

ERISA Preemption After *Rush Prudential*

WALKING ON THE RIM OF THE VORTEX

By Jeffrey E. Dahl*

INTRODUCTION

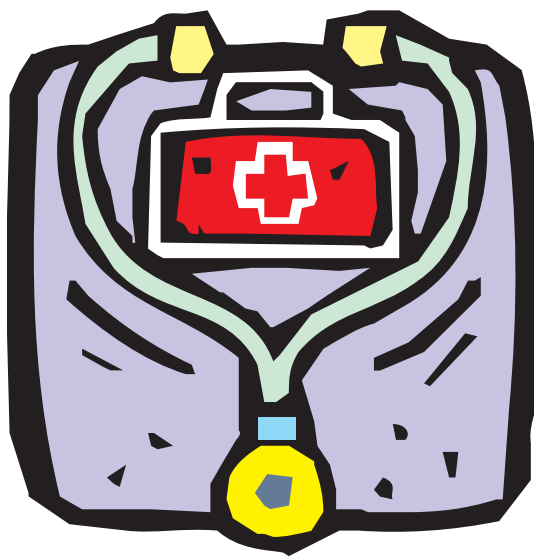
Employee welfare benefit plans, providing health and often disability benefits for employees, are generally funded by employers. Otherwise, employee welfare benefit plans are funded by the purchase of insurance policies. This paper will discuss employee welfare benefit plans that are funded by the purchase of insurance policies. Typically, an insurer not only underwrites the policy but also administers the plan, i.e., receives claims and decides whether there is coverage. The inevitable disputes that arise over coverage and payment, or that arise over a “participant or beneficiary’s eligibility for benefits”, are generally governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (2002) (“ERISA”). ERISA does not govern, however, if the employee welfare benefit plans are expressly exempt from ERISA (“exempt plans”), such as government plans, or plans in which the employer makes no contribution for the payment of premiums and limits its involvement to collecting premiums from the insured employee.¹

When the dispute is governed by ERISA, the health or disability insurance policy is transformed into an ERISA “plan” and is, therefore, interpreted in accordance with ERISA benefits law rather than Texas insurance law. This article will focus primarily on disability policies that are typically part of an employee welfare benefit plan. In light of recent case law, and, in particular, the U.S. Supreme Court decision in *Rush Prudential HMO, Inc. v. Moran*,² this article will also examine whether the remedies provided to Texas insureds in Article 21.21 and 21.55 of the Texas Insurance Code are of any value to an ERISA insured engaged in a dispute with her insurer³

THE PREEMPTION PROVISION AND SAVINGS CLAUSE

The ERISA preemption provision and the savings clause are found in 29 U.S.C. § 1144. The preemption provision, § 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 § 1003(a) of this title and not exempt under § 1003(b) of this title

The savings clause, found in subsection (b)(2)(A) of 1144, asserts: “Except as provided in subparagraph (B) nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”

Subparagraph (B), referred to in the savings clause and known as the “Deemer Clause,” essentially provides that no ERISA plan will be made into an insurer by any state law. The “Deemer Clause” will not be discussed in this article, as this article will address the

accountability of the insurer, not the employer nor the plan, to the insured.

The safe harbor of the savings clause is narrow and remains relatively obscure, despite the passage of time. The sea of fog that hides it is created by a preemption provision and a savings clause that lack specificity and are contradictory rather than complementary. Wrestling with the preemption provision and its savings clause, Justice Souter states in *Rush*:

To safeguard the establishment, operation, and administration of employee benefit plans, ERISA sets minimum standards assuring the equitable character of such plans and their financial soundness, 29 U.S.C. § 1001(a), and contains an express preemption provision that ERISA shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. § 1144(a). A savings clause then reclaims a substantial amount of ground with its provision that nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. § 1144(b)(2)(A). The unhelpful drafting of these antiphonal clauses ... occupies a substantial share of this Court’s time In trying to extrapolate congressional intent in a case like this, when congressional language seems simultaneously to preempt everything and hardly anything, we have no choice but to temper the assumption that the ordinary meaning accurately expresses the legislative purpose ... with the qualification that the historic police powers of the States were not meant to be

superseded by the Federal Act unless that was the clear and manifest purpose of Congress.⁴

THE CURRENT FRAMEWORK OF PREEMPTION ANALYSIS

METROPOLITAN LIFE V. MASSACHUSETTS

As uplifting as the previous quote from the *Rush* opinion might sound, to bring Article 21.21 or Article 21.55 claims on behalf of an ERISA insured and obtain the full relief that those statutes provide is not a sound bet. This elevated starting point where state police powers are treated with reverence crumbles quickly when the citizens of Texas are offered alternative or additional state law remedies to ERISA's remedies under 29 U.S.C. § 1132(a).⁵

