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Matthew G. Vansuch

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**NOT JUST OLD WINE IN NEW BOTTLES: *KENTUCKY ASS'N OF HEALTH PLANS, INC. V. MILLER*<sup>1</sup> BOTTLES A NEW TEST FOR STATE REGULATION OF INSURANCE**

I. INTRODUCTION

The Supreme Court begrudgingly hears ERISA<sup>2</sup> cases.<sup>3</sup> Therefore, even without the two landmark cases decided during the 2002-03 term,<sup>4</sup> one should not be surprised that an ERISA case would be lost in the Supreme Court shuffle.<sup>5</sup> Alas, hidden behind the constitutional blockbusters lies an important case that represents a monumental point in ERISA history and insurance law: *Kentucky Association of Health Plans, Inc. v. Miller*.<sup>6</sup>

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1. Ky. Ass'n of Health Plans, Inc., v. Miller, 538 U.S. 329 (2003).

2. Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (2000) and in several sections of 26 U.S.C. (tax code)). The stated purpose for ERISA was to

protect . . . 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.

29 U.S.C. § 1001(b) (2000).

3. Tony Mauro, "Courtside" (July 14, 2003), available at <http://www.law.com/jsp/printerfriendly.jsp?c=LawArticle&t=PrinterFriendlyArticle&cid=1056139978950>. At his annual talk to the Fourth Circuit Court of Appeals, Chief Justice William Rehnquist described ERISA as "The Employee Retirement, etc. law," saying that "you get so used to these acronyms that you forget what they stand for." *Id.* As Mauro notes, the Chief Justice said that "[t]he thing that stands out about [ERISA cases] is that they're dreary," and the only reason they grant review to them was "duty, not choice." *Id.*

4. Grutter v. Bollinger, 539 U.S. 306 (2003) (diversity in higher education is a compelling state interest); Lawrence v. Texas, 539 U.S. 558 (2003) (Texas law criminalizing consensual adult sexual activity unconstitutional without any state interest).

5. Between the 2001 and 2002 terms, the Supreme Court heard four cases involving benefits questions, and all four involved ERISA. Karen Lee, *Supreme Court's ERISA Decisions Could Increase Health Plan Costs*, EMPLOYEE BENEFIT NEWS, Sept. 15, 2003, available at <http://www.benefitnews.com> (noting this is remarkable considering how few lawsuits reach the Supreme Court). Three of those decisions went against health plan providers. *Id.*

6. 538 U.S. 329 (2003). Chief Justice Rehnquist called *Miller* one of the term's "Cinderella" cases, meaning those cases that are "left behind to clean the stove while the constitutional cases go to the ball." Mauro, *supra* note 3.

The Employee Retirement Income Security Act of 1974 (ERISA)<sup>7</sup> was Congress' response to instability in the private pension fund field.<sup>8</sup> Much of its legislative history revolved around reforming the private pension industry,<sup>9</sup> and not employee benefit plans for non-pensioners.<sup>10</sup> A complex and poorly worded clause<sup>11</sup> preempts all state laws that "relate to" employee benefit plans<sup>12</sup> but "saves" those state laws that regulate insurance.<sup>13</sup> When managed care organizations began providing

7. See *supra* note 2.

8. See Lee R. Russ & Thomas F. Segalla, 1 COUCH ON INSURANCE 3d, § 7:9 (2003) [hereinafter COUCH] (outlining the specific congressional findings that prompted ERISA's enactment); Health, Educ., and Human Servs. Div., U.S. Gen. Accounting Office, Employer-Based Health Plans: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA 30 (GAO/HEHS-95-167 1995) [hereinafter ISSUES, TRENDS, AND CHALLENGES] (providing a short background on lost retirement benefits and pre-ERISA pension legislation).

9. See Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 972 (2000) (noting, in extensive detail throughout the article, that the legislative history included a comprehensive investigation of the consumer abuses in the private pension industry that formed the impetus for ERISA's enactment); 1 COUCH, *supra* note 8, § 7:15 (stating that "disclosure of information as a primary means of protecting employee benefits seems better suited to pensions . . . than health or disability insurance").

10. Bogan, *supra* note 9, at 103 (noting that ERISA "does not provide a complete and coordinated network of rules to govern nonpension employee benefits"). See generally 1 COUCH, *supra* note 8, § 7:15 (presenting general criticisms of ERISA and explaining the difference between pension and welfare benefits).

11. See *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 740 (1985) ("Fully aware of this statutory complexity . . ."). The Supreme Court noted that "[t]he two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting." *Id.* at 739. Simultaneously, the Court has referred to ERISA as a "comprehensive and reticulated statute." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510 (1981) (citing *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980)). But see Bogan, *supra* note 9, at 973-77 (arguing that ERISA is not comprehensive in regards to benefit plans by illustrating the comprehensive regulation of pension funds and, in comparison, minimal requirements for benefit plans).

12. 29 U.S.C. § 1144 (a) (2000) (preemption provision). Section 514(a) of ERISA, 29 U.S.C. § 1144(a) reads:

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

*Id.*

13. 29 U.S.C. § 1144(b)(2)(A) (2000) (savings clause). Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A) reads: "Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." *Id.* There is still a debate whether Congress purposely omitted substantial regulation of non-pension benefit plans. Compare Bogan, *supra* note 9, at 977 (arguing that Congress did not intend to regulate non-pension benefit plans) with *ERISA, The Foundation of Employee Health Coverage: Hearing Before the Subcomm. on Employer-Employee Relations of the House Comm. on Educ. and the Workforce*, 107th Cong. 73-74 (2001) [hereinafter *ERISA Hearing*] (statement of James A. Klein, American Benefits Council):

This [preemption of state laws relating to an employee benefit plan] was not an

services to ERISA-covered plans, states were not able to regulate them as they had done with traditional health care providers.<sup>14</sup> In its place, the public turned to the judiciary, and sometimes the state legislatures, for protection.<sup>15</sup> While state courts have expanded remedies for aggrieved insureds, the Supreme Court has consistently rejected the expansion of ERISA's statutory remedies to include state common law causes of action in tort and contract against insurance-like benefit providers.<sup>16</sup>

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inadvertent outcome . . . . In crafting [the] preemption provisions, Congress made a very conscious choice by opting for a uniform Federal framework for employer-sponsored health plans rather than regulation by fifty different states . . . . [T]he fact that ERISA imposes more detailed standards on pension plans than it does on health plans is evidence of where Congress perceived the more urgent concerns to be at the time of its enactment, not evidence—as many wrongly assume—that ERISA was not intended to fully apply to the health benefit plans sponsored by employers.

