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Use It And Lose It: The Employer's Absolute Right Under ERISA Section 510 To Engage in Post-Claim Modifications of Employee Welfare Benefit Plans

CARL A. GRECI*

[This appeal] involves Acquired Immune Deficiency Syndrome ("AIDS"),¹ a disease that has . . . exacted a heavy toll in terms of human life, and in terms of the financial burden placed on the health care and insurance industries. The cost in terms of human life cannot be measured, or, at this point, alleviated. This case raises the question of who should bear the onerous financial burden of this unprecedented disease, and other similar catastrophic illnesses.²

INTRODUCTION

Approximately one-half of the American work force receives employee health benefits³ through employer "self-insured" plans.⁴ "Self-insurance" is almost synonymous with "no insurance." When a company becomes self-insured, it no longer uses a commercial insurance carrier in the financing of its benefit plan. Instead, the company pays one-hundred percent of the benefits out of its own assets.⁵ In recent years, the self-insurance phenomenon has had a major impact on the terms and provisions of employee welfare benefit plans.

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1. AIDS is caused by an infection of the human immunodeficiency virus ("HIV virus"). This tragic disease breaks down a person's immune system, and is invariably fatal. For a complete legal and medical discussion, see AIDS: CASES AND MATERIALS (Michael L. Closten et al. eds., 1989).

2. Brief for Appellees at statement regarding oral argument (unnumbered page before i), *McGann v. H & H Music Co.*, 742 F. Supp. 392 (S.D. Tex. 1990), *aff'd*, 946 F.2d 401 (5th Cir. 1991), *petition for cert. filed sub nom. Greenberg v. H & H Music Co.*, 60 U.S.L.W. 3638 (U.S. Feb. 3, 1992) (No. 91-1283).

3. Several terms are used interchangeably throughout this Note to refer to employee welfare benefit plans and employee welfare benefits. They include "employee benefit plan" and "employee benefit," "employee health plan" and "health benefit," and "ancillary benefit plan" and "ancillary benefit." For ERISA's definition of "employee welfare benefit plan" and "welfare plan," see *infra* note 18 and accompanying text.

4. Robert Pear, *White House Divided Over AIDS Coverage*, SOUTH BEND TRIB. (IND.), May 18, 1992, at A1; *Legal Experts Predict New Areas of AIDS Litigation in the 1990s*, Daily Lab. Rep. (BNA) No. 152 (Aug. 7, 1990).

5. For an overview of the self-insurance concept, see 2 HEALTH CARE LAW § 14.10 (Michael G. MacDonald et al. eds., 1985).

Employers who provide welfare benefits to employees through self-insured programs fall under the regulatory purview of the Employee Retirement Income Security Act of 1974 (ERISA).⁶ ERISA minimally regulates these plans, however.⁷ This regulatory gap led to the emergence of a new cost-avoidance scheme—the post-claim plan modification. Under post-claim plan modifications, employers have successfully argued that, barring any contractual provision to the contrary, ERISA allows plan modifications at any time—even after a beneficiary has filed a claim—solely to avoid the costs of on-going treatment. While the employer must fully honor the specific claims made prior to the effective modification date, it achieves substantial cost containment by precluding future claims. Thus, the sooner the employer alters the plan to exclude the diagnosed condition, the greater the savings. The diagnosed illness becomes an uninsured or under-insured condition for which the employee cannot realistically obtain new coverage. This can aptly be called the “use it and lose it” policy.

Although section 510 was designed to protect employees from interference by an employer with their rights to welfare benefits, recent court decisions interpreting section 510 of ERISA give employers the absolute and unfettered right to make post-claim plan modifications.⁸ Prior to *McGann v. H & H Music Co.*⁹ and *Owens v. Storehouse, Inc.*,¹⁰ it was unclear whether section 510 would shield employees from an employer’s specific intent to modify a

6. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1988). ERISA preempts all state statutory and common law relating to private employee benefit plans. 29 U.S.C. § 1144. It does not, however, supersede state insurance regulation. *Id.* Therefore, whether “self-insurance” is characterized as a state insurance regulation or an employee benefit plan is important. The Supreme Court has held the latter in *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990). Thus, ERISA preempts all state law relating to self-insured employee benefit plans.

For a complete discussion of ERISA’s preemption clause, see *infra* notes 23-28 and accompanying text. For a thorough discussion of *FMC Corp. v. Holliday*, see James R. Bruner, Note, *AIDS and ERISA Preemption: The Double Threat*, 41 DUKE L.J. 1115 (1992).

7. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1988). See, e.g., Bruner, *supra* note 6; see also *FMC Corp.*, 111 S. Ct. 403, 409-10.

8. *McGann v. H & H Music Co.*, 742 F. Supp. 392 (S.D. Tex. 1990), *aff’d*, 946 F.2d 401 (5th Cir. 1991), *petition for cert. filed sub nom. Greenberg v. H & H Music Co.*, 60 U.S.L.W. 3638 (U.S. Feb. 3, 1992) (No. 91-1283); see also *Owens v. Storehouse, Inc.*, 773 F. Supp. 416 (N.D. Ga. 1991), *appeal docketed*, No. 91-8696 (11th Cir. July 31, 1991); *Levesque v. Marathon Elec. Mfg. Corp.*, No. 90-348-CV-5-4 (W.D. Mo. filed Aug. 1, 1991) (holding that defendant could modify health benefit plan even though it interrupted treatment regimen of plaintiff); *Vogel v. Independence Fed. Sav. Bank*, 728 F. Supp. 1210 (D. Md. 1990).

Although *McGann* couches the employer’s right in “absolute” terms, an employer must nevertheless satisfy certain factors in order to validly modify a plan: (1) the employer must reserve the right to modify benefit plans expressly in its Summary Plan Description, see *infra* notes 19-22 and accompanying text; (2) the employer must not be bound by contrary contractual provisions, such as a labor contract or collective bargaining agreement; and (3) the company must be self-insured, so as to avoid regulation by state insurance laws.

9. 946 F.2d 401.

10. 773 F. Supp. 416.

plan to reduce benefits for a particular claimant. The Fifth Circuit Court of Appeals in *McGann*, however, gave employers the absolute right to make such plan changes. The court found that modifications designed to avoid payment for a particular employee's claim did not violate section 510. In *Owens*, a district court in Georgia also found post-claim plan changes valid under section 510.

This Note examines *McGann*¹¹ and *Owens*,¹² and concludes that the courts' myopic reading of the statute conflicts with the broader policy considerations of ERISA. Part I discusses ERISA in general, and analyzes in particular the relevant sections preventing discrimination in the implementation of employee welfare benefit plans. Part II reviews some of the relevant litigation under section 510, including post-claim modification cases as well as traditional discharge cases. This Note concludes that new judicial and legislative approaches should be taken to improve the effectiveness of section 510 in protecting individual employees, without jeopardizing the employer's need to modify plans in order to remain profitable.

I. AN EMPLOYER'S RESPONSIBILITY UNDER ERISA IN THE PROVISION OF WELFARE BENEFIT PLANS

A. ERISA's General Purpose

Congress passed ERISA in 1974 to make uniform the laws regulating private employee pension and welfare benefit plans.¹³ Prior to its enactment, a variety of state and federal¹⁴ laws regulated pension and welfare benefit

11. *McGann*, 946 F.2d 401.

12. *Owens*, 773 F. Supp. 416.

13. At the time of ERISA's passage, Congress was primarily concerned with the need to regulate pension plans, rather than welfare benefit plans. The increasing frequency of abuse in pension plan management in the 1960s demonstrated the ineffectiveness of existing regulations and common law in managing private sector pensions. David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 443 (1987). Given the fact that approximately 30 million people were covered in private sector pension plans, *id.*, it is not surprising that the vast majority of ERISA's provisions regulate pension benefit plans. Similarly, the legislative history deals almost exclusively with pension benefit plans. H.R. REP. NO. 533, 93d Cong., 2d Sess. 3 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4640. Nonetheless, the few provisions directed toward welfare benefit plans play an extremely prominent, and sometimes exclusive, role in the administration of these plans.

For a thorough discussion of ERISA's history, purpose, and policy, see Gregory, *supra*, at 437-48. See also Michael S. Gordon, *ERISA, ESOPs and Senator Javits: The Mind of a Reformer*, 7 AM. J. TAX POL'Y 3 (1988); Nancy J. Altman & Theodore R. Marmor, *ERISA and the American Retirement Income System*, 7 AM. J. TAX POL'Y 31 (1988); Alicia H. Munnell, *ERISA-The First Decade: Was the Legislation Consistent With Other National Goals?*, 19 U. MICH. J.L. REF. 51 (1985).

14. Some examples of the various federal provisions are the Welfare and Pension Plans Disclosure Act, 29 U.S.C. §§ 301-309 (repealed 1975), and the Labor Management Relations Act, 1947, 29 U.S.C. §§ 141-187 (1988).

plans. Such regulations often did not protect the employee adequately.

In its lofty declaration of policy, Congress spoke of the huge growth of employee benefit plans, their effect on the national public interest, and their close relationship to the well-being of beneficiaries and their dependents.¹⁵ Ironically, however, ERISA does not require an employer to provide benefits to its employees.¹⁶ In an attempt to balance the needs of employees to have benefits with those of employers to control costs, Congress provided for a voluntary system. Under ERISA, employers have no affirmative obligation to provide benefits.¹⁷ Only if an employer chooses to institute a pension or benefit plan does ERISA come into play.