Current preemption analysis usually begins with the United States Supreme Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*.⁶ In *Metropolitan Life*, the Court was asked to decide whether the State of Massachusetts had the right to compel insurance companies to incorporate minimum benefits for mental health care into all health policies that were sold to the residents of Massachusetts. *Metropolitan Life* argued that many of the policies were ERISA plans, and ERISA preempted the Massachusetts state law compelling the insurer to provide certain benefits. In discussing the interplay between the preemption and savings clause, Justice Blackmun stated:

The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the savings clause appears broadly to preserve the States' lawmaking power of much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.⁷

In *Metropolitan Life*, the Court found that the Massachusetts state law requiring minimum mental health care benefits was saved from preemption by the savings clause. *Metropolitan Life* established the analytical framework still used by the courts,

factors: 1) Does the law have the effect of transferring or spreading a policyholder's risk; 2) is the law an integral part of the policy relationship between the insurer and the insured; and 3) is the law limited to entities within the insurance industry?¹⁰

PILOT LIFE V. DEDEAUX: THE U.S. SUPREME COURT SETS UP AN ADDITIONAL HURDLE

Two years after the decision in *Metropolitan Life*, *Pilot Life v. Dedeaux*¹¹ was decided. In *Pilot Life*, the insured, a resident of Mississippi, brought claims of tortious breach of contract, breach of fiduciary duties, and fraud in the inducement against his insurer as a result of being denied long-term disability benefits. The dispute reached the U.S. Supreme Court, which found that the insured's common law claims were completely preempted by ERISA. The plaintiff's claims could not meet the requirements of the savings clause because the plaintiff's claims did not meet any of the McCarran-Ferguson factors or even the common sense requirement of *Metropolitan Life*. The fraud and breach of fiduciary duty claims brought by the plaintiff were claims that can be brought in many different settings and clearly not causes of action exclusively reserved for disputes between insured and insurer. The Court, however, presumably desiring to stem the rising tide of preemption issues, chose not to decide the issue narrowly.

Justice O'Connor, writing for the Court in *Pilot Life*, focused upon the remedial provisions and the interpretation of congressional intent, stating that

"[t]he Solicitor General for the United States as amicus curiae, argues that Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) [29 U.S.C. § 1132 (a)] be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress We agree."¹²



The stated purpose of the McCarran-Ferguson Act, enacted into law by Congress in 1945, was to reserve the power to tax and regulate insurers to the states.

including the U.S. Supreme Court in *Rush*, to determine whether a state statute or common law provision utilized by or for the benefit of insureds is saved from preemption by the savings clause, § 1144(b)(2)(A). According to *Metropolitan Life*, the court should conduct a two-step analysis. The first step is the common sense test: does common sense tell us that the law at issue regulates insurance? The second step, a more technical requirement, is to test the common sense answer by applying the three factors that evolved out of the judicial interpretation of the McCarran-Ferguson Act.

The stated purpose of the McCarran-Ferguson Act, enacted into law by Congress in 1945, was to reserve the power to tax and regulate insurers to the states.⁸ The only trump card dealt to the federal government was that a federal law could supersede state regulation of insurance if the federal law specifically addressed the business of insurance.⁹ Under the McCarran-Ferguson Act, the interpretation of whether a law regulates insurance and therefore must be reserved to the States was distilled by the courts into the consideration of three

The Court took the liberty of adding a preemption hurdle to those already established in *Metropolitan Life*. According to *Pilot Life*, in order to avoid preemption, not only must the insured navigate the precarious straits and find the safe harbor of the savings clause by 1) passing the common sense test and 2) meeting at least one of the McCarran-Ferguson factors, but once there, the insured must then 3) prove that the state law at issue does not conflict with a substantive provision of ERISA. The Court went out of its way in *Pilot Life* to make it clear that any remedy sought under the common law or a State's insurance code is preempted if that remedy conflicts with the ERISA remedies provided for in § 1132(a). Claims for consequential damages, mental anguish damages, punitive damages, or mandatory attorney's fees, are deemed preempted. The Court in *Pilot Life* describes what it believes to be the permissible remedies to an ERISA insured under § 1132(a):

[A] plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits.

Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of the fiduciary. . . . In an action under these civil enforcement provisions, the court in its discretion may allow an award of attorney's fees to either party.¹³

Texas courts and the Fifth Circuit have been compelled to follow *Pilot Life* in finding that bad faith claims, Article 21.21 claims, and Article 21.55 claims are preempted when alternative remedies to the remedies offered under § 1132(a) are sought.¹⁴

In *Cathey v. Metropolitan Life Insurance Co.*, which was a claim requesting coverage for in-home nursing care, the Texas Supreme Court unanimously found that Bette Cathey's state law claims were preempted by ERISA.¹⁵ In the concurring opinion, Justice Doggett, joined by Justices Mauzy and Gammage, lamented the result and expressed disdain for the preemption vortex created by the U.S. Supreme Court's opinion in *Pilot Life*. Justice Doggett ends the concurring opinion in *Cathey* by stating:

This federal court deprivation of state law protections stands in notable juxtaposition with the professed goal of some in Washington to return power to the states. The Texas courts and the Texas legislature are powerless to preserve the rights of workers covered by group benefit plans. Texans have little recourse but to petition their federal legislators to correct what has been an errant jurisprudential path. The time is long past for Congress to reconsider the expanse of ERISA and to resurrect the authority of the states to provide additional protections to their citizens.¹⁶

OTHER SIGNIFICANT U.S. SUPREME COURT DECISIONS: MASSACHUSETTS MUTUAL V. RUSSELL & UNUM V. WARD

IN RUSSELL, THE COURT STOPS AN END RUN

Provisions that appear to provide more expansive remedies than § 1132(a) benefit claims are the fiduciary duty provisions of ERISA, 29 U.S.C. §§ 1104, 1106, 1109. The remedy provision, 29 U.S.C. § 1109, does not allow the insured, even with blocking out front by creative counsel, an end run around the exclusive remedies provided for in § 1132(a). Doris Russell, a Californian, tried this play. Russell brought claims for extra-contractual and punitive damages, which were liberally construed as ERISA § 1109(a) claims for breach of fiduciary duty, against her disability insurer for the improper and untimely processing of her disability claims. The case reached the U.S. Supreme Court. The Court noted that the breach of fiduciary duty provision of § 1109(a), which provides that a fiduciary who breaches the fiduciary duties set out in ERISA may "be subject to such other equitable or remedial relief as the court may deem appropriate, including the removal of such fiduciary," cannot be expanded to allow an insured to collect punitive or extra-contractual damages for the improper processing of a claim.¹⁷ In *Russell*, the U.S. Supreme Court held that § 1109(a) was clearly designed to provide remedies for a breach of fiduciary duty to the ERISA plan rather than to any individual beneficiary.¹⁸

UNUM LIFE INSURANCE COMPANY V. WARD

Another significant U.S. Supreme Court decision regarding ERISA preemption was *Unum Life Insurance Co. of America v. Ward*.¹⁹ *Unum* is another disability case. The insured, a California resident, sued his insurer, Unum Life Insurance

Company, after Unum denied the insured coverage for disability benefits because he did not provide timely notice of his claim. The policy required that a claimant give notice to Unum within one year and 180 days of the date of onset of the disability. The insured admitted to not giving notice within the time required by the policy, but asserted that the California notice-prejudice rule superseded the policy provisions. Under the notice-prejudice rule in California, an insurer must prove prejudice by the late notice in order to successfully reject coverage on that basis. The insured asserted that the notice-prejudice rule excused late notice because Unum did not prove that it was prejudiced by the late notice. The U.S. Supreme Court said the notice-prejudice rule met the requirements of the savings clause as set out in *Metropolitan Life*. Furthermore, the Court said that the notice-prejudice rule cleared the third hurdle imposed by *Pilot Life*; that is, the notice-prejudice rule did not subvert the substantive provisions of ERISA. The Court found that the notice-prejudice rule complemented rather than conflicted with the ERISA provisions.

RUSH PRUDENTIAL HMO V. MORAN

The U.S. Supreme Court decided *Rush* on June 20, 2002.²⁰ The Court granted certiorari because of conflicting decisions in the Fifth and Seventh Circuits on an ERISA preemption question. At issue was whether ERISA preempted a state statute that set up an independent review mechanism to determine whether a medical procedure was necessary. Insureds could utilize this mechanism when their HMO refused to pay for a procedure on grounds that it was not medically necessary. Importantly, if the patient requested the independent review procedure, a decision by the independent physician or panel of physicians in favor of coverage, i.e., that the procedure was medically necessary, trumped the HMO's decision and was binding upon the HMO.

Two years earlier, in *Corporate Health Insurance v. Texas Department of Insurance*, the Fifth Circuit held that ERISA preempted a utilization review provision in the Texas Insurance Code.²¹ Following the preemption analysis established in *Metropolitan Life*, the Fifth Circuit decided that the independent review provisions found in the Texas Insurance Code were saved from preemption because they satisfied the common sense requirement, and further, satisfied two of the three McCarran-Ferguson factors.²² Even so, the Fifth Circuit found that the independent review provisions failed to clear the last and highest hurdle set up by the U.S. Supreme Court in *Pilot Life*. The Fifth Circuit reasoned that because the Texas Insurance Code provisions establishing the independent review bound the insurer to the independent reviewers' decision, the Code provisions essentially provided an alternative remedy to the remedies expressly provided for in § 1132(a) of ERISA and were therefore preempted.²³

