations makes leaving a plan partway through difficult and risky).

[285] *See* Vukadin, *supra* note 121.

[286] *See* EBSA REPORTING GUIDE, *supra* note 27, at 5–8.

[287] *Id.* at 2–5.

[288] *Id.* at 2 (The row entitled "Notification of Benefits Determination" states that "[a]dverse benefit determinations must include required disclosures (e.g., the specific reason(s) for the denial of a claim . . ." must be disclosed only to "[c]laimants (participants and beneficiaries or authorized claims representatives).").

[289] *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28, at 5.

[290] *See* EBSA REPORTING GUIDE, *supra* note 27, at 2.(consider the implication of having to explain to an employer that insurance is not covering a necessary form of care, while an above-board human resources department should handle that, without asking what the coverage is for, it creates issues in advocacy and many small firms do not have actual human resources departments).

requirement for claim denials to be monitored proactively, or the system is reliant on completely asymmetrical information and power holders to reach tenable, reasonable solutions.[291]To frame the asymmetry, consider the following: Instead of Dawn with a brain tumor, it is your family member—one who does not read legal literature on health insurance. They have brain fog and debilitating pain and potentially a small window of operability.[292] What is the chance they will figure out there is a little known subagency that will compel their employer to advocate for them?[293] Will their employer have the resources to fight a 200-billion-dollar insurance company?[294] Would you stake their life on it?

4. Department of the Treasury

The U.S. Department of the Treasury stores Form 5500's, which are forms that organizations with 100 employees or more must use to report their ERISA and ACA compliance information.[295] The Form 5500's are fairly scant,[296] but they provide some raw data for medium-to-large firms on ERISA participation.[297] This reporting determines the number of U.S. residents on ERISA plans.[298] However, the scope of Form 5500 is quite limited: It does not capture those who have employer-sponsored health insurance from firms with under 150 employees. Considering that employers with 100 or more employees must provide insurance plans to their employees and that smaller firms have incentives through tax and labor market realities, the number of people receiving insurance from employers who are not required to send in Form 5500's are immense.[299] Additionally, the Department of the Treasury established the Federal Insurance Office (FOI) in 2010, which collects market data and proposes executive and legislative action.[300] It has stated

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[291] *See* STEWART *supra* note 271.

[292] *See* AM. CANCER SOC'Y, *supra* note 201.

[293] *Id.*

[294] UnitedHealth Group, Annual Report (Form 10-K) 66 (Dec. 31, 2021) (UnitedHealth Group reported $212,206,000,000 in total consolidated assets in 2021).

[295] *See* Dodd-Frank Act, 12 U.S.C. § 5383(a)(1)(C) (2022); *see* U.S. DEP'T OF THE TREASURY, *supra* note 256; *see* U.S. DEP'T OF LAB., EMP. BENEFITS SEC. ADMIN., USER GUIDE 2019 FORM 5500 GROUP HEALTH PLANS RESEARCH FILE 2 (2021) [hereinafter USER GUIDE 2019 FORM 5500].

[296] *See Form 5500*, U.S. DEP'T OF LAB. (2022), https://www.dol.gov/sites/dolgov/files/EBSA/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500/2022-form-5500.pdf [https://perma.cc/F4L2-YL48].

[297] USER GUIDE 2019 FORM 5500, *supra* note 296.

[298] *Id.* Additionally, the Department of the Treasury established the Federal Insurance Office (FIO) in 2010, which collects market data and proposes executive and legislative action. *See* U.S. DEP'T OF THE TREASURY, *supra* note 256. It has stated however, health insurance outside of Medicare and Medicaid is generally outside the scope of FIO. *Id.*

[299] *Id.*

[300] U.S. DEP'T OF THE TREASURY, *supra* note 256.

however, health insurance outside of Medicare and Medicaid is generally outside the scope of FOI.[301]

5. State Enforcement Mechanisms

As states bear the burden of monitoring insurers in most cases.[302] In addition to federal government agencies like EBSA, each state has a Department of Insurance, which exists to enforce and monitor insurance regulations within its respective state.[303] Nevertheless, the interventions of these state agencies are generally preempted in the case of ERISA health care plans, rendering their purpose diminished serve little purpose and resulting in them generally referring the complaints that arise from their consumers to EBSA.[304]

State APCDs are also established under the guidance and control of state departments of insurance.[305] State APCDs function as the monitoring component for participating states.[306] As states are supposed to regulate the business of insurance, they bear the burden of monitoring insurers in most cases.[307] Thirty states have installed APCDs.[308] Each program varies in what and how it captures data, as not all of them explicitly ask for claim denials.[309] But after *Gobeille v. Liberty Mut. Ins.* in the case of ERISA plans, inquiring about claim denials is a moot question.[310] State departments of insurance can ask for claim denial data as much as they want, but the state programs are preempted by the federal government and, therefore, cannot impose penalties for violations.[311]

The lack of enforceability renders APCDs an extremely porous mechanism for accountability.[312] Ultimately, it is unclear whether their data is helpful or not because skewed data can be more detrimental than no data. Consider the difference between having no report on claim denial prevalence and one that shows claims are almost never denied. The first gives no indication of the health of a system, while the second shows that it is a healthy

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[301] *Id.*

[302] *See* CARMAN ET AL., *supra* note 109, at 1–2.

[303] INS. INFO. INST., *supra* note 256.

[304] *See* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 323 (2016); *and see* BARKER & KENT, *supra* note 10, § 8.04(d).

[305] CARMAN ET AL., *supra* note 109, at 5.

[306] *Id.*

[307] *Id.* at 1.

[308] *Id.* at 7.

[309] *Id.*

[310] *See id. See generally* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016).

[311] *See Gobeille*, 577 U.S. at 323.

[312] *See id.*; *see* CARMAN ET AL., *supra* note 109, at 2 ("This [*Gobeille*] has created a significant limitation: ACPDs can no longer mandate submission of data on a large proportion of the population covered by employer-sponsored insurance.").

system and should not be tampered with. But if the second only includes cherry-picked data and, in reality, it is providing cover for an extremely unhealthy system, then the issue with skewed data becomes clearer. When insurance companies get to pick and choose what data is sent to the APCDs, they can quickly turn into government-legitimized marketing tools.[313]

6. The National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC) is a nongovernmental organization with a board comprised of the insurance commissioners for each state.[314] NAIC's stated purpose is to gather data, write model laws, and regulate the market through non-governmental action as professional boards like the American Bar Association might.[315] The NAIC came into existence as a product of the McCarren Ferguson Act, which was enacted in response to burgeoning anti-trust laws in the mid 1800's.[316] It collects data, although it is not clear how effectively; its data, collection methodology, and reach are closely guarded against consumers.[317]

The NAIC serves as a data repository for insurance companies, which allows them to circumvent anti-trust prohibitions on data sharing and ultimately price fixing.[318] On one hand, the NAIC allows for smaller emerging insurance companies to function because their data pools make expectancy value estimates accurate to a degree that small firms would otherwise not be able to achieve.[319] On the other hand, the NAIC allows the U.S. market to operate as a cartel,[320] where competition is somewhat illusory.[321] One justification is that the organization allows firms to be precise when underwriting premiums, but it is not clear if those efficiencies are seen by consumers when contrasted against the backdrop of lacking incentives to compete on service.[322] Healthcare, having an inelastic demand combined with insurers ability to operate as a cartel, leads to insurance companies

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[313] *See infra* discussion section (II)(D).