15. The basic policy provisions of ERISA are outlined in 29 U.S.C. § 1001 (1988):

CONGRESSIONAL FINDINGS AND DECLARATION OF POLICY

(A) BENEFIT PLANS AS AFFECTING INTERSTATE COMMERCE AND THE FEDERAL TAXING POWER

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; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; . . . that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, . . . that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(B) PROTECTION OF INTERSTATE COMMERCE AND BENEFICIARIES BY REQUIRING DISCLOSURE AND REPORTING, SETTING STANDARDS OF CONDUCT, ETC., FOR FIDUCIARIES

It is hereby declared to be the policy of this chapter to protect the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(C) PROTECTION OF INTERSTATE COMMERCE, THE FEDERAL TAXING POWER, AND BENEFICIARIES BY VESTING OF ACCRUED BENEFITS, SETTING MINIMUM STANDARDS OF FUNDING, REQUIRING TERMINATION INSURANCE

It is hereby further declared to be the policy of this chapter to protect the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

16. H.R. REP. NO. 533, *supra* note 13, at 3, *reprinted in* 1974 U.S.C.C.A.N. at 4639 ("[Congress is] constrained to recognize the voluntary nature of private retirement plans.").

17. *Id.*

B. Employee Welfare Benefit Plans Under ERISA

1. Employee Welfare Benefit Defined

ERISA broadly defines an employee welfare benefit plan as follows:

(1) The terms “employee welfare benefit plan” and “welfare plan” mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services¹⁸

As is evident, almost any nonpension benefit provided to an employee falls under the definition of welfare benefit. The breadth of included benefits is mirrored by the actual benefit plans provided by employers. Some provide no employee benefits at all, some offer a minimal package, and others provide elaborate benefit packages. If an employer offers benefit plans to employees, the plans must comply with certain statutory provisions requiring the employer to adequately inform the employee of the availability and terms of the benefits.¹⁹

2. ERISA Requires a Summary Plan Description

The primary manner in which employers provide employees with information pertaining to their benefit plans is via a Summary Plan Description (SPD). Section 102 of ERISA provides that:

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries . . . [Thus] shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. .

(b) The plan description and summary plan description shall contain the following information: . . a description of the relevant provisions of any applicable collective bargaining agreement; the plan’s requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of

18. 29 U.S.C. § 1002.

19. See *id.* § 1022.

any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of this Act).²⁰

Consistent with the overall purpose of ERISA, the case law regarding SPDs has generally been construed liberally in favor of employees. Courts have interpreted SPDs to prevent injustice when plan administrators fail to inform covered participants of the provisions of the plan.²¹ Most importantly, courts have held that any ambiguities or inconsistencies in the plan or the SPD must be resolved in favor of the employee and made binding against the drafter.²² However, an employer can expressly reserve the right to modify or terminate the plan at any time and under any circumstances, leaving employees no cause of action under section 510 when the modification or termination interrupts the treatment regimen. This can result in de minimis coverage or in no coverage at all.²³

While employees are entitled to all the information needed to use and maintain welfare benefits, employers can retain the right to modify or terminate the plan at will. This creates a paradoxical situation. Because an SPD arguably promotes benefit usage, it may likewise increase an employer's incentive to discharge an employee or change plan benefits. That is, by promoting benefit usage, an SPD may simultaneously and unintentionally increase plan modifications. Given that regulatory provisions of ERISA preempt almost all state insurance regulation, such a result is disconcerting.

3. ERISA Preempts Almost All State Statutory and Common Law Relating to Employee Benefits

Primary to understanding the law of employee welfare benefits is recognizing that ERISA preempts almost all state statutory and common law

20. *Id.*

21. *Boutillier v. Libby, McNeill & Libby, Inc.*, 713 P.2d 1110 (Wash. App. 1986), *review denied*, 106 Wash. 2d 1005 (1986).

22. *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 982 (5th Cir. 1991); *see also Kochendorfer v. Rockdale Sash and Trim Co.*, 653 F. Supp. 612 (N.D. Ill. 1987); *Edwards v. State Farm Mut. Auto. Ins. Co.*, 851 F.2d 134 (6th Cir. 1988); *McKnight v. Southern Life and Health Ins. Co.*, 758 F.2d 1566, 1570 (11th Cir. 1985).

23. *See McGann v. H & H Music Co.*, 742 F. Supp. 392 (S.D. Tex. 1990), *aff'd*, 946 F.2d 401 (5th Cir. 1991), *petition for cert. filed sub nom. Greenberg v. H & H Music Co.*, 60 U.S.L.W. 3638 (U.S. Feb. 3, 1992) (No. 91-1283); *Alday v. Container Corp. of Am.*, 906 F.2d 660, 663 (11th Cir. 1990), *cert. denied*, 59 U.S.L.W. 3460 (U.S. Jan. 8, 1991) (No. 90-685); *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988); *Musto v. American Gen. Corp.*, 861 F.2d 897, 912 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989); *Anderson v. John Morrell & Co.*, 830 F.2d 872, 876 (8th Cir. 1987); *Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350 (8th Cir. 1985). The reasoning of such cases, however, is subject to attack. *See infra* notes 51-88 and accompanying text.

concerning employee benefits.²⁴ An important exception to the superceding provision is section 514(b)(2)(A), which states that ERISA will not preempt state law regulating insurance.²⁵ While it is arguably necessary to standardize the pension and welfare benefit systems, the preemption clause has gutted existing state causes of action for which there is no federal counterpart.

Without guidance from Congress as to whether preempted state law and other state issues are relevant in developing a federal common law of employee benefits, courts have interpreted preemption rigidly. This has led to court decisions that are plainly inequitable and contradictory, and that promote bad public policy. Not surprisingly, the preemption clause has been strongly criticized as a failure.²⁶ Indeed, the *McGann* case itself has generated additional commentary with regard to preemption.²⁷ While a complete analysis of ERISA's preemption clause and the subsequent development, or lack thereof, of a federal common law of employee benefits is beyond the scope of this Note, preemption is relevant here because the defendants in both *McGann* and *Owens* became self-insured as part of the plan modification process. Since self-insured plans are subject to preemption under ERISA,²⁸ the employers were able to circumvent state insurance law which would have made the modifications in question illegal.²⁹

II. DISCHARGE AND DISCRIMINATION UNDER SECTION 510

An employee may have redress under section 510³⁰ against an employer for interfering in his or her participation in a welfare benefit plan. Section 510, in relevant part, states:

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an

24. 29 U.S.C. § 1144 (1988). This has been aptly referred to as "one of the most sweeping preemption clauses ever included in any federal legislation." Gregory, *supra* note 13, at 430-32. In one fell swoop, federal law expressly replaced, with few exceptions, an entire body of state law. *Id.*, see also Leon E. Irish & Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REF. 109 (1985).

25. 29 U.S.C. § 1144(b)(2)(B).

26. Bruner, *supra* note 6; Irish & Cohen, *supra* note 24, at 163 ("The language of ERISA section 514(a) has made it impossible to develop a sound or internally consistent jurisprudence of ERISA preemption."); see also *Amato v. Western Union Int'l Inc.*, 596 F. Supp. 963 (S.D.N.Y. 1984), *aff'd in part, rev'd in part and remanded*, 773 F.2d 1402 (2d Cir. 1985), *cert. dismissed*, 474 U.S. 1113 (1986); *Van Orman v. American Ins. Co.*, 680 F.2d 301 (3d Cir. 1982) (showing the court's rigid interpretation of preemption).

27. See, e.g., Bruner, *supra* note 6.

28. See *supra* notes 5-8 and accompanying text.

29. Part III of this Note will comment on preemption as it relates to the *McGann* and *Owens* cases. It will further suggest future congressional revision of ERISA's regulation of employee welfare benefit plans.

30. ERISA § 510, 29 U.S.C. § 1140 (1988).

employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan. . . . It shall be unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he [or she] has given information or has testified . . . in any inquiry or proceeding relating to this Act³¹

Under section 510, if an employee is entitled to a welfare benefit, the employer is prohibited from penalizing that individual for exercising such a right.

Cases under section 510 are generally of two types: discharge³² and discrimination. The prototype discharge case typically involves a situation where the defendant-employer discharges the plaintiff-employee for an alleged legal reason.³³ However, the plaintiff-employee claims that the real reason for the discharge is the plaintiff-employee's use or expected use of welfare benefits and the defendant-employer's desire to avoid or limit benefit costs.³⁴ If the plaintiff-employee can muster enough evidence to prove the defendant-employer's improper motive, which the defendant-employer is unable to rebut, the employee will prevail.

In discrimination cases, an employee typically alleges unequal treatment because an employer explicitly terminates or modifies a benefit plan to exclude or reduce coverage to avoid the cost of a claim filed by an individual or a group.³⁵ As in discharge cases, the employee alleges that employer's

31. *Id.*

32. While this Note discusses discharge cases briefly, more detailed analyses can be found in James Monroe Smith, *HIV/AIDS and Workplace Discrimination: Dickens Revisited—"It Was the Best of Times, It Was the Worst of Times,"* 22 U. WEST L.A. L. REV. 19 (1991); Joan Vogel, *Containing Medical Disability Costs by Cutting Unhealthy Employees: Does Section 510 of ERISA Provide a Remedy?*, 62 NOTRE DAME L. REV. 1024 (1987); William C. Martucci & John L. Utz, *Unlawful Interference with Protected Rights Under ERISA*, 2 LAB. L.J. 251 (1986); Terry Collingsworth, *ERISA Section 510—A Further Limitation on Arbitrary Discharges*, 10 INDUS. REL. L.J. 319 (1988).