14. See, e.g., Katie Cook Morgan, *Leaving the Management of "Managed Care" Up to the States: The Health Insurance Industry and the Need for Regulation of the Regulators*, 65 U. CIN. L. REV. 225, 248-54 (1996) (arguing for a federal insurance commission to create rules and monitor the states' regulation of the insurance industry). Morgan contends that the current system of state insurance regulation, which uses state statutes on unfair insurance trade practice and state departments of insurance, leaves much uncovered and unexamined. *Id.* at 235.

15. Morgan, *supra* note 14, at 245-48 (discussing the advantages and disadvantages of administrative regulation and indirect judicial regulation). Bad faith laws are one way that the courts have protected the rights of insureds by allowing damages beyond the insured interest. 1 ERIC MILLS HOLMES & MARK S. RHODES, *HOLMES' APPLEMAN ON INSURANCE*, § 8.8 (2d. 1996) [hereinafter *APPLEMAN*]. Some state legislatures have enacted bad faith statutes that allow aggrieved insureds to sue their insurer for the pain and suffering caused by an insurer's bad faith denial of benefits. *E.g.*, ALA. CODE § 27-12-24 (2004); ALASKA STAT. § 21.36.125 (2004); ARIZ. REV. STAT. ANN. § 20-461 (2004); ARK. STAT. ANN. § 23-66-206 (2004); CAL. INS. CODE § 790.03(h) (2004); COLO. REV. STAT. § 10-3-1104(h) (2004); CONN. GEN. STAT. § 38a-816(6) (2004); DEL. CODE ANN. tit. 18, § 2304(16) (2004); FLA. STAT. § 626.9541(1)(i) (2004); IDAHO CODE § 41-1329 (2004); IND. CODE § 27-4-14.5 (2004); IOWA CODE § 507B.4(9) (2004); KAN. STAT. ANN. § 40-2404(9) (2004); MASS. GEN. LAWS ANN. ch. 176D, § 3(9) (2004); MICH. COMP. LAWS ANN. § 500.2006 (2004); MINN. STAT. § 72A.20 (2004); MO. REV. STAT. § 375.936(10) (2004); MONT. CODE ANN. § 33-18-201 (2004); NEB. REV. STAT. § 44-1525(9) (2004); NEV. REV. STAT. § 686A.310 (2004); N.H. REV. STAT. ANN. § 417:4 (2003); N.J. REV. STAT. ANN. § 17:29B.4(9) (2004); N.M. STAT. ANN. § 59a-16-20 (2003); N.Y. INS. LAW § 2601 (2003); N.C. GEN. STAT. § 58-63-15 (11) (2004); N.D. CENT. CODE § 26.1-04-03(9) (2004); OR. REV. STAT. § 746.230 (2001); PA. STAT. ANN. tit. 40, § 1171.5(a)(10) (2004); TENN. CODE ANN. § 56-8-104(8) (2003); TEX. INS. CODE ANN. § 21.21-2 (2004); VT. STAT. ANN. tit. 8, § 4724(9) (2003); VA. CODE ANN. § 38.2-510 (2003); W. VA. CODE § 33-11-4(9) (2003). At the same time, the federal judiciary has held some of these statutes preempted by ERISA. *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138 (9th Cir. 2003) (holding a bad faith claim under Montana's Unfair Trade Practices Act completely preempted). Congressional action may be the only way to permit such claims against benefit plans. Robert L. Aldisert, Note, *Blind Faith Conquers Bad Faith: Only Congress Can Save Us after Pilot Life Insurance Co. v. Dedeaux*, 21 LOY. L.A. L. REV. 1343, 1383-96 (1988).

16. *Aetna Health Inc. v. Davila*, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004) (holding that state statutory cause of action against a health maintenance organization was properly removed to federal court under the complete preemption doctrine); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding that Mississippi's common law of bad faith does not regulate insurance for the purposes of the savings clause analysis). See also JOEL L. MICHAELS, "ERISA Preemption of State Law

For nearly two decades, the “regulating insurance” aspect of the savings clause was as confusing and convoluted as trying to distinguish between the casks of unlabeled barrels of old wine that all smelled horribly similar.<sup>17</sup> *Miller* clarified the savings clause analysis by establishing a broad, two-step test for determining if a state law regulates insurance.<sup>18</sup> However, the district courts have been sluggish in recognizing the differences between the tests.<sup>19</sup> The Supreme Court did

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Claims,” 2 HEALTH L. PRAC. GUIDE § 23:21.1 (2003) (“when an employee benefit plan not only provides indemnity ‘benefits,’ but arranges for healthcare services in order to secure those benefits, a claim that the plan acted negligently in it or its agents’ arranging for such services may not fall under ERISA’s enforcement provisions and therefore may be subject to adjudication in state court”). *But see* 1 COUCH, *supra* note 8, § 7:15 (stating that critics view judicial decisions that restrict the remedy for an employer’s or insurer’s breach of ERISA duties as one of the reasons that insurers lack an incentive to behave reasonably and insureds have a reduced ability to enforce their ERISA rights).