[314] ABRAHAM & SCHWARCZ, *supra* note 85, at 112.

[315] *Id.*

[316] *See McCarran-Ferguson Act*, INS. INFO. INST. https://www.iii.org/publications/insurance-handbook/regulatory-and-financial-environment/mccarran-ferguson-act [https://perma.cc/JG6H-B34V] (last visited Feb. 19, 2024); *and see* McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015.

[317] *See* ABRAHAM & SCHWARCZ, *supra* note 85, at 112; *see also* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[318] *See* ABRAHAM & SCHWARCZ, *supra* note 85, at 112–15.

[319] *Id.* at 118–19.

[320] *Id.;* JACK P. FRIEDMAN ET AL., *supra* note 124 (defining a cartel as a group of independent market participants who collude to improve profits and dominate the market). Cartels typically operate in related markets or the same market. *Id.* They are anti-competitive and are generally outlawed through anti-trust laws. *Id.* Cartels price fix, rig bidding, and set output. *Id.*

[321] ABRAHAM & SCHWARCZ, *supra* note 85, at 112*;* JACK P. FRIEDMAN ET AL., *supra* note 124.

[322] ABRAHAM & SCHWARCZ, *supra* note 85.

existing in a prisoners' dilemma.[323] As long as insurance companies all avoid taking new clients outside of open enrollment cycles and provide minimal services for the most costly patients, they can avoid extreme costs.[324] From the consumer perspective, the result is as follows: their current insurer is not giving adequate coverage, but, if they leave, they can be denied coverage by other insurers until open enrolment, and the quality elsewhere will not be significantly different—so why bother leaving?[325]

While NAIC supposedly denial data and helps legislators regulate the market,[326] it only publicly publishes a denial data summary—which is extremely lacking as it has no information on methodology and little breakdown of data.[327] It is unclear what the actual requirements for insurers reporting to NAIC are.[328] NAIC certainly does not have governmental authority to demand data from insurers.[329] The organization states: "Our goal is to bring state regulators together to serve the public interest. We provide tools and resources to help regulators set standards and best practices, provide regulatory support functions, and educate consumers and stakeholders on U.S. state-based insurance regulation."[330]

However, it will not give a detailed report to a non-insurer,[331] which is problematic because , as NAIC is a private organization, this data is likely not discoverable under a Freedom of Information Act request.[332] Considering these factors, it is nearly impossible to assess the credibility of NAIC's claims and, subsequently, the usefulness of its data.[333]

The latest market summary in its entirety is seen below in figure (II)(1):[334]

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[323] *Id.*

[324] 29 C.F.R. §§ 2590.715-2719 (2022); *See infra* discussion section (II)(D)(1).

[325] *See* Vukadin, *supra* note 121.

[326] *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[327] *Contacts and Score Card,* NAT'L ASS'N INS. COMM'R, https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fcontent.naic.org%2Fsites%2Fdefault%2Ffiles%2Finline-files%2Findustry_mcas_2021_scorecard_ltc%2520_all.xlsx&wdOrigin=BROWSELINK (last visited Feb. 19, 2024).

[328] *See* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 323 (2016); *and see* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[329] U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[330] *Regulator,* NAT'L ASS'N INS. COMM'R, https://content.naic.org/regulator [https://perma.cc/T9A5-4NJH] (last visited Jan. 22, 2023).

[331] E-mail from Jacob Kline, NAIC Representative, to Francis Beifuss, author (Nov. 2, 2022, 12:06 EST) (on file with author) (stating, "Thank you for reaching back out. To gain access to MCAS, a CoCode [an insurer identifier] would be necessary to proceed with account creation. Any questions, please let us know. Thanks, Jacob Kline, NAIC Service Desk, National Association of Insurance Commissioners Customer Service and Support/Help Desk, 1100 Walnut St., Ste 1500, Kansas City, MO 64106-2197 P: [816.783.8500|tel:8167838500].").

[332] *See* Freedom of Information Act, 5 U.S.C. § 552(b)(4).

[333] Asudeh et al., *supra* note 254 (detailing how data can be manipulated through cherry-picking to show seemingly accurate information that is highly misleading).

[334] NAT'L ASS'N INS. COMM'R, *supra* note 327.

MCAS State Ratio Distribution Report for Data Year 2021

Health Ratios - National Level

Ratio 1	The number of claim denials to the total number of claims received (Excluding Pharmacy)	0.150
Ratio 2	Percentage of in-network claims (Excluding Pharmacy)	92.197%
Ratio 3	Percentage of out-of-network claims (Excluding Pharmacy)	7.803%
Ratio 4	Percentage of in-network claims paid within 30 days (Excluding Pharmacy)	95.573%
Ratio 5	Percentage of in-network claims denied within 30 days (Excluding Pharmacy)	90.826%
Ratio 6	Percentage of out-of-network claims paid within 30 days (Excluding Pharmacy)	65.764%
Ratio 7	Percentage of out-of-network claims denied within 30 days (Excluding Pharmacy)	84.885%
Ratio 8	Percentage of claims paid (Pharmacy Only)	77.483%
Ratio 9	Insured co payment responsibility to covered lives (Excluding Pharmacy)	$190.21
Ratio 10	Insured coinsurance responsibility to covered lives (Excluding Pharmacy)	$174.99
Ratio 11	Insured deductible responsibility to covered lives (Excluding Pharmacy)	$542.76
Ratio 12	Cost sharing responsibility to covered lives (Pharmacy Only)	$200.51
Ratio 13	Adverse determination grievances per 1,000 member months	1.115
Ratio 14	Adverse determinations overturned to total grievances involving adverse determinations	32.252%
Ratio 15	Adverse determinations upheld to total grievances involving adverse determinations	64.936%
Ratio 16	Grievances not involving adverse determinations per 1,000 member months	0.273
Ratio 17	Customer requested appeals on final adverse determinations to an external review organization (ERO) per 1,000 member months	0.028
Ratio 18	Final adverse determinations upheld upon request for external review to number of requested appeals on final adverse determinations to an external review organization (ERO)	0.616
Ratio 19	Final adverse determinations overturned upon request for external review to number of requested appeals on final adverse determinations to an external review organization (ERO)	0.407

Figure (II)(1)[335]

Yes, that is it.[336] What little information the NAIC's report contained is scant and, based on the information contained within, it is unclear what the actual requirements, if any, exist for insurers reporting to the NAIC.[337] The NAIC has no governmental authority to demand data from insurers.[338] The organization states "Our goal is to bring state regulators together to serve the public interest. We provide tools and resources to help regulators set standards and best practices, provide regulatory support functions, and educate consumers and stakeholders on U.S. state-based insurance regulation."[339] However, the NAIC will not give the detailed report to a non-

[335] *Id.*

[336] *Id.*

[337] *See* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 323 (2016); U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[338] U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 28.

[339] *Regulator,* NAT'L ASS'N INS. COMM'R, https://content.naic.org/regulator [https://perma.cc/T9A5-4NJH]

insurer.[340] Because they are a private organization, this data is likely not discoverable under a Freedom of Information Act request either.[341] Considering these factors, it is impracticable to assess the credibility of their claims and subsequently the usefulness of the data.[342]

7. Private Organizations

In 2011 the Rand Institute published a short article reinforcing the position that the health insurance market, specifically the ERISA market, is essentially unmonitored.[343] Rand found its monitoring was so fragmented and incomplete, there was no trustworthy data—at least in terms of claim denials, this appears to still be the case.[344]

A Google search or even more detailed open-source research will bring up many results from private organizations that make claims on denial prevalence.[345] I have yet to find one that was comprehensive, well sourced, or sourced in fact at all.[346] Many point to Medicare and Medicaid data.[347] Some purport to have studied client markets.[348] In general, open source data comes from marketing products produced for niche markets, and often do not hold up to a cursory interrogation.[349]

8. Summary of Claim Denial Prevalence and Lack of Transparency

As far as claim denial transparency is concerned, there is a strong

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(last visited Jan. 22, 2023).