33. *See, e.g.,* Fitzgerald v. Codex Corp., 882 F.2d 586, 588 (1st Cir. 1989) (holding that, where plaintiff claimed he was terminated in retaliation for and to avoid former wife's attempt to collect health benefits under company's plan, "[t]his is precisely the type of action that section 510 sought to cover and that is essential to the Act's protection"). In another case, the plaintiff in a class action claimed that his employer discharged him and other employees to avoid paying life and medical insurance benefits. The court rejected the defendant's "novel theory" that the plaintiff, a "participant," could not attain additional rights as a "beneficiary," and concluded that "ERISA is thus a remedial statute, the coverage of which should be liberally construed, and exemptions from which should be confined to their narrow purpose." *Kross v. Western Elec. Co.*, 701 F.2d 1238, 1241-42 (7th Cir. 1983) (citation omitted); *see also* *Folz v. Marriott Corp.*, 594 F. Supp. 1007 (W.D. Mo. 1984) (noting that company's claims that plaintiff was discharged for cause were mere pretexts where plaintiff alleged employer terminated him in order to avoid ongoing treatment associated with multiple sclerosis).

34. *See* *Fitzgerald*, 882 F.2d 586; *Kross*, 701 F.2d 1238; *Folz*, 594 F. Supp. 1007.

35. *McGann v. H & H Music Co.*, 742 F. Supp. 392 (S.D. Tex. 1990), *aff'd* 946 F.2d 401 (5th Cir. 1991), *petition for cert. filed sub nom. Greenberg v. H & H Music Co.*, 60 U.S.L.W. 3638 (U.S. Feb. 3, 1992) (No. 91-1283); *Owens v. Storehouse, Inc.*, 773 F. Supp. 416 (N.D. Ga. 1991), *appeal docketed*, No. 91-8696 (11th Cir. July 31, 1991); *see also* *Levesque v.*

goal is to minimize the cost of the plan. Unlike the discharge scenario, however, the employer reduces costs not by discharging the employee or discriminating directly against him, but by modifying the plan to apply to all beneficiaries.³⁶

Common factual themes bind post-claim plan modification cases. First, the plan participant or beneficiary incurs a covered illness that requires him or her to file a claim through the plan for ongoing treatment. Second, the employer becomes aware of the illness, either from the employee directly or by the actual filing of a claim for benefits. Third, the employer proceeds to modify the plan to exclude or provide only de minimis coverage for the diagnosed illness.³⁷ Additionally, decisions in both group and individual cases hold that "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits."³⁸

A. *ERISA in Court: Setting the Stage for McGann and Owens*

To establish that an employer has unlawfully discriminated against an employee or group of employees in violation of section 510, courts have developed a fairly rigid legal standard which plaintiffs must meet.³⁹ In order to establish a prima facie case under section 510, "the employee must demonstrate (1) prohibited employer conduct (2) taken for the purpose of interfering (3) with the attainment of any right to which the employee [is or] may become entitled."⁴⁰ A new twist to the equation was added in

Marathon Elec. Mfg. Corp., No. 90-3488-CV-S-4 (W.D. Mo. Aug. 1, 1991) (permitting defendant to modify health benefit plan even though it interrupted treatment regimen of plaintiff); *Vogel v. Independence Fed. Sav. Bank*, 728 F. Supp. 1210 (D. Md. 1990).

36. *Vogel*, 728 F. Supp. 1210, discussed below, is an atypical discrimination case. In *Vogel*, the plan was modified to expressly exclude the plaintiff from coverage. *Id.* at 1216. Arguably, this is a much easier case to decide.

37. *E.g.*, *McGann*, 946 F.2d at 403.

38. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 91 (1983), *quoted in McGann*, 946 F.2d at 406; *see also Sejman v. Warner-Lambert Co.*, 889 F.2d 1346, 1348-49 (4th Cir. 1989), *cert. denied*, 111 S. Ct. 43 (1990); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464, 1471 (11th Cir. 1986), *cert. denied*, 481 U.S. 1016 (1987); *Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350, 1351-52 (8th Cir. 1985); *Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees*, 740 F.2d 454, 456 (6th Cir. 1984), *cert. denied*, 469 U.S. 1109 (1985).

39. *Gavalik v. Continental Can Co.*, 812 F.2d 834 (3d Cir. 1987), *cert. denied*, 484 U.S. 979 (1987). *Gavalik* is the leading case regarding the appropriate standard by which § 510 claims should be measured. *Id.* at 852. Other courts have followed *Gavalik* in requiring specific intent. *See, e.g.*, *Kimbrow v. Atlantic Richfield Co.*, 889 F.2d 869, 881 (9th Cir. 1989) (finding that employee must prove employer's specific intent to retaliate for employee's exercise of rights under plan), *cert. denied*, 111 S. Ct. 53 (1990); *Clark v. Resistoflex Co.*, 854 F.2d 762, 770 (5th Cir. 1988) (holding that employee must prove specific intent to interfere with employee's pension rights); *Dister v. Continental Group, Inc.*, 859 F.2d 1108, 1111 (2d Cir. 1988) (holding that § 510 claimant must prove specific intent to engage in activity prohibited by § 510).

40. *Gavalik*, 812 F.2d at 852.

*Deeming v. American Standard, Inc.*⁴¹ In *Deeming*, the court stated that "a fundamental prerequisite to a [section] 510 action is an allegation that the employer-employee relationship . . . was changed in some discriminatory or wrongful way."⁴² This last element makes it virtually impossible for a plaintiff's post-claim modification action to succeed beyond summary judgment when the plaintiff is still employed by the employer.

Prior to *Deeming*, a district court in Missouri found a section 510 violation without such a requirement. In *Vogel v. Independence Federal Savings Bank*,⁴³ family members of the decedent, Leonard Vogel, brought an action asserting, inter alia, a violation of ERISA's nondiscrimination provision. In 1975, while holding several offices with the defendant-bank,⁴⁴ Vogel was enrolled, at his own request, in the bank's life and health insurance plan. Seven years later, Vogel suffered a stroke that left him totally disabled.⁴⁵ The insurance plan, which had no cap on major medical coverage, continued to pay for Vogel's care. In response, the insurance carrier increased premiums substantially to recoup some of the expenditures attributed to Vogel. At the same time, federal regulators were pressuring the bank to improve its financial position. Due to these factors, the bank changed insurance carriers in 1985. The new plan covered all employees except Vogel,⁴⁶ whom it expressly excluded. Less than two years later, the bank re-enrolled with its original carrier, again leaving Vogel without coverage. Shortly thereafter, Vogel died. The defendants sought summary judgment, claiming "[m]ere termination of benefits . . . does not constitute unlawful interference" under section 510.⁴⁷ The court found otherwise and held that the facts stated a claim under section 510.⁴⁸

In contrast, federal district courts have allowed employers to modify health benefit plans "so as to deny benefits to a member of a plan during the course of a treatment regimen."⁴⁹ The two cases discussed next both involved employee beneficiaries diagnosed with AIDS who began using health benefits available under the plan to treat the disease. The employees

41. 905 F.2d 1124 (7th Cir. 1990).

42. *Id.* at 1127.

43. 728 F Supp. 1210 (D. Md. 1990).

44. Vogel was on the board of directors and served as chairman of the bank's loan committee, vice president of the bank, and appraiser for a bank subsidiary. *Id.* at 1214.

45. *Id.* at 1215.

46. There was some contention as to whether Vogel was actually an employee of the bank. However, for the purposes of summary judgment, the court determined that Vogel was an employee. *Id.* at 1225.

47. *Id.*

48. *Id.* at 1226.

49. *Owens v. Storehouse, Inc.*, 773 F Supp. 416 (N.D. Ga. 1991), *appeal docketed*, No. 91-8696 (11th Cir. July 31, 1991); see *McGann v. H & H Music Co.*, 742 F Supp. 392 (S.D. Tex. 1990), *aff'd*, 946 F.2d 401 (5th Cir. 1991), *petition for cert. filed sub nom. Greenberg v. H & H Music Co.*, 60 U.S.L.W. 3638 (U.S. Feb. 3, 1991) (No. 91-1283).

then lost their benefits when the employer terminated the existing plan and instituted a new plan which included a cap on AIDS-related coverage.⁵⁰ Both plaintiffs filed suit claiming discrimination under section 510 and both lost on summary judgment.

B. McGann v. H & H Music Co.

John McGann began working for the defendant-employer in 1982. He was diagnosed with AIDS in 1987. Through July, 1988, he used available health care benefits under the employer's plan. In July, 1988, the employer became self-insured,⁵¹ made minor changes to the terms of the plan,⁵² and reduced the maximum life time benefit for AIDS-related illnesses from one million to five thousand dollars.⁵³

McGann alleged discrimination under ERISA section 510.⁵⁴ McGann claimed that the employer terminated the original group health plan because he submitted claims for treatment of a covered illness, and the employer did not want to pay for his ongoing treatment. According to McGann, such cancellation of benefits constituted "discriminat[ion] against a [plan] participant . . . for exercising any right to which he is entitled under the provisions of . . . [the] plan."⁵⁵ Alternatively, McGann averred discrimination based on the fact that the five thousand dollar cap on AIDS and AIDS-related illnesses was directed at, and solely affected, him.