Like the provisions considered by the Fifth Circuit in *Corporate Health*, the Illinois statute at issue in *Rush* bound HMOs to the decision by the independent organization conducting the medical necessity review. Rush Prudential HMO, Inc. and its amici curiae argued in harmony with the Fifth Circuit that ERISA preempted the review mechanism because the review provided the patient an alternative remedy to judicial enforcement under § 1132(a). Rush Prudential HMO, Inc. argued that the *new remedy* was akin to binding arbitration and interfered with the enforcement mechanism of ERISA. In a 5-4 opinion, with Justices Thomas, Rehnquist, Scalia, and Kennedy dissenting, the Court disagreed, and, therefore, disagreed with the Fifth Circuit. Finding that the

independent review statutes were not preempted, the Court stated:

The practice of obtaining a second opinion, however, is far removed from any notion of an enforcement scheme, and once § 4-10 [the Illinois statute at issue] is seen as something akin to mandate for second-opinion practice in order to ensure sound medical judgments, the preemption argument that arbitration under § 4-10 supplants judicial enforcement runs out of steam.²⁴

In addressing *Rush* Prudential's attempts to roll more rocks into the already narrow harbor of the savings clause, the Court offered this warning: "Rush's arguments today convince us that further limits on insurance regulation preserved by ERISA are unlikely to deserve recognition."²⁵

Rush is a significant victory for insureds. The real battle in *Rush* was the insurers' struggle to preserve the deferential standard of review that insurers have enjoyed under ERISA. Both the Illinois and Texas statutes give the independent review physician or panel *de novo* review. No deference to the HMO's decision is required. Anyone who has either filed suit under § 1132(a) or whose claims have been transformed into ERISA benefit claims under § 1132(a) is painfully aware that anytime there are documents within the applicable policy or plan documents incorporated into the policy that give the insurer discretionary authority to decide the terms of the contract with

It follows from the Court's reasoning in *Rush* and its interpretation of the reach of *Pilot Life* that an insured could bring a cause of action under Article 21.21 provided that she was only seeking past benefits and a declaration of rights as to future benefits. In that circumstance, Article 21.21 would meet the savings clause, in accordance with the *Metropolitan Life* framework, and would also satisfy *Pilot Life* because there is no remedy being sought that is not authorized under § 1132(a). If an insured asked for attorney's fees under Article 21.21(16) as a result of success on the benefits claim, that remedy would replace the express remedy provided by § 1132(g),²⁸ which provides that an award of attorney's fees is discretionary rather than mandatory. The attorney's fee provision of Article 21.21(16) probably is preempted under *Pilot Life*.

At first glance, filing under state law statutes and limiting one's remedies to past and future benefits appears pointless and far too exotic when one can accomplish the same thing under § 1132(a). A couple of significant things, however, may be accomplished on behalf of the insured by filing Article 21.21 claims and limiting the remedies sought to back benefits and a declaration as to the insured's rights to future benefits. Assuming the cause of action is brought in state court, removal based upon complete preemption may be avoided. Also, the deferential standard of review may be avoided. *Rush* makes it clear that a deferential standard of review is not a substantive



Under the recently amended ERISA regulations, the time for processing disability claims, and the time for considering an internal appeal of a disability claim, has been reduced.

its insured, the starting point for the insured when he or she goes before the trial court is whether or not the insurer abused its discretion in not paying benefits to the insured.²⁶ This is a heavy burden for the insured and has discouraged many insureds or their lawyers from filing a § 1132(a) action for benefits. Unlike a non-ERISA insurance claim, proof of breach of contract is not enough. In order to prevail on a § 1132(a) benefits claim in the trial court when the insurer is given discretionary authority under the contract, the insured has the burden of proving an arbitrary and capricious denial, similar to the bad faith burden in state court litigation, i.e., no reasonable basis for denial.²⁷ As such, in losing this deferential standard of review in states that provide for an independent review of whether procedures are medically necessary, the insurers incurred a considerable loss when *Rush* was decided.

OKAY, BUT WHAT ABOUT 21.21 CLAIMS?

Rush does not dilute *Pilot Life* in regard to bringing statutory causes of action under Article 21.21 and Article 21.55 of the Texas Insurance Code and seeking their full remedies. The Illinois statute at issue in *Rush* was not preempted because it did not provide a different remedy than those provided for in § 1132(a) and enumerated in *Pilot Life*. A binding "medical necessity" decision by an independent physician or panel may result in benefits being paid that would not have to be paid after a judicial enforcement proceeding under § 1132(a) because the independent body conducts a *de novo* review rather than the trial court's "abuse of discretion" standard of review. However, the ultimate remedy, the award of benefits, is the same remedy that is available under § 1132(a).

provision of ERISA. If one accepts this challenge, however, he or she should reserve enough energy to argue the matter in the appeals court.

WHAT ELSE REMAINS?