The Court refuses to find remedies not found within the wording of the statute. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985) (refusing to imply a private right of action for extra-contractual damages under ERISA § 1109(a) when neither the Act nor the legislative history demonstrated a congressional intent to create a private right of action). Congress intended the federal courts to develop some body of federal common law regarding ERISA, since Congress could not take account of every conceivable activity under an ERISA plan. 1 COUCH, *supra* note 8, § 7:11 (noting that ERISA is a product of legal principles developed in several other fields of law, especially trusts and contracts). However, the federal courts have not looked to state law principles to develop this federal common law, especially as to ERISA remedies. *Id. See, e.g.,* Joshua A.T. Fairfield, Comment, *ERISA Preemption and the Case for a Federal Common Law of Agency Governing Employer-Administrators*, 68 U. CHI. L. REV. 223, 234-52 (2001) (arguing that the federal courts should adopt a common law of agency that conducts a fact-sensitive analysis of the relationship between the employee, employer, and the insurer).

17. *Miller*, 538 U.S. at 340-41 (recognizing confusion in it and the lower courts as a result of its prior decisions, and establishing a new two-part test for a state law regulating insurance). As noted in text § II(A)(2)(c), the Supreme Court previously used “common sense” as the baseline for the saving clause test, with the McCarran-Ferguson factors serving as “guideposts.” *See id.* at 341. *See* text § III(B) and notes 127-36 for the new test. *E.g.,* Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457, 531 (2003) (“As if trying to stuff a square peg into a round hole, a generation of federal judges, including Supreme Court justices, clumsily attempted to resolve savings clause cases using questions that were linguistically inappropriate and confusing”).

18. *Miller*, 538 U.S. at 341. *See* Korobkin, *supra* note 17, at 531 (commenting that the new test is simpler and more appropriate than the business-rooted McCarran-Ferguson factors); *but see* Jason S. Mazer, *Pilot Life Pushed ERISA’s Preemption Pendulum to the Top of Its Arc, but Didn’t Suspend the Law of Gravity*, 78 FLA. BAR J. 10, 14 (Jan. 2004) (suggesting that the Court created more questions than answers in *Miller*).

19. When bad faith claims were at issue, the district courts refused to analyze those laws under the new test. Mazer, *supra* note 18, at 14 (noting the reluctance of the courts to re-analyze these claims under *Miller*). *See, e.g.,* *Dolce v. Hercules Inc. Ins. Plan*, No. 03-CV-1747, 2003 WL 22992148, 2003 U.S. Dist. LEXIS 23890, (E.D. Pa. Dec. 15, 2003); *Ercole v. Conectiv*, No. 03-186 GMS, 2003 WL 21104926, 2003 U.S. Dist. LEXIS 8115, (D. Del. May 15, 2003); *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F. Supp. 2d 296, (E.D. Pa. 2003); *Revells v. Metropolitan Life Ins. Co.*, 261 F. Supp. 2d 1359, 1366 (M.D. AL 2003) (“the law in this circuit is well established that Alabama’s bad faith tort does not regulate insurance and is not saved from preemption. . . . [w]e

not even cite to or rely on *Miller* when it struck down Texas' patient rights statute on the basis of ERISA preemption in *Aetna Health Inc. v. Davila*.<sup>20</sup> Nonetheless, *Miller* is a new blend of wine fermented from a different batch of grapes than those used in the bottling of the casks of old, unlabeled wine barrels that confused everyone, including the Supreme Court.<sup>21</sup> Its two-part test is a "clean break,"<sup>22</sup> and not merely the old McCarran-Ferguson grapes recycled into *Miller*'s vintage.

This Note examines the new test for whether state laws regulate insurance for ERISA purposes and how the Supreme Court's jurisprudential philosophy toward the savings clause has changed. Part II examines ERISA preemption and its impact on the health care industry.<sup>23</sup> Part III presents the appellate and Supreme Court decisions.<sup>24</sup> Part IV analyzes how *Miller* changed the analytical framework for the savings clause.<sup>25</sup> Finally, Part V concludes that *Miller* is not just the old wine test for the regulation of insurance repackaged in new bottles.<sup>26</sup>

## II. BACKGROUND

### A. Federal Preemption of State Law

In *Gibbons v. Ogden*,<sup>27</sup> the Supreme Court held that the Supremacy

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have held on more than one occasion, in precedent binding on this Circuit that the saving clause does not apply to this tort."'). After *Davila*, it would appear that the question of whether ERISA preempts state bad faith claims has become moot. *Davila*, *supra* note 16, 124 S. Ct. at 2495.

20. *Davila*, 124 S. Ct. at 2500 (relying on the reasoning in *Pilot Life* for the proposition that such state causes of action obstruct Congress' objective and purpose in providing a uniform system of providing benefits). Thomas R. McLean & Edward P. Richards, *The 'Aetna Health' Ruling*, NAT'L L.J., Aug. 8, 2004 at 12 (noting that "[c]onspicuously absent from the discussion in *Aetna Health* is any reference to" *Miller*). Two commentators have suggested that since Kentucky's Any Willing Provider statute did not provide a private cause of action, the *Miller* Court did not need to address the issue that was later ultimately decided in *Davila*. Robert T. Horst & Mark H. Rosenberg, *Does Miller Change the Result? Preemption of Bad Faith Claims by ERISA*, FOR THE DEFENSE, May 2004, at 40-41.

21. *Miller*, 538 U.S. at 341 (noting that the "use of McCarran-Ferguson case law in the ERISA context had misdirected attention, failed to provide clear guidance to lower federal courts, and . . . added little to the relevant analysis").

22. *Id.*

23. See text § II and notes 27-105.

24. See text § III and notes 106-49.

25. See text § IV and notes 150-245.

26. See text § V.

27. *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1 (1824) (declaring the State of New York's navigable waters statute granting exclusive privileges to steamship travel in New York waters for thirty years was repugnant to the Constitution and therefore void).