The district court held that an employer "legally [has] the right to make changes in its group medical plan."⁵⁶ The court found that the employer complied with the relevant portions of ERISA in modifying its benefit plan.⁵⁷ Since an employer has discretion in providing welfare benefit plans,

50. Most state insurance laws, including Texas and Georgia, where *McGann* and *Owens* were decided, prohibit insurance carriers from placing cost-caps on different illnesses. Susan B. Garland, *Sure, You Can Get Sick—But Not Too Sick*, BUS. WK., Dec. 3, 1990, at 40; see also Jerry Geisel, *Self-Insurers Can Limit AIDS Benefits: Court*, BUS. INS., Aug. 6, 1990, at 1; *Company May Place Cap on AIDS Benefits Without Violating ERISA, Judge Rules*, Daily Lab. Rep. (BNA) No. 140, at A-3 (July 20, 1990). However, since state insurance laws do not apply to self-insured plans, the employers were able to evade these provisions.

51. For a discussion of the significance of self-insurance, see *supra* notes 5-8 and accompanying text.

52. For example, the individual calendar year deductible was increased substantially, all treatment for chemical dependency was eliminated, and the new plan included a Preferred Provider Organization (PPO) network. Brief for Appellee at 5, *McGann* (No. 90-2672).

53. *McGann*, 742 F Supp. at 393.

54. Brief for Appellant at 11, *McGann* (No. 90-2672).

55. *Id.* at 11, 12 (citation omitted).

56. *McGann*, 742 F Supp. at 394.

57. First, "[a]ccording to ERISA every employer must provide its employees with a summary plan description ('SPD'). 29 U.S.C. § 1022(a)(1). The SPD must be written in a manner calculated to be understood by the average plan participant." *Id.* at 394. Furthermore, "ERISA does not create liability . . . where no contract prohibits or prevents such change." *Id.* (citation omitted).

the court reasoned an employer has the absolute right to modify or terminate⁵⁸ the plan in any way it sees fit so long as it retains the right to do so in its summary plan description and is not bound by any contractual provisions to the contrary.⁵⁹ Thus, the court found it unnecessary to address McGann's alternative claim of discrimination based on the cost-cap because the employer's action did not constitute prohibited conduct.⁶⁰ "McCann [sic] was not entitled to health benefits whose terms never change."⁶¹ Additionally, although it was not necessary to its holding, the court noted that the employer had a legitimate business reason for modifying the plan.⁶²

The Fifth Circuit affirmed the district court's decision that the employer has an absolute right to modify a plan.⁶³ The court noted that "Congress did not intend that ERISA circumscribe employers' control over the content of benefit plans they offered to their employees."⁶⁴ Because the plan could be modified or terminated at any time so long as the employer says so clearly in the summary plan description,⁶⁵ McGann could not establish any

58. *Id.* at 394 (citing *Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350 (8th Cir. 1985)). In another case, the court granted summary judgment to the defendant employer who modified its health plan to limit hospitalization days for conditions related to mental illness to 60 days per annum. The beneficiary-plaintiff, who required hospitalization in excess of 60 days, was in the middle of a treatment regimen when the modification was made. *Levesque v. Marathon Elec. Mfg. Corp.*, No. 90-3488-CV-S-4 (W.D. Mo. filed Aug. 1, 1991) (citing *Hamilton*, 752 F.2d 1350).

59. "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits." *McGann*, 742 F Supp. at 393 (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 91 (1983)).

60. *Id.* at 394.

61. *Id.*

62. Specifically, the court cited the defendant's assertion that the plan "suffered serious financial losses." *Id.* at 393.

63. *Id.* at 403.

64. *Id.* at 407. For example, even if coverage for Alzheimer's disease and coverage for AIDS present equal costs to the employer and the employer seeks to reduce costs, the employer may completely reduce coverage for one illness and leave the other coverage intact. As will be discussed in Part III of this Note, perhaps a fairer approach would be to require pro rata reductions across all benefit categories when employers engage in post-claim plan modifications. Indeed, AIDS is no more costly to treat than many other life-threatening illnesses. See Eric C. Sohlgren, *Group Health Benefits Discrimination Against AIDS Victims: Falling Through the Gaps of Federal Law—ERISA, the Rehabilitation Act and the Americans with Disabilities Act*, 24 Loy. L.A. L. Rev. 1247, 1259 (1991) (noting that heart attacks and organ transplants continue to be covered even though expenses for these can far outstrip expenses related to AIDS); see also Benjamin Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782, 1794-95 (1987).

65. The court cited numerous authorities for the proposition that "'ERISA does not mandate that employers provide any particular benefits,' and does not itself proscribe discrimination in the provision of employee benefits." *McGann*, 946 F.2d at 406 (citing *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983)); see also *Sejman v. Warner-Lambert Co.*, 889 F.2d 1346, 1348-49 (4th Cir. 1989), *cert. denied*, 111 S. Ct. 43 (1988); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464, 1471 (11th Cir. 1986), *cert. denied*, 481 U.S. 1016 (1987); *Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350, 1351-52 (8th Cir. 1985); *Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454, 456 (6th Cir. 1984), *cert. denied*, 469 U.S. 1109 (1985).

right under the plan to which he was or could become entitled. He was only entitled to the benefit for as long as the company chose to provide it. Thus, he failed to show the specific discriminatory intent required under *Gavalik v. Continental Can Co.*⁶⁶

Although McGann attempted to analogize his situation to Vogel's, the Fifth Circuit distinguished *Vogel*. It pointed out that the plan termination in that case expressly affected only Vogel, and could not affect another.⁶⁷ Even if the employer specifically intended to avoid paying for McGann's care, the fact that the termination and modification in McGann's case affected all beneficiaries precluded a discrimination claim under section 510. Likewise, even if the employer modified the plan based on a general prejudice against AIDS victims, section 510 would not protect McGann and other AIDS victims.⁶⁸ While the court paid lip service to the possibility of a claim based on specific discriminatory intent, the court essentially stated that an employer's purpose in instituting the changes was irrelevant.⁶⁹

The court's decision is open to challenge despite its reliance in part on *Aronson v. Servus Rubber, Div. of Chromalloy*.⁷⁰ Although *Aronson* stated that section 510 is directed against discriminatory conduct targeted at individuals rather than discriminatory conduct affecting merely the terms of an employee benefit plan, it also stated that section 510 could possibly apply to a plan modification that "intentionally benefit[ed], or injur[ed] . . . a certain group of employees."⁷¹ Under *Aronson*, if the modification demonstrates "invidious intent" without a "readily apparent business justification," a section 510 action may be available.⁷² Given this, is H & H Music's motive irrelevant, as the Fifth Circuit seems to believe?⁷³ A plan

66. 812 F.2d 834, 852 (3d Cir. 1987), *cert. denied*, 484 U.S. 979 (1987).

67. *McGann*, 946 F.2d at 405-06. In holding that *Vogel* was not applicable, the court expressly refused to comment on whether it felt *Vogel* was properly decided. *Id.* at 406.

68. *Id.* at 408.

69. *Id.* at 404-05, 408. Specifically, the court stated:

We assume that the defendants' knowledge of McGann's illness was a motivating factor in their decision to reduce coverage for AIDS-related expenses, that this knowledge was obtained either through McGann's filing of claims or his meeting with defendants, and that McGann was the only plan beneficiary then known to have AIDS.

We assume that discovery of McGann's condition—and realization of the attendant, long-term costs of caring for McGann—did in fact prompt defendants to reconsider the \$1,000,000 limit with respect to AIDS-related expenses and to reduce the limit for future such expenses to \$5,000.

Id. at 404 n.4, 405 n.6.

70. 730 F.2d 12 (1st Cir. 1984), *cert. denied*, 469 U.S. 1017 (1984). *Aronson* involved an action by former employees to recover benefits that they believed were due under a profit-sharing plan. The court held that the plan authorized a partial termination, and that the employer complied with those provisions. *Id.* at 15-16.

71. *Id.* at 16.

72. *Id.*

73. See *McGann*, 946 F.2d at 405, 408.

modification made because of a personal bias against McGann or people with AIDS could certainly be characterized as invidious. Indeed, commentators have noted that since the cost of AIDS treatment is "not necessarily greater than those related to other life-threatening illnesses normally covered without question by health plans, . . . singling out HIV infection . . . for exclusions or caps does not have an objective justification."⁷⁴ McGann also argued that section 510 is modeled after section 8(a)(3) of the National Labor Relations Act (NLRA),⁷⁵ which prohibits an employer from discriminating in hiring or tenuring of employment to "encourage or discourage membership in any labor organization."⁷⁶ If successful, such an interpretation would convert otherwise legal plan modifications into section 510 violations, if made for a retaliatory or discriminatory reason.