In addition to the survival of statutory claims that have remedies consistent with ERISA, a portion of the Article 21.55 provisions governing the prompt payment of claims meets the savings clause requirements and complements, rather than conflicts with, the substantive provisions of ERISA. Under the recently amended ERISA regulations, the time for processing disability claims, and the time for considering an internal appeal of a disability claim, has been reduced.²⁹ Although some extensions are permitted, the general rule is that the insurer will have forty-five days to pay after the initial disability claim is made and another forty-five days for consideration of the insured's appeal if the claim is initially denied. Clearly, the specific time provisions contained within Article 21.55 are preempted because they conflict with the express time provisions of ERISA.

However, the catchall provision, Article 21.55 § 3(f), states:

Except as otherwise provided, if an insured delays payment of a claim following its receipt of all items, statements, and forms reasonable requested and required, as provided under Section 2 of this article, for a period exceeding the period specified in other applicable statutes or, in the absence of any other specified period, for more than 60 days, the insurer shall pay damages and other items as provided for in Section 6 of this article. (emphasis added).

This provision ties in neatly with the ERISA payment

schedule. If the insurer does not pay disability benefits within the time allotted by ERISA, and through a judicial enforcement proceeding under § 1132(a) it is determined that benefits were due, the insurer has violated Article 21.55 because it failed to pay the benefits due in a timely manner.³⁰

Section 6 of Article 21.55 provides the remedy: Payment of 18% interest on the past benefits due *as damages* in addition to attorney's fees. The attorney's fee provision of § 6 is preempted because it conflicts with the substantive provisions of ERISA. ERISA, strangely, dictates that attorney's fees are awarded at the discretion of the court. The 18% provision, however, should apply even in the ERISA context provided it is viewed as interest rather than damages.³¹ The provision falls within the savings clause because it meets the common sense test and two of the three McCarran-Ferguson factors: The prompt payment of claims is 1) integral to the insured-insurer relationship and 2) is a remedy limited to the insurance industry. Further, the interest award does not interfere with the substantive provisions of ERISA, but rather complements the ERISA disability payment timetable. Because ERISA is silent on the issue of prejudgment interest, application of the 18% on the benefits awarded clears *Pilot Life's* requirement that the state law cannot conflict with a substantive provision of ERISA.

This argument was successfully used in a § 1132(a) benefits claim in the Eleventh Circuit. In this ERISA health benefits case, the Eleventh Circuit upheld an Alabama statutory 18% interest rate imposed upon insurers that denied claims that were later determined to have been covered.³² In *Hansen v.*

promote its underlying purpose, which is "the prompt payment of claims made pursuant to policies of insurance."

The theme of the *Rush* opinion, which provides value to an ERISA insured that does not have a medical necessity claim, is that state statutes regulating insurance are not to be summarily sacrificed to the preemption vortex.

AGENCY PROBLEM

Because many individuals depend upon a large portion of each paycheck to cover their basic needs, a sudden loss of one's income due to disability can wreak havoc on an individual and often his or her family. In instances where an insured is not entitled to disability benefits, not much can be done. When the evidence supports a finding of disability, however, benefits should be paid promptly.

CASE STUDY

Our firm is currently litigating an ERISA disability benefits case in which our client worked in a management position for a company for approximately fourteen years before his headaches became so severe that he could no longer work. He had been treated for some time for his debilitating headaches and his employer accommodated his health problems by transferring him to a less stressful position, all without success. Our client's headaches eventually grew so severe that by mid-morning he could only sit motionless in a dark room to alleviate



What additional remedies can the insured potentially rely upon to make him or her whole? Virtually none.

Continental Insurance Co., the Fifth Circuit acknowledged that because ERISA is silent on the award of prejudgment interest, "it is appropriate to look to state law for guidance in determining the rate of interest."³³ In *Hansen*, prejudgment interest was awarded at the rate of 10%.³⁴

Importantly, Article 21.55(6) provides for 18% interest as damages. Outside the ERISA context, the insured is entitled to both the statutory penalty of 18% and prejudgment interest.³⁵ In a § 1132(a) benefits claim, however, the 18% statutory penalty should be characterized as interest. If it is characterized as damages, it will run afoul of the rule imposed by *Pilot Life* by conflicting with the remedial provisions of ERISA.

Clearly, the purpose of the prompt payment of claims provisions of Article 21.55 is as applicable in an ERISA context as in a non-ERISA context. Given the limited remedies available—past due benefits and a declaration of rights concerning future benefits—the insured's right to equitable relief under § 1132(a) provides the appropriate vehicle for the court to apply the 21.55(6) statutory penalty as interest in a case where the insurer should have paid the claim. Not only does the application of the statutory interest rate compliment the ERISA benefits provision § 1132(a), it is supported by the Texas Insurance Code provisions in Article 21.55(7) and Article 21.55(8). Article 21.55(7) provides that the remedies of 21.55 are "in addition to any other remedy or procedure provided by any other law or at common law." Article 21.55(8) declares that the provisions of 21.55 are to be construed liberally to

his pain. No longer able to fulfill his job responsibilities, our client quit in January of 1998 and applied for long-term disability benefits with his insurance carrier. Because the disability policy was paid for by his employer, it was an ERISA plan.