[340] E-mail from Jacob Kline, NAIC Representative, to Francis Beifuss, author (Nov. 2, 2022, 12:06 EST) (on file with author) (stating, "Thank you for reaching back out. To gain access to MCAS, a CoCode [an insurer identifier] would be necessary to proceed with account creation. Any questions, please let us know. Thanks, Jacob Kline, NAIC Service Desk, National Association of Insurance Commissioners Customer Service and Support/Help Desk, 1100 Walnut St., Ste 1500, Kansas City, MO 64106-2197 P: [816.783.8500|tel:8167838500].").

[341] *See* Freedom of Information Act, 5 U.S.C. § 552(b)(4).

[342] Asudeh et al., *supra* note 254 (detailing how data can be manipulated through cherry-picking to show seemingly accurate information that is highly misleading).

[343] U.S. DEP'T. OF LAB. & U.S. DEP'T. OF HEALTH AND HUM. SERV., *supra* note 45.

[344] *Id.*

[345] CHANGE HEALTHCARE, *The Change Healthcare 2022 Revenue Cycle Denials Index* (2022)*;* Jacqueline LaPointe, *Hospital Claim Denials Steadily Rising, Increasing 23% in 2020,* TECHTARGET (Feb. 4, 2021), https://www.revcycleintelligence.com/news/hospital-claim-denials-steadily-rising-increasing-23-in-2020 [https://perma.cc/K4B2-4GFL] (these results are indicative of what is findable; it pools all kinds of claims and is targeted toward hospitals, so they do not paint a clear picture of the ERISA market. Other sites generally cite Kaiser research, which is on CMS markets and does not give data on ERISA markets. One site that is now apparently defunct claimed 30% of ERISA claims were denied each year, the NAIC claims its around 15% this past year, but provides no evidence. What is clear, is there is a clear lack of reliable data.).

[346] CHANGE HEALTHCARE, *supra* note 345; LaPointe, *supra* note 345.

[347] CHANGE HEALTHCARE, *supra* note 345; LaPointe, *supra* note 345.

[348] CHANGE HEALTHCARE, *supra* note 345; LaPointe, *supra* note 345.

[349] CHANGE HEALTHCARE, *supra* note 345.

argument that there is none.[350] There appears to be no open-source way to determine whether certain insurers are worse than others.[351] There also appears to be no agency or department that actively tracks ERISA insurer behavior.[352] Instead, the agencies meant to handle complaints leave it to individual consumers to send complaints.[353]

If the numbers look anything like the Medicare and Medicaid numbers,[354] somewhere around twenty percent of claims are denied on their initial submission.[355] Incentives are markedly different for an ERISA insurer and Medicare claim administrator, so there is not a good reason to suspect the numbers would be the same, especially considering ERISA insurers are essentially unmonitored.[356]

Less than one percent of Medicare claims are appealed.[357] If the ERISA markets have a similar trend, or even at a much greater rate, consider a 500% increase in appeals, would still mean over ninety five percent of ERISA claim denials go without appeal.[358] It is unlikely that more denials generate complaints that make it to an actual regulating agency than are actually appealed.[359] What is more likely, however, is that some subset of appeals, likely those that fail, eventually end up as complaints.[360] According to LexMachina® analytics, 2021 only saw 2,764 cases filed alleging wrongful denials, including life and disability claims.[361] Considering there were over 178,000,000 people on ERISA health plans in 2021, that is a tiny number.[362] Without good reporting requirements, this problem will remain in the shadowy space between un-and-underreporting.[363]

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[350] *See infra* discussion section (II)(C)(1)-(8).

[351] *Id.*

[352] *Id.*; *see* JANET L. YELLEN ET AL., *supra* note 267.

[353] EBSA REPORTING GUIDE, *supra* note 27, at 5-8.

[354] Karen Pollitz et al., *supra* note 43.

[355] *Id.*

[356] Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 128 (2008); Çagatay Koç, *The Productivity of Healthcare and Health Production Functions*, 13 HEALTH ECON. 739, 741-743 (2004); *see infra* discussion section (III)(C)(1)-(8); David McAdams & Michael Schwarz, *Perverse Incentives in the Medicare Prescription Drug Benefit*: 44 no. 2 INQUIRY: THE J. OF HEALTHCARE ORG. PROVISION & FIN.157 (2007).

[357] Karen Pollitz et al., *supra* note 43.

[358] *See id.*

[359] *See generally* Andres Almazan et al., *Firms' Stakeholders and the Costs of Transparency* (Nat'l Bureau of Econ. Rsch., Working Paper No. 13647, 2007).

[360] *Id.*

[361] Michael T. Graham et al., *8 Best Practices for Handling ERISA Benefit Claims*, LEXISNEXIS LAW 360 (Sept. 27, 2019), https://www.law360.com/articles/1203105/8-best-practices-for-handling-erisa-benefit-claims [https://perma.cc/6MLG-6587].

[362] KEISLER-STARKEY & BUNCH, *supra* note 18, at 4–5; Mark P. Cussen, *Top 5 Reasons Why People Go Bankrupt,* INVESTOPEDIA (Mar. 4, 2021), https://www.investopedia.com/financial-edge/0310/top-5-reasons-people-go-bankrupt.aspx [https://perma.cc/3U5L-G6VS].

[363] *See generally* Almazan et al., *supra* note 359.

D. Preemption

The keystone holding up the other layers of insurer protection, is express and conflict pre-emption. Federal preemption occurs when federal law supersedes state law as a result of a conflict, whether express or implied, between state law and federal law.[364] ERISA § 1144(a) states:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.[365]

This means individual state legislatures have little to no ability to curb maladaptive outcomes of ERISA.[366] There are some actions state legislatures can take through a complicated scheme of delegation that leaves certain criteria to them, for fully-insured plans and claim administrators of self-funded plans.[367] States can dictate to some extent what an insurer can do by making insurance industry-wide requirements, that avoid express preemption, but likely do not avoid conflict preemption.[368] States cannot dictate reporting, administration standards, or generally enforce previsions, and, after *Gobeille v Liberty Mut. Inc.*, states cannot even enforce penalties for insurer non-compliance with programs left to their discretion.[369] State statutory controls are impotent given their toothlessness and seemingly nonexistent enforcement.[370] The effect of preemption is calcification of the circular protection created by the first two layers of immunity (i.e., damages immunities and consulting physician malpractice immunity) and institutionalizes the lack of transparency.[371]

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[364] *Preemption*, CORNELL L. SCH. LEGAL INFO. INST. (last visited Jan. 30, 2024), https://www.law.cornell.edu/wex/preemption [https://perma.cc/LXQ2-TM23].

[365] Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1144(a).

[366] Margaret G. Farrell, *supra* note 121, at 254–56.

[367] *See* Humana Inc. v. Forsyth, 525 U.S. 299, 311–12 (1999) (discussing the place of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015, in ERISA and when state reverse preemption may apply); *and see* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) (holding that certain state surcharge requirements avoiding preemption because they are insurance industry-wide).