McGann cited ERISA's legislative history to support his contention. During debate on ERISA, Senator Vance Hartke (D. Ind.) referred to section 8(a)(3) when explaining section 510: "[S]ection [510] . . . made it illegal to 'discharge, fine, suspend, expell [sic], discipline or discriminate' against plan participants to defeat rights under the act or a plan. The language parallels section 8(a)(3) of the National Labor Relations Act and should do the trick"⁷⁷ At the time of Hartke's statement, courts had already interpreted section 8(a)(3) in such a way as to convert what would otherwise be legal employer conduct into an NLRA violation due to anti-union animus.⁷⁸

74. Arthur S. Leonard, *Ethical Challenges of HIV Infection in the Workplace*, 5 NOTRE DAME L.J. ETHICS & PUB. POL'Y 53, 71 (1990); see, e.g., Smith, *supra* note 32, at 45 (arguing that it is probably discriminatory to place a cap on HIV/AIDS claims when there are numerous other costly diseases). Smith provides numerous sources citing the notion that there are other diseases more costly than AIDS that have an impact on the assets of employer-provided welfare benefit plans. *Id.* at 45 n.74.

75. 29 U.S.C. § 158(a)(3) (1988) ("It shall be an unfair labor practice for an employer by discrimination in regard to hire or tenure of employment or any term or condition of employment to encourage or discourage membership in any labor organization.").

While McGann's § 8(a)(3) argument is based on ERISA's legislative history, at least one commentator has suggested that analysis under § 510 should be more lenient toward the employee than § 8(a)(3). See Vogel, *supra* note 32 at 1052.

76. 29 U.S.C. § 158(a)(3).

77. 119 CONG. REC. 30,374 (1973) (statement of Sen. Hartke); see *Lojek v. Thomas*, 716 F.2d 675, 680-81 (9th Cir. 1983); *West v. Butler*, 621 F.2d 240, 245 (6th Cir. 1980).

78. For example, the Supreme Court has held that while an employer may liquidate his entire business regardless of motive, an employer commits a § 8(a)(3) violation when it closes part of its business if the purpose is to discourage unionism. *Textile Workers Union v. Darlington Mfg. Co.*, 380 U.S. 263, 273-75 (1965). For additional cases, see *NLRB v. Southern Beverage Co.*, 423 F.2d 720 (5th Cir. 1970); see also *NLRB v. Brown*, 380 U.S. 278 (1965); *NLRB v. Erie Resistor Corp.*, 373 U.S. 221 (1963). More recent decisions have been consistent with these precedents. For examples, see *Sure-Tan, Inc. v. NLRB*, 467 U.S. 883, 895-96 n.6 (1984); *Teamsters Local Union No. 171 v. NLRB*, 863 F.2d 946, 955 (D.C. Cir. 1988) (explaining that the key question to be determined under § 8(a)(3) is "whether the employer's actions are motivated by anti-union considerations") (quoting *NLRB v. Berger Transfer & Storage Co.*, 678 F.2d 679, 691 (7th Cir. 1982)), *cert. denied sub. nom. A.G. Boone Co. v.*

Under this section 8(a)(3) analogy, H & H Music's admission that it modified the plan to specifically avoid McGann's medical claim thus could be construed as retaliation for having filed a claim. The changes may also have been discriminatory if McGann could have proven that they were based on a desire to exclude benefits to him exclusively, or on a general prejudice against people with AIDS.⁷⁹ In any situation, the court should examine the facts and circumstances surrounding the modification to decide whether the employer modified the plan in a discriminatory manner or for a retaliatory reason.⁸⁰

McGann's case would have survived summary judgment had the court entertained this line of argument. Unfortunately, the Fifth Circuit avoided the entire intent issue. It found that a plan modification which applies to all plan participants, at least in theory, is not prohibited employer conduct, pure and simple. Thus, because of the court's reasoning, McGann failed to get to first base. The court's analysis leaves a huge gap in section 510's protection. As will be discussed briefly in Part III, an interpretation of section 510 that incorporates a section 8(a)(3)-like intent factor is needed to give full effect to the statute and avoid absurd results.

Another difficulty with the Fifth Circuit's decision is its reliance on *Moore v. Metropolitan Life Insurance Co.*⁸¹ The *Moore* court added judicial gloss to ERISA's legislative history. The court found that Congress rejected automatic vesting plans *because* employers need the freedom to control rising and unpredictable health care costs. In defending post-claim plan modifications, it noted that Congress recognized the employer's need to change the level of the benefits provided to employees due to inflation and changing technology.⁸² While this interpretation seems credible in today's health-care economy,⁸³ the fact that Congress chose not to require vesting of welfare benefits does not necessarily mean that employers have the unfettered right to modify their plans to adversely affect an employee after he or she becomes ill and files a claim.

NLRB, 490 U.S. 1065 (1989). See also Vogel, *supra* note 32, at 1026, 1046-56 (arguing that § 8(a)(3) and relevant provisions of other remedial labor statutes provide principles and approaches for interpreting and extending § 510).

79. Leonard, *supra* note 74 and accompanying text.

80. *Southern Beverage*, 423 F.2d at 720.

81. 856 F.2d 488, 491 (2d Cir. 1988).

82. *McGann*, 946 F.2d at 407 (quoting *Metropolitan Life*, 856 F.2d at 492). While this argument is unsupported in ERISA's legislative history, it is not completely without reason. Locking employers into a specific benefit package without any means to modify it could result in one of two outcomes: either the employers will go bankrupt or they will provide de minimis benefits to avoid risking financial ruin. In either case, both the employer and employee lose. Employers either end up with a ruined business or have difficulty attracting good workers because of limited benefit packages. Employees either are out of a job after the plan bankrupts the company or else are forced to accept positions with minimal benefits.

83. See *infra* notes 134-40 and accompanying text.

The *Moore* court cites the following legislative history to support its claim that employers have an absolute right to modify employee benefit plans at any time:

[T]he term "accrued benefit" refers to pension or retirement benefits and is not intended to apply to certain ancillary benefits, such as medical insurance or life insurance, which are sometimes provided for employees in conjunction with a pension plan, and are sometimes provided separately. To require the vesting of these ancillary benefits would seriously complicate the administration and increase the cost of plans whose primary function is to provide retirement income.⁸⁴

Reliance on this legislative history is completely inapt. This legislative history concerns welfare benefits within a pension plan, not the welfare benefit plan itself as in *McGann*. Congress merely determined that welfare benefits within a pension plan would not vest. The quoted language has nothing to do with whether an employer can modify a plan to avoid paying for a participant's benefits after he or she gets sick.

The judicial gloss of the *Moore* court, despite its plausibility, misses the point. There is little evidence that Congress intended to give employers the absolute, unfettered right to modify their benefit plans. The courts, then, should decide this question under the federal common law of ERISA, perhaps using general contract principles.⁸⁵ Alternatively, rather than allow the employer to reserve the absolute right to modify plans merely by saying in the summary plan description that the plan can be modified at any time for any reason, the courts should require more explicit language. One alternative would be to require the employer to actually state in unequivocal language that it reserves the right to change the plan even if the employee gets sick and even if the purpose of the change is to shift the cost of care from the plan to the employee. Granted, the result may not be any fairer, but at least the employee would have adequate notice.

In a situation where the legislative history is silent on an issue, basic canons of statutory construction require that courts devise a statutory interpretation that does not achieve an absurd result. Nevertheless, the *McGann* court promotes such absurd results.

Under the *McGann* court's philosophy, an employee has a valid claim when his employer fires him to avoid paying for his treatment.⁸⁶ Yet, an employee does not have a valid claim when the same employer modifies the

84. *Metropolitan Life*, 856 F.2d at 491 (citing H.R. REP. No. 93-807, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4670, 4726; S. REP. No. 93-383, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4890, 4935).

85. See, e.g., Vogel, *supra* note 32, at 1061.

86. See, e.g., *Fitzgerald v. Codex Corp.*, 882 F.2d 586, 589 (1st Cir. 1989); *Kross v. Western Elec. Co.*, 701 F.2d 1238, 1241-42 (7th Cir. 1983); *Folz v. Marriott Corp.*, 594 F. Supp. 1007 (W.D. Mo. 1984).

benefit plan to avoid paying for the same employee's treatment.⁸⁷ A rule that permits a cause of action for a section 510 violation when the employer fires the employee, but not when the employer continues to employ the worker can be characterized only as absurd. Such an interpretation also leaves a huge gap in the statute's enforcement mechanism as it relates to welfare benefits. If ERISA is a remedial statute to be liberally construed in favor of the participant beneficiary,⁸⁸ and such statutes should be interpreted so as not to produce absurd results, the courts have put the wrong gloss on the statute in permitting employers to achieve with post-claim modifications what they could not achieve through wrongful discharge.

C. *Owens v. Storehouse, Inc.*

A similar case decided almost simultaneously with *McGann* achieved the same result.⁸⁹ Richard Owens was diagnosed with AIDS in November, 1988. He received about \$116,000 in health benefits under his employer's plan, which contained a \$1,000,000 lifetime benefit. In October, 1990, the company became self-insured and placed a \$25,000 cap on AIDS-related claims. It notified Owens that he was ineligible for additional benefits.⁹⁰

Owens sued under section 510 and simultaneously sought a temporary restraining order to direct the employer to continue paying benefits for the treatment of his AIDS-related health problems.⁹¹ The court reluctantly denied the order, noting that the employer had a legitimate business purpose for making changes.⁹² The company's reasons aside, the court found disturbing

87. *McGann*, 946 F.2d 401; *Owens v. Storehouse, Inc.*, 773 F. Supp. 416 (N.D. Ga. 1991), appeal docketed, No. 91-8696 (11th Cir. July 31, 1991).

88. *West v. Butler*, 621 F.2d 240, 244 (6th Cir. 1980).

89. *Owens*, 773 F. Supp. 416.