Disability benefits were initially denied, but then granted after six months of deliberation by the carrier. After twenty-four months, however, the disability benefits were discontinued based on the theory that our client's disability was, in part, due to a mental disease or disorder. The carrier reached this decision despite the fact that there was no clinical evidence to suggest that his headaches were due to a mental disease or disorder.³⁶ In fact, the "mental status examination" performed at the request of the carrier showed no mental infirmities. When the disability benefits stopped in the spring of 2000, our client and his wife had no choice but to file bankruptcy. In the summer of 2001, our client was diagnosed with Shy-Drager syndrome, a progressive disorder of the central nervous system that remains the cause of his severe headaches. There is no known cure for Shy-Drager, and it generally causes death 7-10 years after the onset of the symptoms. The medical records of the diagnosis and treatment of our client for Shy-Drager were forwarded to the insurance carrier in January of 2002, but the carrier still refused to pay the claim.

This case is not unique in the sense that disability benefits are often denied with little justification in spite of the treating physician's diagnosis of total disability. Further, presuming that our client will eventually be paid what is due to him, the delay

in payment of benefits to an insured is not unique. This case is meant to illustrate the agency problem that has been created by the limited remedies provided to claimants under ERISA.

THE AGENCY PROBLEM

An “agency problem” is typically described in a corporate setting, where managers within the company have interests that are not aligned, and often adverse to the owners of the company. The stories of Enron, WorldCom, etc. graphically illustrate agency problems, as managers (including CEO’s) have destroyed the value of their companies due to a blind obsession with personal wealth and power. When the duty of good faith and fair dealing and statutory regulations such as Article 21.21 and Article 21.55 are imposed upon insurers dealing with claims made by their insureds, Texas law has compelled the alignment of the interests of the insureds and insurers. The insurer is compelled to act in the insured’s best interest because of the common law and statutory regulations imposed upon it. Similarly, a corporate manager, with the right incentives imposed upon her, would be compelled to act in the best interest of the owner(s) of the company. As explained by Justice Ray in *Arnold v. National County Mutual Fire Insurance Co.*:

In the insurance context, a special relationship arises out of the parties’ unequal bargaining power and the nature of insurance contracts which would allow unscrupulous insurers to take advantage of their insureds’ misfortunes in bargaining for settlement or resolution of claims. *In addition, without such a [breach of good faith and fair dealing] insurers can arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed.*

An insurance company has exclusive control over the evaluation, processing and denial of claims.³⁷ (emphasis added).

There is no duty of good faith and fair dealing, however, in the ERISA context. Nor, if one is asking for remedies inconsistent with remedies provided for in § 1132(a), are there any statutory claims of unfair settlement practices that can be made under ERISA. As such, an alignment or agency problem evolves. The previous case study raises several questions: What penalties will be imposed upon a carrier for denying disability claims in spite of overwhelming evidence of disability? What additional remedies can the insured potentially rely upon to make him or her whole? Virtually none. The carrier may have to pay attorney’s fees, but those fees are discretionary rather than mandatory.³⁸ Although the factors considered in awarding attorney’s fees under ERISA are written as if they impose punishment, the award of attorney’s fees hardly serves as an adequate deterrent for arbitrary denials, nor does it make the insured whole. If the Texas legislature and the Texas courts considered an attorney’s fee provision an adequate deterrent to arbitrary delays or denials, there would never have been a reason for the creation of common law standard of good faith and fair dealing, Article 21.21, nor Article 21.55. Breach of contract claims would have been enough to deter insurers from performing acts which were in their best interest, but not in the insured’s best interest. The attorney’s fee provision of ERISA only provides some hope that a disabled insured, without money to pay a lawyer and without the bait of a potentially large contingency fee, can still find a lawyer to pursue the claim in hopes of payment on the back end.

More than eleven years have passed since Justice Doggett urged congressional legislation in order to give back some rights to the States to protect their ERISA insureds, and nothing has changed. The insurer is given very little incentive to pay close

claims, or to timely pay clear-cut claims. The void places claims adjustors in a difficult position on ERISA disability claims. On the one hand, we will presume that they want to act ethically and pay valid claims.³⁹ On the other hand, given no meaningful downside risk and the number of claimants that give up after an internal appeal, the numbers, no doubt, suggest that denial of many covered claims, and certainly close claims and delay in the payment of covered claims, is more profitable. In an ERISA environment, the claims adjustors cannot rely upon the law to compel them to do what they want to do anyway because there is no legal compunction to act ethically. The incentive to maximize profits is not counterbalanced by a downside risk of paying consequential damages or punitive damages. Although they may be too busy or otherwise disinclined to see it, the adjustors face the void.