[368] Margaret G. Farrell, *supra* note 121, at 254–56; *see also* BARKER & KENT, *supra* note 10, at § 8.04(d)(i)-(iii) (2nd 2022).

[369] Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016); Farrell, *supra* note 121, at 254-256.

[370] *Contra Gobeille*, 577 U.S. at 323 ("These various requirements are not mere formalities. Violation of any one of them may result in both civil and criminal liability."); *see* Peter K. Stris, *supra* note 8, at 396–98; *and see* Sharon J. Arkin, *supra* note 20.

[371] *See Gobeille*, 577 U.S. at 323; *see* also discussion *infra* Sections II.A—C.

ERISA preemption has made this problem unavoidable in all American territories.[372] Its pervasiveness makes Dawn's story not a lone anecdote, but a representation of an unknown number of patients unable to access needed care.[373] The number is unknown because there is no agency that tracks denials of ERISA health claims.[374] What is known, however, is that around sixty percent of personal bankruptcies filed in the U.S. are due to medical expenses, yet only around eight and a half percent of the country is without health insurance.[375]

1. Reverse Preemption and McCarran-Ferguson Act

Insurance has a strange history when it comes to preemption.[376] Insurers are allowed to share information in ways that would normally violate anti-trust laws.[377] The rationale is a public policy concern: insurance policies and investments are heavily regulated to ensure solvency.[378] These policies and investments are supposed to provide a societal safety net, even if privately paid for.[379] In that effort, minimum rates can be more accurately set if markets are better understood.[380] Insurance companies were shaken when anti-trust laws were instituted, but, shortly thereafter, the McCarran-Ferguson Act was instituted to abate their worries.[381]

The McCarran-Ferguson Act left regulating "the business of insurance" to the states,[382] meaning states could avoid federal control of insurance.[383] This notion of giving states control over one aspect of the traditionally federally dominated (i.e., preempted) field of insurance is known as "reverse preemption."[384] When Congress enacted ERISA in 1974, it created another wrinkle in the preemption law.[385] For employer sponsored healthcare plans, ERISA preempts state laws regarding some aspects of what plans must cover, like emergency care; and it preempts, in entirety, administration and enforcement of plans. Much of plan construction,

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[372] *See Gobeille*, 577 U.S. at 323; *and see Forsyth*, 525 U.S. at 311–12.

[373] *See* Bryant, *supra* note 1; *see* U.S. DEP'T OF LAB. & U.S. DEP'T OF HEALTH AND HUM. SERV., *supra* note 45; *see also* discussion *infra* Section II.(C).

[374] *See* EBSA REPORTING GUIDE, *supra* note 27, at 5–8; see also *infra* discussion section (II)(C).

[375] KEISLER-STARKEY & BUNCH, *supra* note 18, at 4–5; Lina Velikova, *supra* note 194.

[376] *See* ABRAHAM & SCHWARCZ, *supra* note 85, at 112–17.

[377] *Id.*

[378] *Id.*

[379] *Id.*

[380] *Id.*

[381] *Id.*

[382] *See* ABRAHAM & SCHWARCZ, *supra* note 85, at 112–17.

[383] *Id.*; *see also* McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015.

[384] BARKER & KENT, *supra* note 10, at § 8.04(d).

[385] *See generally* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1001–1461; *and see* BARKER & KENT, *supra* note 10, at § 8.04(d).

however, is still left largely to the states, because of reverse preemption granted through the McCarran-Ferguson Act.[386]

2. Preemption By Plan Type and Component

There is another layer of division regarding self-funded and fully-funded plans.[387] It is simpler to first understand that plans are split into two parts: administration and funding.[388] The entity that actually pays the medical bill—the funding component—is the insurer.[389] The administrator is the entity that files forms, receives claims, manages some degree of records, and carries on other general administration duties.[390] This arrangement can be confusing because the employer is also technically the *plan administrator*, while the insurance companies that actually administer plans are referred to as *claim administrators*.[391]

In a fully-funded plan, the distinction between plan and claim administration are much less clear, but the terms hold.[392] In the more common version of self-funded plans, the insurer is the employer, and the administrator is a hired contractor—typically a major insurance carrier.[393] A normal self-funded arrangement works as follows: large firm employers like Amazon or Target pay for the medical bills of their employee, but the employee probably has an Aetna, Humana, or other insurance card in their wallet.[394] Insurance companies, in this example, likely manage plans more efficiently than their client-firms, so they manage claims and interface with care providers. There is a final category. Although seemingly very uncommon, except possibly for employees of insurance companies or large healthcare firms, self-funded plans are self-administered.[395] It would seem this scenario would also make the distinction moot.[396]

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[386] *See* BARKER & KENT, *supra* note 10, at § 8.04(d); *see also* McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015.

[387] Rebecca Wilson, *Self Funded vs Fully Insured vs Level Funded Plans*, BLUE RIDGE RISK PARTNERS (Aug. 10, 2021), https://www.blueridgeriskpartners.com/blog/eb-types-of-health-plans [https://perma.cc/G9S8-2Z3S].

[388] *The Basics of an ERISA Life, Health, and Disability Insurance Claim—Part Three: Plan and Claims Administrators*, MCKENNON L. GRP. PC, https://mslawllp.com/the-basics-of-an-erisa-life-health-and-disability-insurance-claim-part-three-plan-and-claims-administrators/#:~:text=In%20contrast%20to%20the%20Plan,and%20dismemberment%20insurance%20benefits%2C%20etc. [https://perma.cc/H5N9-RPGA] (last visited Feb. 20, 2024).

[389] *Id.*

[390] *Id.*

[391] *See id.*

[392] *Id.*

[393] Wilson*, supra* note 387; *see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1002(16); *see also* U.S. DEP'T OF LAB. & U.S. DEP'T OF HEALTH AND HUM. SERV., *supra* note 45, at 2.

[394] ABRAHAM & SCHWARCZ, *supra* note 85, at 112.

[395] *Id.; see* Wilson *supra* note 387.

[396] *See id.*

Fully-funded plans are preempted by ERISA in a multilayered system of preemption and reverse preemption, where states can mandate how the plans may be written except in the ways ERISA dictates, by its Savings Clause; and they are entirely preempted as to administration and enforcement; allowing insurers to enjoy the effective immunity granted to them through ERISA. [397]

Self-funded employer-insurer plans are fully preempted, by ERISA's Deemer Clause, which means they can be written almost however the employer-insurer wants, so long as they include the relatively few requirements of ERISA.[398] However, the claim administrator may only be preempted as they would if they were part of a fully-funded plan.[399] ERISA plan requirements are narrow and meant to cure specific problems or holes in state guidelines.[400] This means self-funded may be the worst of both worlds, because they can legally deny coverages that their home states would normally require while enjoying administrative immunities.[401]

3. Consequences of Express Preemption

Preemption has made it impossible to meaningfully impact wrongful insurer practices for decades.[402] *Aetna v. Davila* is the hallmark case in which the Supreme Court unanimously held that state causes of action for bad faith were preempted by ERISA.[403] The reasoning was that for claims of negligent administration of duties, there was no way to separate the claims of the state law violation and the implicit ERISA violation.[404] The Court determined Congress's intent was to have a single system of enforcement, which has grown to mean that even state civil causes of action for conspiracy, fraud, and breach of fiduciary duty are also preempted.[405] In effect, the *Davila* holding forces litigants to work within the bounds of ERISA's statutorily defined remedies, which are few and diminutive.[406]

The determination made in *Gobeille* left uncertainty about the

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[397] *See generally* Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008); *and see generally* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016); *see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1144(a); *see also* BARKER & KENT, *supra* note 10, at § 8.04(d).