Clause in the United States Constitution<sup>28</sup> nullifies state laws that “interfere with, or are contrary to, the laws of Congress.”<sup>29</sup> When faced with a preemption issue, the courts begin “with the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless that [is] the clear and manifest purpose of Congress.”<sup>30</sup>

### 1. Regulation of Insurance

Between 1869 and 1944, the states were the sole regulators of the insurance industry.<sup>31</sup> With the McCarran-Ferguson Act,<sup>32</sup> Congress

28. Article VI, § 2 states:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. CONST. art VI, § 2.

29. *Gibbons*, 22 U.S. at 211. Chief Justice Marshall then stated, “In every such case, the act of Congress or the treaty is supreme; and the law of the State, though enacted in the exercise of powers not controverted, must yield to it.” *Id.*

30. Bogan, *supra* note 9, at 961 (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (finding that the historic police powers of the state will not be deemed superseded by Federal law unless that was the clear and manifest purpose of Congress)).

31. In 1869, the Supreme Court held that “issuing a policy of insurance is not a transaction of commerce.” *Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183 (1869), *overruled by U.S. v. South-Eastern Underwriters Ass’n*, 322 U.S. 533 (1944), *reh’g denied*, 323 U.S. 811 (1944). The Court overturned *Paul* in 1944, holding that Congress could regulate insurance transactions under the Commerce Clause. *South-Eastern Underwriters*, 322 U.S. at 552-53. This meant that the federal antitrust act – the Sherman Act – applied to the insurance industry. *Id.* While the industry may have wanted federal regulation in 1869, it feared such action in 1944. ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW § 21[a] (3d ed. 2002); Charles D. Weller, *The McCarran-Ferguson Act’s Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L.J. 587, 591-92 (1978) (noting the fear of federal takeover, including that of Justice Jackson in his dissent to *South-Eastern Underwriters Ass’n*); Spencer L. Kimball & Ronald N. Boyce, *The Adequacy of State Insurance Rate Regulation: The McCarran-Ferguson Act in Historical Perspective*, 56 MICH. L. REV. 545, 554 (1958) (noting that some in the industry thought the end of the world was about to come); Note, *Applications of Federal Antitrust Laws to the Insurance Industry*, 46 MINN. L. REV. 1088, 1089 (1961-62) (highlighting the industry’s cry to Congress that the natural result of increased competition would be many insolvent companies); Linda M. Lent, *McCarran-Ferguson in Perspective*, 48 INS. COUNSEL J. 411, 412 (1981). To limit the impact of *South-Eastern Underwriters Ass’n*, the industry focused its attention on legislation most favorable to it, which later became the McCarran-Ferguson Act. JERRY, *supra*, § 21[a]. Congress initially rejected a complete exemption from the antitrust acts for the industry, but eventually adopted legislation drafted and proposed by the National Association of Insurance Commissioners (NAIC). Weller, *supra*, at 593-97, 599 (providing the legislative history of McCarran-Ferguson and noting that Congress adopted “almost verbatim” a couple of sections from the NAIC’s proposed bill).

32. McCarran-Ferguson Act of 1945, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (2000)).

exerted federal authority to regulate the industry while simultaneously announcing that it favored state regulation.<sup>33</sup> The purpose was “to throw the whole weight of [Congress’] power behind the state systems.”<sup>34</sup> It made “the business of insurance, and every person engaged therein” subject to state laws that “relate to the regulation or taxation of such business,”<sup>35</sup> but a federal law that seeks to “invalidate, impair, or supersede” a state law “enacted . . . for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business” may preempt the state law if the federal law is “specifically relate[d] to the business of insurance.”<sup>36</sup>

McCarran-Ferguson failed to define a critical phrase: “business of insurance.”<sup>37</sup> Eventually, the Supreme Court established a three-prong test to determine whether an insurer’s activity constituted the “business of insurance”: “first, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.”<sup>38</sup>

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33. Section 1 of McCarran-Ferguson stated “that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.” McCarran-Ferguson Act § 1, 15 U.S.C. § 1011 (2000).

34. Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 429-30 (1946). See Weller, *supra* note 31, at 598-99 (noting that Congress and the NAIC shared the same purposes). NAIC considered the preservation of state insurance commissioners’ powers of regulation and taxation as its highest priority and greatest success. *Id.*

35. McCarran-Ferguson Act § 2(a), 15 U.S.C. § 1012(a) (2000) (“State regulation”).

36. McCarran-Ferguson Act, § 2(b), 15 U.S.C. § 1012(b) (2000) (“Federal regulation”). This subsection also states that “to the extent that such business is not regulated by State law,” the Sherman Act of 1890, the Clayton Act of 1914, and the Federal Trade Commission Act of 1914 would “be applicable to the business of insurance.” *Id.*; JERRY, *supra* note 31, § 21[b]. McCarran-Ferguson permits state and federal laws that both regulate the business of insurance to exist side-by-side if the federal law is not construed as invalidating, impairing, or superseding a state law or if the purpose of the state law is not to regulate the business of insurance. JERRY, *supra*, § 21[d].

37. JERRY, *supra* note 31, § 21[d][1] (noting that this omission lead to an uneasy accommodation between state and federal authority in this area). The exemption was initially interpreted expansively by the lower courts, only to be narrowed by the Supreme Court in subsequent cases. Eric Peter Gillett, Comment, *The Business of Insurance: Exemption, Exemption, Who Has the Antitrust Exemption*, 17 PAC. L.J. 261, 281-82 (1985-86).

38. Metropolitan Life Ins. Co. v. Mass., 471 U.S. 724, 743 (1985) (citing Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982) (establishing the use of the three McCarran-Ferguson factors in ERISA savings clause analysis)). These factors were only guideposts, and a state law did not have to satisfy all three criteria to survive preemption. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 373 (2002) (citing UNUM Life Ins. Co. v. Ward, 526 U.S. 358, 373 (1999)). For a discussion of what the Court meant by risk-spreading, see Robert P. Rothman, Note, *The Definition of “Business of Insurance” Under the McCarran-Ferguson Act After Royal Drug*, 80 COLUM. L.