90. To be fair to the company, it should be noted that:

[a]lthough the AIDS limitation was made effective March 1, 1990, defendant continued to honor approximately \$90,000 worth of plaintiff's claims in excess of the \$25,000 cap because the claims experienced as a whole for the first half of the 1990 plan year were running less than budget. By October, however, this benevolence had to end as the financial condition of both the plan and the company deteriorated. After apprising plaintiff by letter of its intention to adhere strictly to the modified terms of its employee benefit plan, defendant forwarded plaintiff an additional \$7500 as a 'transitional' benefit.

Id. at 418.

91. *Owens v. Storehouse, Inc.*, 773 F. Supp. 414 (N.D. Ga. 1990) (denying restraining order) [hereinafter *Owens I*, to distinguish it from case of same name appearing at 773 F. Supp. 416].

92. The plaintiff was one of five employees who had AIDS out of a total work force of 160. The employer contended that its decision to modify the plan was driven by the fact that it faced a "substantial premium increase and other limitations" from its reinsurer. *Id.* at 415. Additionally, the employer submitted financial data to the court under seal. The court, upon reviewing the data, concluded that the employer had a "most legitimate business reason for modifying the plan to cap its exposure for medical benefits payable to AIDS-infected [sic]

the specter that ERISA permits a plan to be modified "so as to deny benefits to a member of a plan during the course of a treatment regimen."⁹³

Nevertheless, in granting the defendant's summary judgment, the court abandoned its concerns with a "legitimate business purpose" and adopted the reasoning in *Deeming*.⁹⁴ The court distinguished between actions affecting the benefit plan and actions affecting the employee-employer relationship. Quoting *Deeming*, the court held that an employee had no cause of action for the latter⁹⁵ and noted that "section 510 of ERISA simply is not the appropriate vehicle for redressing the unilateral elimination of severance benefits accomplished independently of employee termination or harassment."⁹⁶

The *Owens* court's reliance on *Deeming* is unfortunate as the decision in *Deeming* is not strongly supported. *Deeming* cites Senator Hartke's statement made in support of section 510 during Senate debate of ERISA. Senator Hartke wanted to make sure that section 510 would protect employees who were discharged by employers just prior to vesting, not that ERISA section 510 protected terminations exclusively.⁹⁷ Senator Javits, to whom Hartke addressed the questions, merely affirmed that section 510 would provide a remedy to those who are discriminatorily discharged.

Deeming points to this legislative history to support its proposition that a fundamental change in the employee-employer relationship must occur to have a section 510 claim. However, the entire discussion between Senator Hartke and Senator Javits was limited to the context of employers discharging employees immediately prior to vesting. The language of section 510 is much broader than vesting. Merely because the legislative history suggests section 510 is applicable when there is a change in the employee-employer relationship, it does not necessarily follow that section 510 protects employees *only* in such situations.

The *Owens* court also relies, in part, on *West v. Butler*.⁹⁸ In this case, the Sixth Circuit concluded that "it appears Congress designed section 510 *primarily* to protect the employment relationship that gives rise to an individual's pension rights."⁹⁹ However, the term "primarily" is equivocal.

plan members. If the plaintiff's motion were granted, [it] could cause either the entire medical benefit plan for all 100-plus employees to be ended, or financial ruin to the employer." *Id.* The plaintiff's inability to post bond influenced the court in denying the motion; had the order been granted and had the employee lost at trial, it was uncertain whether the employer would have been able to recover the expense of providing continued coverage for Owens's benefit in the interim. *Id.* at 416.

93. *Id.* at 415-16.

94. *Deeming v. American Standard, Inc.*, 905 F.2d 1124, 1128 (7th Cir. 1990).

95. *Owens*, 773 F. Supp. at 419 (quoting *Deeming*, 905 F.2d at 1127).

96. *Id.* (quoting *Deeming*, 905 F.2d at 1128).

97. 119 CONG. REC. 30,044 (1973).

98. 621 F.2d 240 (6th Cir. 1980).

99. *Id.* at 245 (emphasis added).

It means "originally" or "chiefly," not "exclusively."¹⁰⁰ While protecting the employee-employer relationship may be the "primary" purpose of section 510, in any event it is not the exclusive purpose of this broad provision.

The *West* court concluded nonetheless that "discrimination, to violate Section 510, *must* affect the individual's employment relationship in some substantial way."¹⁰¹ How the court got from "primary" to "must" is unclear. To convert a Senate discussion about whether a provision applies to a particular situation into a statement that the sole purpose of the provision is to apply to those situations is just not supportable.

There is another reason why it makes little sense to graft the requirement that a section 510 claim must adversely affect the employee-employer relationship. *Vogel*¹⁰² cannot be reconciled with *Deeming*,¹⁰³ *West*,¹⁰⁴ or *Owens*¹⁰⁵ because the employee-employer relationship was not adversely affected. The employee in *Vogel* was merely invidiously excluded from the benefit plan.¹⁰⁶ Even if the defendant in *Owens* expressly excluded or limited coverage for the plaintiff by name, as in *Vogel*, the employee would have no valid claim under section 510 according to *Deeming*. It is difficult to imagine that Congress intended such an absurd result.

Thus, narrowly construing section 510 to apply only to actions that discriminatorily affect the employee-employer relationship is not supported by the legislative history or applicable case law. It also creates the paradox that an employee can only lose benefits if he or she continues to work for the employer, regardless of whether the employer's intent is invidious.¹⁰⁷ An

100. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 983 (2d College ed. 1982).

101. *West*, 621 F.2d at 245-46 (emphasis added).

102. *Vogel v. Independence Fed. Sav. Bank*, 728 F. Supp. 1210 (D. Md. 1990).

103. *Deeming v. American Standard, Inc.*, 905 F.2d 1124 (7th Cir. 1990).

104. *West*, 621 F.2d 240 (6th Cir. 1980).

105. *Owens v. Storehouse, Inc.*, 773 F. Supp. 414 (N.D. Ga. 1990), *appeal docketed*, No. 91-8696 (11th Cir. July 31, 1991) (*Owens I*, *supra* note 91).

106. *Vogel*, 728 F. Supp. 1210.

107. Senator Hartke's comments in support of § 510, cited by both the *Deeming* and *West* courts, also mention constructive discharge. *Deeming*, 905 F. Supp. at 1127 n.2; *West*, 621 F.2d at 245. Arguably, if a post-claim modification is invidious enough to rise to the level of constructive discharge, the discharge and discrimination cases could be reconciled. However, such a modification probably would not rise to the level of a constructive discharge. Constructive discharge occurs when an employer deliberately makes an employee's working conditions so intolerable that the employee is forced into voluntary resignation. The concept of constructive discharge has been applied previously in ERISA cases. See *Kreis v. Charles O. Townley, M.D. & Assoc.*, 833 F.2d 74 (6th Cir. 1987). The conditions of employment must be such that a "reasonable person in the employee's shoes would have felt compelled to resign." *Yates v. Avco Corp.*, 819 F.2d 630, 636-37 (6th Cir. 1987) (citations omitted). The court must examine both the objective feelings of the employee and the intent of the employer. *Meyers v. City of Cincinnati*, 728 F. Supp. 477 (S.D. Ohio 1990), *aff'd in part and rev'd in part*, 934 F.2d 726 (6th Cir. 1991). The employee's feelings cannot be unreasonably sensitive. *Id.* at 481. As well,

employee cannot lose benefits if he or she is discharged for using them.

Taken together, *McGann* and *Owens* appear to provide a clear path for employers to cut their benefit costs by modifying plans on a post-claim basis. To successfully enact a post-claim plan modification, the employer must satisfy at least four criteria. First, employers must include a statement in their SPD that states clearly that the benefits may be unilaterally changed at any time.¹⁰⁸ Second, employers must be free of any contracts that bind them to benefit terms.¹⁰⁹ Third, the activity on its face must be directed at the plan and not a specific employee-employer relationship.¹¹⁰ Fourth, in most states, the plan must be self-insured if the post-claim modification includes placing caps on or excluding particular illnesses but not others.¹¹¹

This artificially narrow interpretation of section 510 permits employers to modify health insurance coverage after an employee's need for the coverage arises. The result is that employers have an excellent way to control health insurance costs even after the covered illness has been diagnosed and claims have been filed. The employee is left with a preexisting condition, inadequate or no health insurance, and no cause of action under ERISA. This harsh result is not mandated by ERISA, and some actions by both the judiciary and the legislature could invigorate section 510 as it relates to post-claim modifications.

the employer is assumed to intend the foreseeable consequences of his or her conduct. *Id.* Thus, the dispositive question is whether a post-claim modification of a health benefit makes working conditions so intolerable that a reasonable person would feel compelled to leave. The effect of a post-claim modification may, in addition to being financially devastating, be personally humiliating. Notably, the "psychological impact" in a constructive discharge case is important.

Yet some problems exist in making this analogy. First, the post-claim modification must be defined as a "working condition." Generally, courts would define working condition as something more like the physical and social surroundings, and not particular pay or benefits. *See, e.g., Meyers*, 728 F. Supp. at 477-82. Second, courts are more likely to find constructive discharge where the employer cannot provide any reason to justify the different treatment of similarly situated employees. In this case, the cost of treatment is clearly a concern and at least one of the reasons the changes were made. Finally, did the employer intend the action in question—that the employee resign? Arguably, in *McGann* and *Owens* the employer was indifferent as to whether the employee stayed or left. The employer's goal was accomplished at the time the plan was modified and the employee could no longer receive benefits. For the purposes of avoiding costs under the plan, it is irrelevant whether the employee stays on or not. Consequently, the employer probably does not have the intent needed to establish constructive discharge.