[398] 29 U.S.C. §§ 1144(b)(2)(A)–(B); *see also* Edward Alburo Morrissey, *Deem and Deemer: ERISA Preemption Under the Deemer Clause as Applied to Employer Health Care Plans with Stop-Loss Insurance; Legislative Reform.,* 23 J. of Legis., no. 2, 307, 308–309 (1997).

[399] 29 U.S.C. §§ 1144(b)(2)(A)–(B).

[400] 29 U.S.C. §§ 1191(a).

[401] *Id.*

[402] *Id.*; *see* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1144(b)(2)(A)-(B); Morrissey, *supra* note 398*; and see Metro Life Ins. Co.*, 554 U.S. 105.

[403] *See generally* Aetna Health Inc. v. Davila, 542 U.S. 200 (2004).

[404] *Id.* at 212–14.

[405] BARKER & KENT, *supra* note 10, at § 8.04(d)(ii).

[406] *Id*.

efficacy of state reporting agencies that now run on assumed goodwill by insurers.[407] An example of how preemption has impacted efforts in transparency may be seen in The Agency for Healthcare Quality and Research (AHRQ); they collect all the participating states' data and produce comprehensive reports annually.[408] In their report, there are no mentions of claim success or denial rates—in the AHRQ's most recent 224-page report, the word claim(s) only appears once.[409]

Preemption calcifies the issues created by ERISA's circular immunity structures by obstructing the system whenever a state attempts to cure the problem in any meaningful capacity.[410] The statutory construction suffocates the Supreme Court of the United States by keeping them from providing any constitutional relief, or at least it has up to this point.[411] So far, the Court has upheld that (1) reporting systems cannot impose fines; (2) state laws cannot be used to create penalties of their own for ERISA protected plans; and (3) insureds cannot receive treble, consequential, or punitive damages in most cases.[412] But, ERISA preemption may also be the best vehicle for rapid sweeping correction of the problems, because reforms would supersede similarly problematic state law while resolving ERISA's inherent issues.[413]

III. SYNTHESIS OF THE ISSUES

Because of the immunities available for insurers of ERISA plans, through damages immunities, consulting physician malpractice immunity, and lack of transparency, calcified by the current preemption structure, there is a clear perverse incentive for insurers to wrongfully deny claims.[414] The cost of a long-term patient is exorbitant.[415] The goal of an insurer is to have as few dollars in claims awarded as possible.[416] The best way to achieve that is to have insureds in hospitals or treatment facilities as little as possible. There are two basic ways to achieve this: (1) to take steps to have a healthier pool of insured, and (2) deny care for insureds.[417] The first method can be

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[407] *See generally* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016).

[408] AGENCY FOR HEALTHCARE RSCH. & QUALITY, *supra* note 154.

[409] *See* G. EDWARD MILLER ET AL., *supra* note 154; *Id.* at 26.

[410] *See generally* BARKER & KENT, *supra* note 10, at § 8.04.

[411] *See, e.g.,* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016); Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008); Aetna Health Inc. v. Davila, 542 U.S. 200 (2004).

[412] *See Gobeille*, 577 U.S. at 312; *Glenn*, 554 U.S. at 105; *Aetna Health Inc.*, 542 U.S. at 200.

[413] *See Gobeille*, 577 U.S. at 312; *Glenn*, 554 U.S. at 105; *Aetna Health Inc.*, 542 U.S. at 200.

[414] *See, e.g., Glenn*, 554 U.S. at 123–24 (Roberts, C.J., concurring).

[415] *See* AM. CANCER SOC'Y, *supra* note 201; *see infra* discussion section (II)(B).

[416] *See infra* discussion section (I)(D).

[417] *See* Steve Aldana, *18 Wellness Program Incentive Ideas from the Best Corporate Wellness Programs In 2023*, WELLSTEPS (Feb. 7, 2023) https://www.wellsteps.com/blog/2020/01/02/wellness-program-incentive-ideas/

accomplished by incentivizing health initiatives like movement programs, where insureds receive discounts on their premiums for meeting movement goals, tracked through pedometers, smartphones, smartwatches, etcetera.[418] Healthy lifestyles undoubtedly reduce the aggregate need for healthcare.[419] It does not, however, guarantee health; and health is a moving target for most, with periods of greater and lesser attention to it.[420]

The second way to keep people out of hospitals is to deny their care, especially diagnostic care.[421] Diagnostic care identifies expensive illnesses like cancer or genetic illnesses.[422] But, treatments like chemotherapy are not covered unless they are medically necessary.[423] Medical necessity cannot be established without diagnostics.[424] Diagnostics are frequently cost prohibitive, without insurance.[425] For example, a single MRI screening may cost $10,000.[426] By the time cancer becomes symptomatic, patients are often in somewhat advanced stages, and other diseases, like Lupus or Lou Gehrig's disease, may not become symptomatic until a steep decline in the insured's health or crisis is imminent.[427] If diagnoses are delayed for a few months by a denial, that may be the difference between whole stages of cancer, operability or inoperability, and preventable suffering or catastrophic loss.[428]

There is a cynical reading that makes clear economic sense. For health insurers, they must only cover claims made during a policy year.[429] If an employee becomes horribly ill, they have a great propensity to be unable to work.[430] If they are unable to work, they probably will not stay employed very long.[431] People with serious conditions like late-stage cancer move to Medicare or Medicaid, where their care is government subsidized and mostly

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[https://perma.cc/Z7NV-XU8B].

[418] *Id.*

[419] *Id.*

[420] *Id.*

[421] *See* discussion *infra* Sections I.D.–II.A-B.

[422] *See* AM. CANCER SOC'Y, *supra* note 201; 29 C.F.R. §§ 2590.715-2719; 29 U.S.C. §§ 1181-1191(d).

[423] SARA ROSENBAUM ET AL., U.S. DEP'T OF HEALTH AND HUMAN SERV., MEDICAL NECESSITY IN PRIVATE HEALTH PLANS: IMPLICATIONS FOR BEHAVIORAL HEALTH CARE 30 ("Similarly, when the denial is based on medical necessity, the rule requires the plan either to explain the scientific or clinical judgment used in applying the plan's terms or to include a statement that such an explanation will be provided free of charge if requested.").29 C.F.R. §§ 2590.715-2719; 29 U.S.C. §§ 1181-1191(d).

[424] *29 U.S.C. § 1144(b)(2)(A); Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008).*

[425] *See* AM. CANCER SOC'Y, *supra* note 201.

[426] *See* Nick Versaw, *How Much Does an MRI Cost?* COMPARE.COM (Feb. 1, 2022), https://www.compare.com/health/healthcare-resources/how-much-does-an-mri-cost [https://perma.cc/M9E8-LBHL].

[427] *See* AM. CANCER SOC'Y, *supra* note 201; LUPUS FOUND. OF AM., *Lupus Facts and Statistics* https://www.lupus.org/resources/lupus-facts-and-statistics [https://perma.cc/4MWW-HJM7] (last visited Jan. 22, 2022).

[428] *See* AM. CANCER SOC'Y, *supra* note 201.

[429] Rebecca Wilson, *supra* note 387.

[430] *See* AM. CANCER SOC'Y, *supra* note 201.