The incentives for an ERISA disability insurer to deny a covered claim, or to pay the claim in a dilatory fashion, are as follows:

- 1) no damages besides the payment of benefits due;
- 2) no right to a jury trial;⁴⁰
- 3) generally a deferential standard of review in the trial court—was the insurer’s denial of coverage arbitrary and capricious;⁴¹
- 4) discretionary attorney’s fees;
- 5) an offset for social security benefits, pension benefits, etc.;
- 6) a complex body of law that often causes insureds to throw in the towel;
- 7) increased profits in the near term; and
- 8) reaping the benefits of the time value of money.

What does the insured have as leverage to compel the ERISA disability insurer to pay:

- 1) often a sympathetic story;
- 2) payment of interest on past benefits due; and
- 3) perhaps payment of the insured’s attorney’s fees if the insured can find representation and prove the equivalent of bad faith in the trial court.

THE NEED FOR BALANCE

Although the individuals within the insurance company may want to do the right thing, there is very little financial incentive for the ERISA insurer to pay disability benefits promptly. Further, it is absurd that Texas offers its citizens so many protections when they buy homeowner’s insurance or car insurance, but offer meager protections regarding their citizens’ health care or payment of disability benefits to replace a lost income stream. Presumably, ERISA preemption has reduced the cost of disability policies for companies that employ Texas citizens, and, therefore, has promoted its stated purpose of encouraging employers to provide benefits. However, despite the intention expressed in the savings clause (in terms of remedies), no real counterbalance has been established to preserve the State’s police powers or to protect disabled ERISA insureds. The creation of this preemption vortex is hardly the landscape that Congress intended when it passed the McCarran-Ferguson Act more than fifty years ago. The McCarran-Ferguson Act provides that insurance laws are a State’s concern, and a State’s police powers to regulate insurance must not be impaired by any act of Congress unless the federal act specifically relates to the business of insurance.⁴² Legislation will be the only way to resurrect the intent of Congress and to restore some sort of balance to the insured-

insurer relationship when the insured's policy is part of an ERISA plan.

CONCLUSION

The U.S. Supreme Court's opinion in *Rush Prudential HMO, Inc. v. Moran* is a step in the right direction because it gives the ERISA insured some power to extract herself from

feeble. She can provide nothing to the carrier that will compel the carrier to pay the claim. One thousand arbitrary denials by the same carrier do not provide leverage to the one thousand and first claimant. She would be entitled to benefits, prejudgment interest, and perhaps attorney's fees, just as the first claimant might have been if she litigated the claim. From a financial perspective, grinding a legitimate disability claimant down and then settling for seventy cents on the dollar makes



From a financial perspective, grinding a legitimate disability claimant down and then settling for seventy cents on the dollar makes good business sense.

the deferential standard of review under which coverage denials are reviewed by the courts. *Rush* does not provide any benefit for the practitioner looking to bring traditional state law causes of action against an ERISA insurer, such as a bad faith or Article 21.21 claim, and request additional remedies to those provided for in § 1132(a). *Rush*, however, supports the proposition that different roads to § 1132(a) benefits exist. Therefore, so long as an ERISA insured seeks remedies consistent with the remedies provided for under § 1132(a) of ERISA, a cause of action brought under Article 21.21 should survive preemption because it meets the savings clause requirements of *Metropolitan Life*, and it does not conflict with a substantive provision of ERISA. In addition, *Rush* supports survival of some prompt payment provisions within Article 21.55, provided the practitioner argues that the 18% penalty be applied as interest and not as damages.

The legal position of an insured in a disability case remains

good business sense. The eventual downside is being shunned in the marketplace for not paying valid claims. Yet, given the recent disability cases that I have reviewed, I see no evidence that pressure from the marketplace is adequately deterring ERISA insurers from delaying or denying claims even though there is no reasonable basis for delay or denial. The preemption vortex is not the landscape that Congress intended when it passed the McCarran-Ferguson Act and the ERISA savings clause. Both laws reserve the regulation of the business of insurance to the States. Although the concurring opinion in *Cathey v. Metropolitan Life Insurance Co.* was authored more than eleven years ago, the elegant argument for a restoration of the state's authority over insurance matters is no less relevant now than it was at the time that the opinion was written. "The time is long past for Congress to resurrect the authority of the states to provide additional protections to their citizens."⁴³

* Attorney, Harkins, Latimer & Dahl, P.C., San Antonio, HDLAW.com.

1. The technical criteria that exclude a non-exempt plan from ERISA are as follows: 1) No contributions are made by an employer or employee organization; 2) participation in the program is completely voluntary for employees or members; 3) the sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check offs and to remit them to the insurer; and 4) the employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, from administrative services actually rendered in connection with payroll deductions or dues check offs. *Hansen v. Cont'l Ins. Co.*, 940 F.2d 971, 976-977 (5th Cir. 1991).
2. 122 S. Ct. 2151 (2002).
3. For the purposes of this paper, reference to Article 21.21 shall mean the unfair settlement practices listed in Article 21.21(4)(10) and the remedies provided in Article 21.21(16) of the Texas Insurance Code. Reference to Article 21.55 shall mean Article 21.55 of the Texas Insurance Code.