108. 29 U.S.C. § 1022 (1988).

109. For example, employers cannot be bound by a collective bargaining agreement regulated under the National Labor Relations Act, 29 U.S.C. §§ 151-169 (1988).

110. *Deeming*, 905 F.2d at 1127. Indeed, in *McGann*, counsel for the defendant aptly stated: "we never terminated McGann. We terminated the plan, and a self-insured company can offer whatever benefits it wants." Garland, *supra* note 50 (quoting Mark A. Huvard, attorney for H & H Music Co.).

111. *See, e.g., supra* note 50 and accompanying text.

III. RECOMMENDATIONS

Although lacking Congressional underpinnings, the court's point in *Moore v. Metropolitan Life Ins. Co.*¹¹² is well taken in light of rising health care costs that wreak havoc on employers and their employee benefit plans.¹¹³ The courts in *McGann* and *Owens* both noted that the defendants had legitimate business reasons for making the changes.¹¹⁴ If ERISA prohibits employers from modifying plans once instituted, some will face financial hardships from which they will not recover; others, in order to avoid financial hardships, will merely provide de minimis benefits or none at all. The *McGann* court believed any involvement on its part to prevent the post-claim modification would inappropriately involve the judiciary in what is the sole domain of the employer—determining what benefits it should provide to its employees.¹¹⁵

As mentioned above, the result in *McGann* creates a gap in section 510 protection. The employer wishing to avoid payment of benefits can accomplish its end without actually or constructively severing the employee-employer relationship.¹¹⁶ Thus, a reasonable approach permits section 510 actions even though the employee-employer relationship remains intact. Under this scenario, a post-claim modification could possibly state a cause of action under section 510. Nonetheless, in some instances post-claim modifications may be necessary if the company and the benefits of the remaining employees are at risk. The recommendations below could be followed by the courts in a post-claim modification case. In addition, Congress could enact changes to ERISA sections 1022 and 510 to more

112. 856 F.2d 488 (2d Cir. 1988).

113. *Id.* at 492.

114. *McGann v. H & H Music Co.*, 742 F. Supp. 392, 393-94 (S.D. Tex. 1990), *aff'd*, 946 F.2d 401 (5th Cir. 1991), *petition for cert. filed sub nom. Greenberg v. H & H Music Co.*, 60 U.S.L.W. 3638 (U.S. Feb. 3, 1992) (No. 91-1283); *Owens v. Storehouse Inc.*, 773 F. Supp. 414, 415 (N.D. Ga. 1990), *appeal docketed*, No. 91-8696 (11th Cir. July 31, 1991) (*Owens I*, *supra* note 91).

115. Specifically, the court said:

McGann interprets section 510 to prevent an employer from reducing or eliminating coverage for a particular illness in response to the escalating costs of covering an employee suffering from that illness. Such an interpretation would, in effect, change the terms of [the] plan. [D]efendants would be effectively proscribed from reducing coverage for AIDS once McGann contracted that illness and filed claims for AIDS-related expenses. If a federal court could prevent an employer from reducing an employee's coverage limits for AIDS treatment once that employee contracted AIDS, the boundaries of judicial involvement would be sorely tested.

McGann, 946 F.2d at 407-08.

116. Arguably, it seems that the easiest way for the employer to avoid paying pension benefits is to discharge employees. Thus, § 510 probably works effectively to protect pensions and vested benefits even if its application is limited to the frustration of the employee-employer relationship.

clearly define the scope of when and how a plan should be modified to prevent discrimination. Finally, Congress must look anew at ERISA's pre-emption clause, which has had the inadvertent effect of driving employers to self-insurance, perhaps contrary to the long-term interests of both employers and employees.

A. "Grandfather" in Participants with a Preexisting Condition Unless the Employer Can Prove that it is Economically Unfeasible

An employer should be able to implement a post-claim modification that interrupts a participant's treatment regimen only if the employer can demonstrate that it is economically unfeasible¹¹⁷ to "grandfather" in the particular participant with regard to that preexisting condition.¹¹⁸ "Grandfathering" meets the short-term needs of the participant to have continued coverage and, if feasible, the long-term need of the employer to modify the plan and maintain its fiscal integrity. Those who relied on the coverage and now find themselves with a condition that requires treatment are allowed to have the treatment continue, while those who do not have such a condition have notice of what is covered and what is not.

Otherwise, post-claim modifications (under a worst-case scenario) give employers the luxury of having their proverbial cake and eating it too. They can attract the best employees with the lure of a plethora of expensive benefits, and then systematically modify the plan as employees diagnosed with expensive illnesses file treatment claims. Moreover, employees who rely on coverage with a reasonable expectation of using the benefits will likely be unable to obtain coverage elsewhere, after being diagnosed with the condition.¹¹⁹ "Grandfathering" prevents a situation where employers enacting post-claim modifications create a whole new class of persons "who

117. Through the common law of ERISA, courts will need to fashion a working definition of "unfeasible" over time. The following definition, although drawn from a case which was ultimately reversed, may be helpful: "[The company] must demonstrate not that the costs of the medical insurance plan far outweigh the insurance premiums paid by retirees, but rather that the contractual promises previously made are now avoidable because of some unforeseen contingency that threatens the financial base of the entire corporation." *Musto v. American Gen. Corp.*, 615 F. Supp. 1483, 1500 (M.D. Tenn. 1985), *rev'd*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989); *see also* Frances Figetakis, Comment, *Retiree Welfare Benefits: ERISA, LMRA, and the Federal Common Law*, 20 AKRON L. REV. 455, 465 (1987).

118. This suggestion has already drawn fire. *See* David Katz, *Employers Need a Moral Yardstick for AIDS Benefits*, NATIONAL UNDERWRITER, PROPERTY & CASUALTY/RISK & BENEFIT MANAGEMENT EDITION, Jan. 6, 1992, Dec. 30, 1992 [sic] (double issue) at 9, 18 (proposing "grandfather" option). *But see* Steven Straw, *Letter to the Editor*, NATIONAL UNDERWRITER, PROPERTY & CASUALTY/RISK & BENEFIT MANAGEMENT EDITION, Mar. 3, 1992, at 59 (attacking the proposal).

119. Because of the preexisting condition, insurers will either refuse to cover the existing condition or will do so at such a high premium rate that only the most wealthy could afford such coverage.

believe they are covered . . . and then find that they aren't."¹²⁰ The counterargument to such fears, however, is that employers, afraid of losing good will from both the community and prospective employees, will refrain from routinely enacting post-claim modifications out of their own economic interest.¹²¹

Even though welfare benefits do not vest,¹²² at least one court has noted that employees rely on welfare benefits before actually using them.¹²³ In fact, welfare benefits represent a primary inducement for accepting and maintaining employment.¹²⁴ The company which provides benefits receives an economic benefit in the form of lower turnover and the attraction of better workers. Unlimited plan modifications and terminations turn the plan into a mere gratuity.¹²⁵

B. *Pro Rata Reductions*

If the employer establishes that it is unfeasible to "grandfather" in those with a preexisting condition, cuts in the plan should be permitted. To avoid discriminatory impact on any individual, there should be a presumption that the reductions be made on a pro rata basis. For example, if the defendant in *McGann* needed to cut \$500,000 from its benefit plan to remain solvent, it should be proscribed from exacting the cuts from one illness or category, such as AIDS. The reductions should be prorated across all categories to a level that would create the \$500,000 savings needed. Thus, adequate cost savings are achieved and no particular party is forced to bear the entire burden. This approach would jibe with many existing state insurance laws which already prohibit different cost caps on different illnesses.

120. Garland, *supra* note 50 (quoting Robert L. Liebross, attorney with the American Association of Retired Persons, who submitted a brief supporting *McGann*). Additionally, post-claim modifications effectively create a new class of partially-uninsured individuals and families in society. With Congress already struggling to deal with the millions of people in the United States without health insurance, one wonders if Congress actually intended ERISA to permit employers to transfer to the federal government the costs of their beneficiaries' most expensive illnesses on a post-claim basis.

121. Indeed, employers may feel that they have an implicit contract to provide the "promised" benefits once claims are submitted, even though ERISA, according to the courts, permits post-claim modifications. Additionally, employers benefit from providing benefit plans through lower turnover, less training, and a more talented work force. Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1118 (1988).

122. Some commentators have suggested that they should. See, e.g., Vogel, *supra* note 32, at 1026.

123. *Musto v. American Gen. Corp.*, 615 F. Supp. 1483, 1505 (M.D. Tenn. 1985), *rev'd*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989).

124. See Figetakis, *supra* note 117, at 465.

125. *Musto*, 615 F. Supp. at 1497.

Should the employer prefer to institute more targeted reductions, the burden would shift to the employer to show that these are not retaliatory or discriminatory. For example, an employer may want to make different level cuts between preventive benefits, elective benefits, and major medical benefits, based on some type of targeting or prioritization.