[431] *Id.*

no longer the problem of large insurers. [432] So, if insurers can keep insureds from being diagnosed with a serious illness until their illness is so out of hand that disability, hospice, or death are the outcome, insurers can save tremendous amounts of money.[433] In these cases, insurers may have to cover some costs they previously denied, and pay their attorneys' billable hours.[434] But even the high cost of defense is much cheaper than the cost of taking an insured through a multi-decade fight with recuring cancer, especially if the ratio of denials to legal action are as low as they appear.[435] Without serious penalty exposures from injured parties, the parties with a motivation for seeking correction—the people affected by insurers' casual indifference—will continue to be treated like infrequent, inexpensive parking tickets in a very, very, expensive parking lot.[436]

IV. SOLUTIONS

A. Transparency and Data

Insurers should have to forward all claim denials to a governing agency; the EBSA is a logical choice that should produce a report similar to the CMS system, which systemically documents claim denials under the Medicaid and Medicare systems.[437] In addition to denials, insurers should send a total number of claims received, processed, dollars paid, and an estimate of dollars denied to EBSA. While requiring that volume of data would be a large task, there is already a road map for how it could be accomplished.[438] CMS has the system and knowledge base—since CMS plans are generally administered by large insurance companies, these companies already know how to comply with the tentative procedural requirements.[439] Thus, the solution is a matter of resource allocation rather than issue-based legislation.[440] This solution would be the easiest step toward improving the ERISA health insurance market.

In addition to borrowing from CMS' roadmap regarding claim denials, EBSA should also utilize the AHRQ's interactive reports through their Medical Expenditure Panel Survey Insurance Component Data Tool.[441]

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[432] *Id.* at 14.
[433] *See infra* discussion Sections (II)(A),(B).
[434] *Id.*
[435] *Id.;* AM. AM. CANCER SOC'Y, *supra* note. 201; Karen Pollitz et al, *supra* note 43.
[436] *See infra* discussion section (I)(D).
[437] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1143; Karen Pollitz et al., *supra* note 43.
[438] *Id.*
[439] *Id.*
[440] 29 U.S.C. § 1143.
[441] AGENCY FOR HEALTHCARE RSCH. & QUALITY, *supra* note 154.

This solution would be an ideal landing page for the data collected by the EBSA.[442] Making data about claim denial rates public would help provide a market solution.[443] With trustworthy data, it would be easier for employers to make informed decision on which insurers provide quality service.[444]

B. Removal of Immunities

1. Civil Penalties

The prohibition of consequential and punitive damages must be expressly repealed.[445] This, by itself, would greatly alter the terrain of ERISA markets.[446] Actual penalties would change the cost-benefit analysis of every denial by incentivizing insurers to be diligent in their claim merit analysis. Moreover, the solution would democratize advocacy for insureds by making contingency representation viable.[447] Expressly authorizing attorneys' fees would also be a positive step, but it would not be as complete as authorizing special damages.[448] Part of the problem is there is little to no incentive for aggrieved patients to sue insurers if it is too late for them to benefit from the denied treatment—like a cancer patient who is now too advanced to benefit from interventions, and, instead moves to hospice.[449] That loss of chance is not accounted for by attorneys' fees, but it would improve the availability of representation for many.[450]

Medical consultants working for insurers who make claim decisions need to have their decisions weighed as either descriptive or diagnostic.[451] Descriptive decisions determine if a claim stated what it purports to claim.[452] For example, a claim states a patient has a broken tibia in their left shoulder—

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[442] *See id.*

[443] *See generally* Asudeh et al., *supra* note 254; *see also* discussion *infra* Sections I.(D), II.(C). Publicizing accurate denial rate data could diffuse some insurer benefits for operating as a cartel. Insurers would be subject to informed consumer market inputs and would have to carefully balance anti-competitive behavior against drawing regulator attention. In other words, they could uniformly have high denial rates, which would be more likely to draw the attention of regulators, or they could compete with each other.

[444] Asudeh et al., *supra* note 254;

[445] *See* 29 U.S.C. § 1132; *and see* Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985) ("Thus, the relevant text of ERISA, the structure of the entire statute, and its legislative history all support the conclusion that in § 409(a) Congress did not provide, and did not intend the judiciary to imply, a cause of action for extracontractual damages caused by improper or untimely processing of benefit claims.").

[446] *See infra* discussion I.(D), II.(A).

[447] *Id.;* DERFNER & WOLF, *supra* note 193.

[448] DERFNER & WOLF, *supra* note 193.

[449] *See* AM. CANCER SOC'Y, *supra* note 201, at 22–23.

[450] *See What is the 'Loss of Chance' Doctrine in Medical Malpractice Cases?*, POWERS & SANTOLA, LLP, https://www.powers-santola.com/blog/loss-of-chance/#:~:text=Under%20the%20loss%20of%20chance,is%20harmed%20by%20the%20disease. [https://perma.cc/X9KP-FTAE] (last visited Feb. 21, 2024).

[451] *See* 29 C.F.R. §§ 2590.715-2719 (2022); *see also* ROSENBAUM ET AL., *supra* note 423.

[452] ROSENBAUM ET AL., *supra* note 423.

of course shoulders do not have tibias, so, if a consulting physician were to point this out, it would merely be descriptive.

Diagnostic decisions determine medical necessity.[453] For example, if a claim for an MRI is denied on grounds of medical necessity, the consulting physician making that determination would own it, as would any other physician seeing a patient.[454] When consulting physicians' decisions are subject to medical malpractice, the relationship between insurers' physicians and practitioners should be less adversarial because incentives to deny valid claims would be countered by the disincentives of malpractice exposure.[455]

If insurers want to deny claims based on medical necessity, then they should have some skin in the game.[456] If insurers want one of their physicians to provide a second opinion, then that must be done in a reasonable time frame and without burden to their insureds, given the context of a specific diagnosis, and under a looming hammer of bad faith.[457]

Additionally, if an insurer makes a determination for non-medical necessity reasons—like a specific service is not covered—and it is determined that it is medically necessary and should have been covered, insurers should be subject to medical malpractice as would a hospital that oversees the misdiagnosis of a patient.[458] Denial or delay, whether from an insurer or a care provider, are differences without distinction in terms of outcome.[459] These changes would shift the incentives for consulting physicians and insurers, towards a greater emphasis on expeditious and effective treatments that produce a pool of healthier insureds.[460] It might even create an incentive for research and development of inexpensive, long-term curative treatments that are normally not clearly incentivized by the healthcare industry.[461]

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[453] ROSENBAUM ET AL., *supra* note 423.

[454] *See* RESTATEMENT (THIRD) OF TORTS § 3(e) (AM. L. INST. 1997).

[455] *Id.*

[456] *See infra* discussion sections (I)(D), (II)(B).

[457] *But see* 29 C.F.R. §§ 2590.715-2719 (2022); *but see* 29 U.S.C. § 1132 (2022).

[458] *See infra* discussion section (II)(B).

[459] *Id.;* Vukadin, *supra* note 121, at 12–13.

[460] *See* Aldana, *supra* note 417. *See generally* Anna Chorniy et al., *Regulatory Review Time and Pharmaceutical Research and Development*, 30 HEALTH ECON. no. 1, 113 (Jan. 2021).