4. *Rush*, 122 S. Ct. at 2158-2159.
5. 29 U.S.C. § 1132(a) is the provision within ERISA under which an insured may bring a cause of action for past due benefits and a declaration as to her rights to future benefits. In this article, a suit for benefits brought under ERISA will often be simply referred to as a § 1132(a) claim.
6. 471 U.S. 724 (1985).
7. *Id.* at 739, 740.
8. 15 U.S.C. § 1011 (2002).
9. *Id.*
10. *See Unum Life Ins. Co. of America v. Ward*, 526 U.S. 359 (1999).
11. 481 U.S. 41 (1987).
12. *Id.* at 50-51.
13. *Id.* at 53.
14. *Hogan v. Kraft Foods*, 969 F.2d 142 (5th Cir. 1992) (Violations of Article 21.21, 17.50 of the DTPA, breach of duty of good faith and fair dealing, negligence, and intentional infliction of emotional distress not saved); *Ramirez v. Inter-Cont'l Hotels*, 890 F.2d 760 (5th Cir. 1989) (Article 21.21 not saved from preemption); *Cathey v. Metro. Life Ins. Co.*, 805 S.W.2d 387 (Tex. 1991) (Article 21.21, claims under the DTPA, and Article 21.55 claims not saved).
15. *Cathey v. Metro. Life Ins. Co.*, 805 S.W.2d 387 (Tex. 1991).
16. *Id.* at 394.

17. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).
18. *Id.* at 149-150.
19. *Unum Life Ins. Co. of America v. Ward*, 526 U.S. 359 (1999).
20. *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002).
21. *Corp. Health Ins. Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000).
22. *Id.* at 537-538.
23. *Id.* at 539.
24. *Rush*, 122 S. Ct. at 2169.
25. *Id.* at 2168.
26. *Gooden v. Provident Life & Accident Ins. Co.*, 250 F.3d 329, 332-333 (5th Cir. 2001).
27. *See, e.g., Aboul-Fetough v. Employee Benefits Comm.*, 245 F.3d 465, 472 (5th Cir. 2001).
28. 29 U.S.C. § 1132(g) (2002).
29. 29 C.F.R. § 2560.503-1 (2002).
30. This argument is made in accordance with the line of cases which allow recovery under the remedial provisions of 21.55 when coverage is denied in good faith then later found to have been wrongfully denied in a judicial proceeding. *Higgenbotham v. State Farm Mut. Auto. Ins. Co.*, 103 F.3d 456 (5th Cir. 1997). *See also Cater v. USAA*, 27 S.W.3d 81 (Tex. App.—San Antonio 2000, pet. denied).
31. TEX. INS. CODE ANN. Article 21.55(6) (Vernon 2002).
32. *See, e.g., Florence Nightingale Nursing Serv., Inc. v. Blue Cross/Blue Shield*, 41 F.3d 1476, 1484 (11th Cir. 1995).
33. 940 F.2d 971, 984 (5th Cir. 1991).
34. *Id.* at 383-985.
35. *See Oram v. State Farm Lloyds*, 977 S.W.2d 163, 169 (Tex. App.—Austin 1998, no pet.).
36. Like most disability policies, the policy at issue limits disability coverage to twenty-four months if the disability is caused, in whole or in part, by a mental disease or disorder.
37. *Arnold v. Nat. County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987).
38. The factors that the Court is to consider in deciding whether to award attorney's fees in an ERISA disability case are as follows: 1) the degree of the opposing parties' culpability or bad faith; 2) the ability of the opposing party to satisfy an award of attorney's fees; 3) whether an award of attorney's fees against the opposing party would deter other persons acting under similar circumstances; 4) whether the parties requesting attorney's fees sought to benefit all participants of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and 5) the relative merits of the parties' position. *See Lain v. Unum Life Ins. Co. of America*, 279 F.3d 337 (5th Cir. 2002).
39. This assumption takes a Kantian view of human nature. That is, humans are born with an innate sense of right and wrong and derive happiness or some sense of self-fulfillment from acting ethically. If one adopts a view of human nature endorsed by the philosopher Thomas Hobbes rather than that of Immanuel Kant, that is, that we are fundamentally selfish and without laws and punishment we would have a "war of all against all", the insured in an ERISA case is in deep trouble.
40. *See Calmia v. Spivey*, 632 F.2d 1235 (5th Cir. 1980).
41. *See Gooden v. Provident Life & Accident Ins. Co.*, 250 F.3d 329, 332-333 (5th Cir. 2001).
42. 15 U.S.C. § 1012 (2002).
43. *See Cathey v. Metro. Life Ins. Co.*, 805 S.W.2d 387, 394 (Tex. 1991).