C. *Avoid the Unintended Incentive for Becoming Self-Insured*

As *McGann* and *Owens* demonstrate, employers interested in placing caps on particular illnesses, most likely through a post-claim modification prompted by a recent employee claim, must become self-insured in order to make the change.¹²⁶ ERISA's preemption clause unintentionally created this impetus when it preempted all state law relating to employee benefits, and paradoxically and contradictorily, added an exception that permitted states to continue regulating their insurance industry.¹²⁷ When the Supreme Court held that the exception does not apply to self-insured plans,¹²⁸ the message became clear: become self-insured and ERISA preemption shields you from your state's insurance laws.¹²⁹ Accordingly, employers, whether or not competent to manage their own plans, have a statutory incentive to drop their insurance carrier, become self-insured, and thus maximize their freedom in deciding what benefits to provide to their employees.

There should be no "accidental" incentive for becoming self-insured. Two recommendations should help in this area. First, employers who claim to be self-insured but hire an insurance company to manage their plan or secure "stop loss" insurance should be subject to state insurance laws.¹³⁰ Courts should therefore interpret state statutes to allow those who benefit from and rely on the insurance industry in the implementation of their plans to be subject to the laws of that industry.¹³¹

Second, Congress could amend ERISA section 514¹³² to exempt state-mandated benefit laws from ERISA preemption. This would reverse the

126. Garland, *supra* note 50.

127. 29 U.S.C. § 1144(a), (b)(2)(A) (1988).

128. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); Bruner, *supra* note 6, at 1116-17.

129. See also Thomas B. Stoddard, *Now You're Insured, Now You're Not*, N.Y. TIMES, May 23, 1992, at 23.

130. Some states permit employers to hire insurance companies to administer their self-insured plan or allow employers to purchase "stop loss" insurance and still retain their self-insured status. Daniel M. Fox & Daniel C. Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL'Y 47, 63-65 (1988). Generally speaking, "stop loss" insurance is coverage that the self-insured employer obtains to protect itself from either an unusually large number of claims or an extremely expensive one. In short, "stop loss" insurance provides protection against unanticipated expenses. 2 HEALTH CARE LAW, *supra* note 5.

131. This proposal has been raised by at least one commentator. Fox & Schaffer, *supra* note 130, at 63-64.

132. 29 U.S.C. § 1144 (1988).

statutory incentive toward self-insurance. In the absence of strong federal leadership in welfare benefit protection, states are familiar enough with their industries, markets, and governmental structure to protect the interests of their citizens. They can identify what benefits should be mandated. ERISA should not be allowed to preempt laws relating to the content of benefits since ERISA is silent on this issue.¹³³ With regard to welfare benefits, ERISA should be a floor, not a ceiling.

D. *The Need for National Health Insurance*

This Note would be remiss if it did not underscore the need for the United States to join other industrial democracies in implementing a comprehensive national health insurance program. With such a program, this entire Note would be moot. Indeed, there is ample evidence that the rising cost of health care associated with welfare benefit plans is crippling both employers who provide such coverage and employees who lack such coverage.¹³⁴

The cost of employee benefit plans, particularly health benefits, continues to rise much faster than inflation¹³⁵ and constitutes a large share of employers' expenses¹³⁶ and employees' compensation.¹³⁷ In the absence of assistance from the federal government, employers must find ways to cut costs to protect the solvency of their plans and to remain competitive in a world market economy.¹³⁸ Conversely, all but the wealthiest individuals remain dependent upon employee welfare benefit plans to cover the expensive costs of care—especially for serious catastrophic illness.¹³⁹ Thus, both

133. Stoddard, *supra* note 129.

134. See, e.g., *Congressional Action on Health Reform Unlikely This Session, Borzi Tells ABA*, 19 PENS. REP. (BNA) No. 33, at 1485 (Aug. 17, 1992) (stating that health care costs at General Motors Corporation alone total three billion dollars annually).

135. "Over the past three decades, with the sole exception of the two oil shock years, health care has outstripped CPI [Consumer Price Index] growth. . . [H]ealth care inflation [has increased] at two or more times the rate of CPI growth." *Health Care for the Uninsured: Hearings Before the Subcomm. on Health for Families and the Uninsured of the Senate Comm. on Finance*, (part 2 of 2), 101st Cong., 2d Sess. 156 (1990) (statement of Walter B. Maher, director, Fed. Relations, Human Resources Office, Chrysler Corp.).

136. See, e.g., *id.* at 163.

137. *Id.* at 234 (statement of Health Policy Coalition).

138. "[Health care] inefficiency is creating an enormous economic effect on our international competitiveness." *Id.* at 4 (statement of Hon. Donald W. Riegle, Jr., Senator from Michigan, Chairman of Subcomm. on Health for Families and the Uninsured). For example, Chrysler Corporation reported that the cost of health insurance for current and retired workers is \$700 per car for cars produced in the United States. The cost of health care per car on Chryslers built "across the river" in Canada is only \$200. *Id.* at 4-5.

139. For example, the average lifetime tab for treating AIDS is \$75,000, and this is by no means the most expensive of all catastrophic illnesses. Garland, *supra* note 50. For discussion of the costs of treating AIDS relative to other catastrophic illnesses, see Sohlgren, *supra* note 64; Schatz, *supra* note 64.

employers and employees have an interest in shifting the actual costs of an illness to each other—regardless of whether it is covered by the existing benefit plan. Employees who become ill want their employer to honor its “promise” to provide the services prescribed in the plan. Employers, absent any explicit contractual obligations, want the right to modify their plans any time and for any reason.

The energy expended in this colossal loss-shifting game is wasteful social and economic activity which, when the dust clears, leaves approximately forty million Americans either uninsured or underinsured. Even when an employer successfully enacts a post-claim modification excluding someone who *now* has a preexisting condition, if that illness is financially catastrophic, the employee will likely end up on Medicaid, with public funds ultimately paying for the cost of care anyway. Thus, while a full discussion of national health insurance is clearly beyond the scope of this Note, the very problems discussed here urgently beckon such a system.

With specific regard to the *McGann* case, the Supreme Court, in deciding whether to grant certiorari, invited the Solicitor General in March, 1992 to submit a brief.¹⁴⁰ The Bush Administration, because of alleged differences within the Cabinet,¹⁴¹ did not file a brief until October 16, 1992.¹⁴² Earlier, the Department of Health and Human Services (DHHS) had argued that *McGann* should be overruled by the Supreme Court.¹⁴³ Since more than half of all employees now work for companies that have self-insured plans, the prospect of losing benefits the moment one needs them most threatens to undercut the nation's private health insurance system and greatly concerns DHHS. However, the Labor Department strongly supported maintaining the employer's absolute right to modify its plan, especially given rising costs. The Administration apparently followed the Labor Department in taking its stand that the lower courts were correct in permitting H & H Music to enact a post-claim modification of its benefit plan.¹⁴⁴

CONCLUSION

The rising cost of employee health benefits presents a substantial challenge to employers in their efforts to both provide benefits to their employees and still remain solvent. While ERISA does not require employers to provide

140. *Greenberg v. H & H Music Co.*, 112 S. Ct. 1556 (1992), *reviewing petition for cert. McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991).

141. See Malcom Gladwell, *When Benefits Changes Leave Employees Vulnerable: AIDS Case Targets Federal Self-Insurance Law*, WASH. POST, Aug. 20, 1992, at A1, A4.

142. *AIDS Victim Had Insurance Slashed by Employer* (CNN News, Oct. 16, 1992), available in LEXIS, Nexis Library, CNN File [hereinafter *AIDS Victim*]. The Bush Administration filed a brief supporting the denial of certiorari. *Id.*

143. Pear, *supra* note 4.

144. *AIDS Victim*, *supra* note 142.

benefits, it does regulate the plans of employers who choose to provide benefits. Overall, ERISA provides an adequate mechanism for regulating benefits and preventing wrongful discharges by employers to avoid paying benefits.

However, as the post-claim modification cases demonstrate, ERISA has some blind spots. In section 510 actions, courts have begun interpreting the interference provision narrowly to exclude discriminatory actions that fail to impair the employee-employer relationship. Courts have also held that since employers have an absolute right to modify their welfare benefit plans, no analysis of intent is necessary when the proposed change theoretically applies to all plan participants. It is simply not prohibited conduct, no matter how invidious. As this Note has shown, the case law and legislative history certainly do not demand this harsh result. Employees who rely on a plan, file a claim, and are then subject to a post-claim modification, have no realistic expectation of securing new health insurance and must bear the cost of the illness. In many cases, individuals will deplete their assets until they are eligible for Medicaid or other public assistance.

Because courts interpret ERISA so narrowly, ignoring its sister statute, section 8(a)(3) of the National Labor Relations Act,¹⁴⁵ ERISA needs fine tuning. Section 510 must be interpreted in the same manner as section 8(a)(3). While the courts conceivably have power to make these changes under the common law of ERISA, Congress should, in the absence of judicial action, amend ERISA to provide a structure for permitting post-claim modifications only when it is infeasible to "grandfather" in participants with a preexisting condition. Such modifications, unless the employer establishes that they are not retaliatory, should be pro rata across all illness categories. In the interim, Congress should also look at ERISA to eliminate any artificial incentives for self-insurance. Employers should become self-insured only when it is in the overall interest of the plan, not to avoid state insurance laws which prohibit cost-cap discrimination between categories of disease. Finally, both employers and employees would benefit substantially from a national health system that spreads these catastrophic losses, which individuals and all but the largest employers are unable to bear, over society as a whole.

145. 29 U.S.C. § 158(a)(3) (1988).