[461] *See* Chorniy et al., *supra* note 460 (detailing contemporary financial issues in pharmaceutical research and development, which lead to high prescription drug costs). One of the primary effects of high research and development costs is that it makes pharmaceutical companies capital intensive. For pharmaceutical companies with the traditional incentive to find treatments, there is an incentive to develop innovative treatments only if there is a subsequent profit sufficient to justify not investing that capital in other market sectors. This makes the barrier finding treatments for rare disease or creative solutions less desirable, or possibly untenable, from the perspective of a traditional pharmaceutical company. However, for an insurance company, the incentives are reversed: its incentive is to have people have as little and as inexpensive care as possible by denying claims and refusing to pay.

2. Criminal penalties

There is only one criminal statute under ERISA and it requires willful intent.[462] This willful intent standard should be adjusted to a progressive intent standard, starting at strict liability. This would be in addition to—or superseding when incompatible—the current fine structure.[463] Strict liability may seem harsh, but the purpose of strict liability is typically to capture wrongful omissions of a duty.[464] As the punishment structure would be progressive, the penalties for violations that were merely due to inadequate care in performing statutory obligations would be relatively low, saving the greater punishments for more egregious behavior.[465]

3. Enforcement

There are too many organizations responsible for regulating the ERISA market and no clear leader.[466] There needs to be a single program manager that can lean on other organizations for appropriate support.[467] The EBSA already does this in a very limited extent.[468] They should be empowered with resources and a mandate requiring them to fill a similar role for benefits plans as the SEC does in monitoring securities fraud.[469] The scope of the EBSA's concern needs to be expanded and modified to enforce against claim administrators, as opposed their current role primarily pursuing employers and making employers do the heavy lifting at their own expense.[470] In removing barriers to individual civil recovery, the expectation of massive increase in the EBSA's case load, or whichever agency ultimately bears the burden, would be greatly reduced.[471]

C. The Question of Preemption

Express preemption, while terrible in its current form, could be a double-edged sword: By leaving it in place, market-wide changes could be

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[462] 29 U.S.C. 1131 (2022).
[463] *Id.*; 29 U.S.C. 1132 (2022).
[464] 4 ARKIN, BUSINESS CRIME: CRIMINAL LIABILITY OF THE BUSINESS COMMUNITY ¶16.01 (Matthew Bender ed., 2022).
[465] *Id.*
[466] *See infra* discussion section (II)(C).
[467] *Id.*
[468] *See generally* YELLEN ET AL., *supra* note 267.
[469] *See What We Do*, SEC. EXCH. COMM'N, https://www.sec.gov/about/what-we-do [https://perma.cc/C2YC-EE94] (last visited Mar. 1, 2023).
[470] *See generally* YELLEN ET AL. *supra* note 267*; see infra* discussion section (II)(C).
[471] *See* DERFNER & WOLF, *supra* note 193 (discussing the ban of awarding attorneys' fees under ERISA as an obstacle to recovery).

implemented rapidly; though leaving preemption completely intact is not necessary to have such rapid reform.[472]

Selectively curtailing the express preemption clause could allow for rapid sweeping change. By modifying the Deemer and Savings clauses,[473] the worst examples of abusive plan writing in self-funded markets could be curtailed as they are in fully-funded markets, without becoming overburdensome to employers.[474] ERISA already meets its stated objective of standardizing requirements for multistate employers by the fact that employee plans can all relate to a single state, generally the employing organization's state of issuance.[475] This removes the justification to disallow specific state consumer protection regulations as seen in *Aetna v. Davila.*[476] Modifications should make clear where states have been given the burden of regulation they have the benefit of enforcement powers and would solve the issue of all-payer databases not having any ability to enforce data collection on denials.[477] Empowering state administrations, while allowing the federal government to set minimum standards, floor preemption, appears the most appealing option for ERISA health insurance beneficiaries.[478]

Removing the preemption clause would not completely remove preemption; it would, however, send employer-sponsored health insurance into field preemption, and there would at least be the robust amount of conflict preemption.[479] The McCarran-Ferguson Act would make the outcome a mess of small battles over state versus federal power.[480] This option would take a considerable rethinking of the current regulatory landscape and would likely cause national instability and uncertainty in the short term. It would also leave consumers in some states with few protections.[481] Accordingly, selective modifications of the current express preemption ERISA landscape are an optimal solution.

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[472] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1144.

[473] 29 U.S.C. § 1144(b)(2)(B); 29 U.S.C. § 1144(b)(2)(A).

[474] 29 U.S.C. § 1144 (b)(2)(B); Morrissey, *supra* note 398.

[475] 29 U.S.C. § 1001.

[476] *See* Aetna Health Inc. v. Davila, 542 U.S. 200, 201 (2004).

[477] *See* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 323 (2016); *and see* CARMAN ET AL., *supra* note 109.

[478] William W. Buzbee, *Asymmetrical Regulation: Risk, Preemption, and The Floor/Ceiling Distinction*, 82 N.Y.UNIV. L. REV. 1547, 1558 (Dec. 2007).

[479] *See* BARKER & KENT, *supra* note 10, at § 8.04(d).

[480] *See generally* McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015; *see* Humana Inc. v. Forsyth, 525 U.S. 299, 308 (1999) (noting that, because the McCarran-Ferguson Act gives the sates powers in a reverse preemption scheme, modern implicit preemption would not apply to this Act under the field preemption doctrine but may still apply under conflict preemption if there is a direct conflict between the Act and state statutes where meeting both standards is impossible).

[481] *Id.*

D. Market Stabilization

The aforementioned proposed solutions (e.g., imposing civil and criminal penalties and selectively modifying ERISA's express preemption) will likely increase the cost of employer-sponsored healthcare.[482] Although, premiums are determined on the pretext of normal risk, these solutions *will* impact net profits for insurers.[483] Despite the inevitable criticism that these proposed changes will make health insurance less affordable, if the market operated in good faith it should not. Because these changes simply hold welfare benefits insurers accountable for not honoring their obligations, as every other type of insurer already must.[484] For insurers who do not act in bad faith, these changes should have little to no impact on their profitability.[485] In fact, such changes would provide a market advantage for lawful insurers because they could underwrite premiums without the level of consideration for litigation as their dubious competition would have to.[486]

It is important that these changes do not adversely affect insureds and the overall labor market, and the following few realistic solutions present themselves, given current political will and public opinion.[487] First, health insurance companies are already subject to regulations that are meant to curtail what their margins on premiums can be, although it appears this rule has had a negligible impact.[488] Applying this concept, existing regulations could be adjusted to tighten gaps and base the premiums margin limit to a before-litigation-is-factored-in amount, with some level of allowance for normative litigation costs for large firms.[489] The worst offenders would not be able to shift the total of their litigation costs into their overall profitability, but firms within a normative range would be able to.[490] This would incentivize insurers to avoid litigation, and the best way to do this would be to provide valid care.[491]

Second, expanding existing ACA individual plan markets may be able to balance the risk pooling and insurance burden between employers and the public sector, while keeping rates for healthcare low through public-

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[482] *See* discussion *infra* Sections II.D, III.A-B, & IV.B-C. If insurance firms are no longer able to elude accountability, they will likely become less profitable, and these costs would be passed on to consumers.

[483] ABRAHAM & SCHWARCZ, *supra* note 85, at 383-384.

[484] *See infra* discussion section (IV).

[485] *See generally* BARKER & KENT, *supra* note 10, at § 8.04; *see* discussion *infra* Section IV.

[486] BARKER & KENT, *supra* note 10, at § 8.04.

[487] *See infra* discussion sections (I)(E), (II).