## 2. Employee Benefit Plans

In the domain of employee benefit plans, ERISA can preempt a state law in either of two ways: by completely preempting the state law cause of action or by superseding the state law if the two conflict.<sup>39</sup>

### a. Complete Preemption – ERISA § 502(a)

The Court may find that a statute has extraordinary preemptive force, one that “converts an ordinary state common-law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.”<sup>40</sup> Essentially, the only area of law that remains is federal, as “any claim purportedly based on that pre-empted state law is considered, from its inception, a federal claim, and therefore arises under federal law.”<sup>41</sup> ERISA happens to be one of two laws<sup>42</sup> in which the Supreme Court has

REV. 1475 (1980).

39. See S. Candice Hoke, *Preemption Pathologies and Civic Republican Values*, 71 B.U.L. REV. 687, 747 (1991), who notes that some courts see complete preemption as a species of field preemption, which she views as incorrect. She says that the complete preemption doctrine has not been viewed as a necessary incident of all field preemption. *Id.* She also notes that field preemption—federal occupation of a field of regulation—arises in two ways: (1) by express congressional enactment or administrative regulation, or (2) by judicial implication from a legislative scheme. *Id.* at 738. See also ALI-ABA Conference on Life and Health Insurance Litigation, SH084 *Update on ERISA Litigation Developments* 148, (May 1-2, 2003) (Elizabeth J. Bondurant, Andrea K. Cataland, and Ronald Dean, authors) (explaining complete and conflict preemption in terms of ERISA).

40. *Caterpillar Inc. v. Williams*, 482 U.S. 386, 393 (1987) (citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987) (holding that Congress intended ERISA § 502(a)(1)(B) to completely preempt any civil complaint raising state law causes of action)) (noting that the complete preemption doctrine is an independent corollary to the well-pleaded complaint rule). See David L. Trueman, “The Well Pleased Complaint Rule and Complete Preemption,” HEALTH LAW HANDBOOK § 2:4 (Alice G. Gosfield ed., 2003) (discussing the basis for this exception to the “well pleaded complaint rule”).

41. *Caterpillar*, 482 U.S. at 393. This is a “jurisdictional doctrine whose predicate is a judicial determination that the ‘preemptive force’ of a particular federal regulatory law is ‘so powerful as to displace entirely any state cause of action.’” Hoke, *supra* note 39, at 747 (citing *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 23 (1983) (holding that even if ERISA precluded enforcement of the appellant’s state-law claims, ERISA created no counterpart to appellant’s state-law claims and thus had not pre-empted the causes of action)). If a state law claim is completely preempted, then it “arises under” federal law and meets federal question jurisdiction. *Id.*

42. Hoke, *supra* note 39, at 747. The Labor Management Relations Act, specifically § 301 (29 U.S.C. § 185 (1988)), preempts state law claims whose resolution depends on interpretation of a collective bargaining agreement. *Id.* In *Caterpillar*, 482 U.S. at 393 n.8 (citing *Oneida Indian Nation v. County of Oneida*, 414 U.S. 661, 675 (1974) (noting the unique position of the Native American petitioner in relation to the federal government and recognizing, in this situation, the petitioner’s state law tort claim arose under federal law)), the Court noted that a state law tort claim for right to possession of Indian tribal lands “arises under” federal law. *Id.*

applied complete preemption.<sup>43</sup>

In the context of ERISA, complete preemption arises from the statute's civil enforcement provision, section 502(a).<sup>44</sup> This section provides limited, but exclusive, remedies<sup>45</sup> that allow plan participants or beneficiaries to recover a denied benefit, to enforce rights under the terms of the plan, or to clarify rights to future benefits under the terms of the plan<sup>46</sup> by suing the health plan, a plan administrator, or other fiduciary.<sup>47</sup> A "catch-all"<sup>48</sup> provision permits a participant, beneficiary,

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43. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (holding that the complete preemption of certain state law claims by ERISA § 502(a)(1)(B) satisfies federal question jurisdiction).

44. ERISA § 502(a) is codified as 29 U.S.C. § 1132(a) (2000). *See generally* Barbara Quackenbos, *ERISA Litigation: Some Common Issues*, in *HEALTH CARE LITIGATION: WHAT YOU NEED TO KNOW AFTER PEGRAM 205-19* (Karen S. Boxer et al. eds, 2000).

45. *See* Karl W. Pilger, *Commentary, Title 29, Chapter 18, § 1144 Other Laws*, 2003 NAT'L INST. FOR TRIAL ADVOCACY (noting that this provision, in connection with section 514(a), supplants state law causes of action for wrongful denial of benefits, and claims regarding benefits based upon breach of contract, negligence, bad faith, misrepresentation, estoppel, tortious interference with contract, fraud, breach of fiduciary duty, defamation, emotional distress and wrongful death from denial of medical care). *But see* STEPHEN S. ASHLEY, *BAD FAITH ACTIONS: LIABILITY AND DAMAGES* § 9:17 (2d ed. 1998, Oct. 2003 update), § 9:19 (arguing that the comprehensive civil enforcement scheme should not encompass state laws which regulate insurance, including a judicially recognized cause of action for bad faith, specifically directed to the insurance industry). *See generally* Charles J. Steele & Jacqueline M. Saue, "ERISA Remedies," 2 *HEALTH L. PRAC. GUIDE* § 14:18 (2003); ASHLEY, *supra* § 9:17 (arguing that Congress did not intend uniformity for insurance companies providing policies to employee welfare benefit plans). ERISA was supposed to be a scheme by which plan administrators would be subject to a uniform body of rules regulating their conduct, as implemented by the preemption clause, with the savings clause preserving state regulation of insurance companies that provided policies to employee welfare benefit plans. ASHLEY, *supra* § 9:17. If Congress wanted to create uniformity across the board, there would have been no need for the savings clause. *Id.*

46. 29 U.S.C. § 1132(a)(1)(B) (2000). *See* ASHLEY, *supra* note 45, § 9:17 (describing this remedy as the employee's "breach of plan claim"). If a participant seeks to enforce personal rights, then this is the section that allows such a claim. 29 U.S.C. § 1132(a)(1)(A) (2000).