[488] *See* Steve Cicala et al., *Regulating Markups in US Health Insurance*, 11 AM. ECON. J. OF APPLIED ECON., 71, 71–72 (2019).

[489] *Id.*

[490] *Id.*

[491] *Id.*

private competition.[492] This may be much more welcomed by the health insurance lobby if the statutory changes to liability immunities suggested were implemented.[493] If it is harder to avoid honoring coverages and the associated penalties are significant, then having a public option that may be more appealing to chronically ill patients could blunt their losses.[494]

Australia uses a model that may be a good model for the U.S. to evaluate for a public program.[495] The Australian model is analogous to the U.S. education system, where everyone pays for the public system, but may choose to use a private option in actual practice. For the U.S., in healthcare it may be more politically palatable to have a system where people can revert to the base tax rate if they opt-out by purchasing a private healthcare plan.[496] If they do not opt-out by purchasing a private plan, then their rate would be progressive and based on a bracket.[497] The goal would be to maintain a much more cost-effective option, that curtails cost by reduced administrative burdens and a not-for-profit incentive scheme.[498]

Third, a less expansive stop gap would be to expand Medicare and Medicaid subsidies.[499] Subsidizing certain claims through Medicare or Medicaid, burdens on employers would be limited, and the incentives to block diagnostic care would be reduced.[500] ACA individual plan markets already do this, where certain drugs or treatments may be covered through additional government coverage.[501] This solution would, therefore, be mutually beneficial for both insurers as private markets would keep people longer and retain a larger share of patients who would otherwise end up completely covered under public healthcare once they were no longer able to work.[502] But, private markets would also be alleviated from some of the catastrophic costs of some insureds—similar to an outside umbrella policy.[503]

Overall, therefore, the perverse incentives existing within the ERISA landscape—from damages immunities, consulting physician malpractice

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[492] *See* Matthew Fiedler, *Designing A Public Option That Would Reduce Health Care Provider Prices*, UCS LEONARD D. SHAEFFER CTR. FOR HEALTH POL'Y & ECON. & BROOKINGS (2021), https://www.brookings.edu/essay/designing-a-public-option-that-would-reduce-health-care-provider-prices/ **[**https://perma.cc/77WQ-QR8B**].**

[493] *Id.; see also* Cicala et al., *supra* note 488.

[494] *See* Cicala et al., *supra* note 488.

[495] *See generally* STEPHEN DUCKETT, THE AUSTRALIAN HEALTH CARE SYSTEM (6th ed. 2022).

[496] *Id.*

[497] *Id.*

[498] *Id.*

[499] *See* Cynthia Cox et al., *Nine Changes to Watch in ACA Open Enrollment 2023*, KAISER FAM. FOUND. (Oct. 27, 2022) https://www.kff.org/policy-watch/nine-changes-to-watch-in-open-enrollment-2023/ [https://perma.cc/ZU88-4YUR].

[500] *Id.*; *see infra* discussion (I)(B).

[501] Cox et al., *supra* note 499.

[502] *Id.*; *see* Cicala et al., *supra* note 488.

[503] Cox et al., *supra* note 499; ABRAHAM & SCHWARCZ, *supra* note 85, at 667.

immunity, lack of transparency, and preemption—would be significantly reduced through a multitude of remedies, most already available to the public and some through legislation, such as through removing civil damages immunities, requiring EBSA reporting of claims denials, selective modifications to express preemption clause under ERISA, and making the aforementioned adjustments for price increases for insurers and insureds.

CONCLUSION

ERISA has created an untenable healthcare landscape by allowing insurers to profiteer off a completely asymmetrical legal and procedural scheme. Mechanisms of accountability have been hollowed out, leaving only an illusory bulwark for consumers and a very real wall guarding insurers' profits.[504] As a result, insurers have a license to steal from over half the country that seems to be completely un-tracked.[505]

Currently, insurers are immune from claims of bad faith.[506] If caught, they only pay for what they promised in the first place.[507] It is unknown how many claims are actually denied annually, but, if the CMS system where claim administrators are not nearly as conflicted as they are in fully-funded insurance plans deny around 18% of claims annually, it belies rationality to think a less monitored and more conflicted claim administrator would deny fewer than 18% of claims.[508] Consider the volume of 20% of claims generated by 178,000,000 people.[509] If the CMS data holds for ERISA plan appeals, then less than 1% of that massive number is appealed.[510] Even a generous margin of error is given, say between 0.5% and 5% of claims are appealed, or otherwise circumvented, that still leaves 95% or more denied claims left alone.[511] How many of those are for diagnostic treatments?[512]

In addition to lacking accountability through lacking data on claims denials, insurers are faced with perverse incentives: when held liable for the tiny fraction of claims they face, they are only subjected to paying some defense attorney's fees, which pales in comparison to the cost of a thirty-year-old, like Dawn Smith, who would have otherwise beat her first cancer

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[504] *See* Cicala et al., *supra* note 488*; see infra* discussion section II.

[505] *See infra* discussion section II.(C).

[506] *See* Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1132; *and see* Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985).

[507] Karen Pollitz et al, *supra* note 43; *see infra* discussion section II.(A).

[508] Karen Pollitz et al, *supra* note 43; *see infra* discussion section II.(C).

[509] Karen Pollitz et al, *supra* note 43; *see infra* discussion section II.(C).

[510] Karen Pollitz et al, *supra* note 43.

[511] *Id.*

[512] U.S. DEP'T. OF LAB. & U.S. DEP'T. OF HEALTH AND HUM. SERV., *supra* note 45 (finding claim denials to diagnostic testing where more commonly frivolous than others).

diagnosis.[513] Even by delaying the process of care, insurers can cut a lot of working years off of a claimant's life. Once someone is too sick to work, the common trend is to leave the ERISA market and to enter into either Medicare or Medicaid.[514] Even if insureds stay on their ERISA plan for one reason or another, one round of hospice is a lot cheaper than a lifetime of chronic illness or multiple rounds of catastrophic care.[515] Belief in a comforting illusion, that other predatory markets only normalized because industry leaders had sudden changes of heart, will not fix our deranged healthcare market.[516]

Fixing our national issues regarding access to healthcare will take deliberate, forceful, and thoughtful interventions.[517] We can start by immediately instituting a comprehensive tracking system for denials of care and, ideally, by eventually removing civil damages immunities, selectively repealing express preemption under ERISA, and controlling for the increase in price that will cause for care. If we can do that, the illusion of the redress for wronged beneficiaries might be dispelled, stirring the sedated legislators, so they can get to the business of stripping immunities and holding insurers to do no harm. So, hopefully, people like Dawn can focus more on acquiring essential treatment and diagnoses, rather than on being consumed with wrongful claim denials from their insurers, in order to receive the care that they so clearly deserve.[518]

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[513] *See* AM. CANCER SOC'Y, *supra* note 201; *see* Bryant, *supra* note 1.

[514] *See* AM. CANCER SOC'Y, *supra* note 201, at 8.

[515] *Id.* at 23.

[516] *See* Tim Devaney, *Dem Bill Cracks Down on Payday Lenders,* THE HILL (Apr. 7, 2016, 1:52 PM EST), https://thehill.com/regulation/legislation/275499-dem-bill-cracks-down-on-payday-lenders/ [https://perma.cc/DW66-RMKN].

[517] *See, e.g.*, Fiedler, *supra* note 492; *see, e.g.*, Cicala et al., *supra* note 488.

[518] *See* Bryant, *supra* note 1.