47. Quackenbos, *supra* note 44, at 207. Relief under this provision is different from relief for breach of fiduciary duty, *supra* note 39, or a statutory violation of ERISA. *Id.* Whether couched in an enforcement of a beneficial right to a trust or contractual obligation, the usual defendants are the health plan itself, the plan administrator, and possibly a claims administrator. *Id.* The employer-sponsor of the plan is not usually sued. *Id.* (citing *Gelardi v. Pertec Corp.*, 761 F.2d 1323, 1325 (9th Cir. 1985)). However, in *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997), and *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 234-35 (3d Cir. 1994), the courts allowed the person or entity that controls the plan administration to be sued. Quackenbos, *supra*, at 207-08. 29 U.S.C. § 1132(d) (2000) permits an employee benefit plan to sue and be sued. For various breaches of fiduciary duties, plan participants, beneficiaries, fiduciaries, and the Secretary of the Department of Labor may sue for relief to remedy that breach. 29 U.S.C. § 1132(a)(2) (2000). 29 U.S.C. § 1109 establishes that the individual who breaches a fiduciary duty is personally responsible:

to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of

fiduciary, or the Secretary of Labor to bring a civil action to obtain other legal or equitable relief if other remedies are unavailable.<sup>49</sup> While these remedies may adequately address the needs of pensioners, they are not particularly suited to the type of damages that a benefit plan participant will endure as a result of a denial of benefits.<sup>50</sup> The Court has been delicate in deciding whether state laws supplant or supplement this civil enforcement scheme.<sup>51</sup>

#### b. Conflict Preemption – ERISA § 514(a)

Federal law may preempt state regulation over a particular area even if Congress has not entirely displaced the matter.<sup>52</sup> This occurs when the state regulation conflicts with federal law, so that it “is impossible to comply with both state and federal law, or where the state law stands as an obstacle to the accomplishment of the full purposes and

assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

*Id.* This cause of action may be described as the “breach of trust claim.” *ASHLEY, supra* note 45, § 9:18.

48. Quackenbos, *supra* note 44, at 210. *See* *Varity Corp. v. Howe*, 516 U.S. 489 (1996) (noting that the structure of ERISA § 502 suggests that the “catch-all” provisions act as a safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy).

49. 29 U.S.C. § 1132(a)(3) (2000) provides for the following:

(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

*ASHLEY, supra* note 45, § 9:18 (admitting that use of this term suggests relief traditionally available in a court of equity). But “equitable” may also mean “fairly adapted to meet the needs of the particular case.” *Ashley* views this as the “equitable relief claim.” *Id.*

50. 1 *COUCH, supra* note 8, § 7:15 (“recovering amounts wrongfully denied by the plan administrator may ordinarily be adequate as to pension benefits, since denial of these benefits rarely causes the kind of significant consequential damages that may follow the denial of health care benefits”). “An initial denial of [health care] benefits can prevent access to needed medical care, leading to injuries or damages” that exceed the amount of the initial claim. *Id.*

51. *See* *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386-87 (2002) (holding that state-mandated independent review of and coverage for services deemed medically necessary by such a reviewer were part of the state’s regulatory scheme and did not provide a new cause of action under state law or enlarge a claim beyond benefits available through ERISA, and thereby fell within the saving clause). *See also* William M. Acker, Jr., *Can the Courts Rescue ERISA?*, 29 *CUMB. L. REV.* 285 (1998) (questioning whether Congress intended ERISA to have a broad remedial purpose, and arguing that regardless, the implementation of this remedial scheme is in shambles because Congress has abdicated a perceived societal problem to the courts).

52. *See* *Bogan, supra* note 9, at 961-62 n.43 (citing *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984) (noting that a state law is pre-empted to the extent it actually conflicts with federal law, that is, when it is impossible to comply with both state and federal law, or where the state law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress)).

objectives of Congress.”<sup>53</sup> Three subsections of ERISA section 514 provide the framework for federal preemption of state laws.<sup>54</sup> Section 514(a) says that ERISA “supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”<sup>55</sup> Even state laws consistent with its substantive requirements are preempted because this provision was intended to displace all state laws that fall within its sphere.<sup>56</sup> Congress wanted to eliminate the multiplicity of regulation that hampered the efficient administration of benefit plans and replace it with a uniform administrative scheme and standard procedures for claims processing and benefit disbursement.<sup>57</sup>

Interpreting this clause caused courts major headaches.<sup>58</sup> After

53. *Id.* (citations omitted).

54. *See generally* 1 COUCH, *supra* note 8, § 7:31 (describing the preemption framework). ERISA preemption is an affirmative defense that should be pleaded in the answer. *Id.* *See* Acker, *supra* note 51, at 287 (calling ERISA preemption “super-duper preemption”).

55. 29 U.S.C. 1144(a) (2000). *See generally* 1 COUCH, *supra* note 8, § 7:32 (discussing the preemption clause and its “relate[s] to” language). 29 U.S.C. § 1144(c) (2000) defines “State laws” and “States” for purposes of this clause as:

(1) The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term “State” includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

*Id.* Employee benefits, not “insurance,” are the focus of ERISA. 1 COUCH, *supra* note 8, § 7:14.

56. *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985) (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983) (establishing the “related to” or “connection with” analyses for the preemption clause)).

57. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (determining that ERISA expressly preempted a state statute that automatically revoked the designation of a spouse as the beneficiary of a nonprobate asset upon divorce, as applicable to ERISA plans because the statute directly conflicted with ERISA’s requirements that plans be administered, and benefits be paid, in accordance with plan documents); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Inc.*, 514 U.S. 645, 661-62 (1995) (holding that a state statute that required hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by other plans was not preempted by ERISA because the surcharges did not relate to an employee benefit plan). *But see Bogan*, *supra* note 9, at 997 (arguing that preemption is contrary to ERISA’s goals and objectives).

58. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523-24 (1981) (noting that the phrase “relates to” “gives rise to some confusion where. . . it is asserted to apply to a state law ostensibly regulating a matter quite different from pension plans”). *See also* *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 334-35 (1997), where, in concurrence, Justice Scalia illustrates the Court’s growing frustration with litigation over ERISA preemption:

Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeals regarding ERISA preemption of various sorts of state law. The rate of acceptance, moreover, has not diminished (we have taken two more ERISA pre-emption cases so far this Term),

several cases, the Court developed the basic identifiers of a state law that “relates to” a benefit plan, primarily focusing on how closely a state law must relate to a benefit plan to be preempted.<sup>59</sup> A law “relates to” a benefit plan “if it has a connection with or reference to such a plan.”<sup>60</sup> But the law’s effect on benefit plans may be “too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.”<sup>61</sup> A state law that “produce[s] such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers an indirect economic effect,” would be preempted.<sup>62</sup> These tests require a court to examine the terms of the law and the practical effect that the law will have on the operation of the plan.<sup>63</sup>

### c. Saving State Insurance Regulation Law from Preemption – ERISA § 514(b)(2)(A)

Consistent with McCarran-Ferguson’s preference for state regulation of insurance and the premise that insurance is not its focus,<sup>64</sup>

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suggesting that our prior decisions have not succeeded in bringing clarity to the law.

As he further noted, “applying the ‘relates to’ provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else.” *Id.* at 335. See Acker, *supra* note 51, at 300 (arguing that federal court jurisdiction to adjudicate routine, employee welfare benefit plan claims under ERISA should be abolished, except when federal statutory or regulatory requirements are at issue).

59. ISSUES, TRENDS, AND CHALLENGES, *supra* note 8, at 33.

60. *Shaw*, 463 U.S. at 96-97. The Court relied on Black’s Law Dictionary. *Id.* at 97 n.16 (citing BLACK’S LAW DICTIONARY 1158 (5th ed. 1979) (“Relate. To stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with”).

61. *Id.* at 100 n.21. In *Dillingham*, 519 U.S. at 325, the Court simplified its “relate to” philosophy: “[w]here a State’s law acts immediately and exclusively upon ERISA plans, as in *Mackey* [v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 828 n.2 (1988) (law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision)], or where the existence of ERISA plans is essential to the law’s operation, as in [D.C. v. Greater Washington Bd. of Trade, 506 U.S. 125, 129 (1992) (law “impos[ed] requirements by reference to [ERISA] covered programs”)] and *Ingersoll-Rand* [Co. v. McClendon, 498 U.S. 133, 140 (1990) (common-law cause of action premised on the existence of an ERISA plan)], that ‘reference’ will result in pre-emption.” *Id.* at 324-35.

62. *N.Y. State Conf.*, 514 U.S. at 668 (finding that hospital surcharges were not preempted). See generally 1 COUCH, *supra* note 8, § 7:33-34 (stating the types of state fair employment practice laws and state claims for emotional distress that “relate to” an ERISA benefit plan).

63. 1 COUCH, *supra* note 8, § 7:32 (discussing the development of the “relate[s] to” test and its application). If only a portion of a state statute is preempted, the unaffected portions of the statute remain. *Id.*

64. 1 COUCH, *supra* note 8, § 7:14 (noting that “ERISA’s admittedly significant impact on insurance is . . . primarily indirect,” resulting from the “ever-increasing proportion of the nation’s life, health, and similar insurance being provided on a group basis as part of the group insured’s employment benefits”).

ERISA “saves” state laws that regulate insurance from preemption.<sup>65</sup> “State law” has been broadly interpreted, in accordance with ERISA’s sweeping definition.<sup>66</sup>

Before *Miller*, the Court relied on a two-pronged test to determine whether a state law regulates insurance for ERISA purposes.<sup>67</sup> In *Metropolitan Life Insurance Co. v. Massachusetts*, the Court said that the state’s mandated benefits law “regulate[ed] the terms of certain insurance contracts” as a “common-sense view of the matter,” and therefore saved it from preemption.<sup>68</sup> The Court also borrowed the three factors from the McCarran-Ferguson “business of insurance” test.<sup>69</sup> After *Miller*, the Court released itself from the confines of the McCarran-Ferguson factors, loosening the tight grip on what is considered a state insurance regulation.<sup>70</sup>

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65. 29 U.S.C. § 1144(b)(2)(A) (2000). “Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” *Id.* For an in-depth analysis of the pre-*Miller* savings clause test, see Karen A. Jordan, *ERISA Pre-Emption: Integrating Fabe into the Savings Clause Analysis*, 27 RUTGERS L.J. 273 (1996) (arguing that a McCarran-Ferguson analysis should be integrated into the ERISA pre-emption analysis).

66. See 29 U.S.C. § 1144(c) (2000), *supra* note 55; see also 1 COUCH, *supra* note 8, § 7:36 (noting that, at the time, the broad definition was offset by the equally narrow interpretation given to what “regulates insurance”). Whether a state law that addresses insurance as a whole, or some portion of that business, is preempted depends on the specific activity that is addressed by the law, the specific type of insurance that is addressed, and the individual court’s view as to the meaning of the ERISA preemption framework. *Id.* at § 7:41 (noting that the state laws are too numerous and diverse to state a single rule on this issue). “Laws governing the traditional activities of insurers . . . are generally held not to be preempted when addressed to insurers as a class.” *Id.* Most recent court decisions have held that common-law breach of contract claims are preempted, *id.* at § 7:42, and so far as they are applied to a basic activity connected to an ERISA plan, state tort laws are generally preempted, *id.* at § 7:43 (noting that fraud, various types of negligence, wrongful cancellation, and outrageous conduct have been preempted). Bad faith, emotional distress, and punitive damages have all been held to be preempted by most of the courts that have heard these claims. *Id.* at § 7:44 (noting that these claims are preempted as they apply to activity connected to an ERISA plan).

67. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (establishing the use of the three McCarran-Ferguson factors in saving clause analysis); *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 740 (1985) (adopting the “common sense” prong). See 1 COUCH, *supra* note 8, § 7:36 (presenting an overview of the saving clause analysis).

68. *Metropolitan Life*, 471 U.S. at 740 (noting that they were “stat[ing] the obvious” about the law). See text § IV(c)(2) for an examination of *Metropolitan Life*’s analysis of the state law.

69. *Metropolitan Life*, 471 U.S. at 742-43 (“The case law concerning the meaning of the phrase “business of insurance” in the McCarran-Ferguson Act also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws “which regulate insurance” (citation omitted)). *But see* ASHLEY, *supra* note 45, § 9:17 (arguing that the “business of insurance” and the “regulates insurance” analyses are fundamentally different).

70. See 1 COUCH, *supra* note 8, § 7:36 for the observation that the broad definition of “state laws” was tempered by the equally narrow interpretation given to the requirement that the law be one which regulates insurance before the law was found to be preempted. *But* “Supreme Court’s

#### d. Protecting Self-Insured Employee Benefit Plans – ERISA § 514(b)(2)(B)

To further encourage employers to provide benefit plans to their employees, Congress limited the states' ability to regulate those benefit plans.<sup>71</sup> States would not be able to reach the plans by simply "deeming" them to be insurance companies and then exerting their insurance regulation power.<sup>72</sup> In *Metropolitan Life*, the Court distinguished between "insured and uninsured plans, leaving the former open to indirect regulation while the latter are not."<sup>73</sup> Employers responded quickly and established self-funded plans to cover their employees.<sup>74</sup>

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New Savings Clause Test Means More Indirect State Regulation of Self-Funded Plans," *Employer's Guide to Self-Insuring Health Benefits*, May 2003, available at <http://thompson.com/libraries/benefits/self/samplenews/self0305.html?template=:templates:printfriendly> (believing that instead of clarifying the definition of insurance saved from preemption and minimizing confusion, the Court has opened a Pandora's Box, resulting in endless litigation over what states may do under *Miller's* expansive ruling).

71. 29 U.S.C. § 1144(b)(2)(B) (2000) reads as follows:

(B) Neither an employee benefit plan described in [29 USCS § 1003(a)], which is not exempt under [29 USCS § 1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

*Id.*

72. *Id.* See 1 COUCH, *supra* note 8, § 7:35 (discussing self-funded plans). Even if a self-insured welfare benefit plan specifically stated that it would conform to all "applicable" state laws, the deemer clause prevents a state from considering these plans to be insurance. *Id.* See also JOEL L. MICHAELS, "Overview [State Regulation of TPA and UR Functions]," 2 HEALTH L. PRAC. GUIDE § 23:12 (2003) (discussing the advantages of managed care plans contracting with self-insured employers to provide many of the features of managed care, while permitting the employer to retain the advantages of self-insurance). *But see* Dennis K. Schaeffer, Comment, *Insuring the Protection of ERISA Plan Participants: ERISA Preemption and the Federal Government's Duty to Regulate Self-Insured Health Plans*, 47 BUFF. L. REV. 1085 (1999) (arguing that the federal government has a duty to compensate for the lack of any regulation of self-insured health plans through comprehensive and reasonable regulation of employee welfare benefit plans, a responsibility that ERISA has prevented the states from assuming).

73. *Metropolitan Life*, 471 U.S. at 747. While there is a split in judicial opinion, most courts hold that an employer's purchase of "stop-loss" insurance does not deprive an otherwise self-insured plan of its protection under the deemer clause. 1 COUCH, *supra* note 8, § 7:35 (noting that a minority of courts have found to the contrary).

74. See ISSUES, TRENDS, AND CHALLENGES, *supra* note 8, at 9-14 (estimating that in 1993, nearly half of plan participants (44 million) were enrolled in self-funded health plans, up from about one-quarter in 1968). Many self-insured employers purchase stop-loss or stop-gap insurance to cover extraordinary expenses above and beyond a particular level. *Id.* The circuits are split over whether states may regulate the stop-loss insurance that employers purchase for their self-insured plans. See Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of*

## B. The Fight for Quality Health Care

### 1. The Overlap between Contract and Tort

For plan participants and beneficiaries,<sup>75</sup> ERISA provides exclusive civil remedies.<sup>76</sup> The type of cause of action that seeks damages from a managed care company and/or its contracting medical groups and doctors determines a plaintiff's possibility of success.<sup>77</sup> Claims subject to ERISA preemption<sup>78</sup> are limited to an uphill battle with a contract claim,<sup>79</sup> where the remedies are limited to recovery of the benefits owed.<sup>80</sup> Federal law does not deter employers and plan administrators

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*Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 233 (1997) (arguing that ERISA should not be construed to preempt states from enforcing their insurance laws against a stop-loss plan's insurer).

75. 29 U.S.C. § 1002(7) (2000) (defining "participant" as an "employee or former employee of an employer. . . who is or may become eligible to receive a benefit"). A former employee with either a "reasonable expectation of returning to covered employment" or a "colorable claim to vested benefits" may be a participant. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). See also Andrew M. Campbell, Annotation, *Construction and Application of Employee Retirement Income Security Act of 1974 (29 U.S.C.A. §§ 1001 et seq.) by U.S. Supreme Court*, 150 A.L.R. Fed. 441 § 24 (1998). 29 U.S.C. § 1002(8) (2000) (defining "beneficiary" as a "person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder").

76. 29 U.S.C. § 1132(a) (2000). See text § II(A)(2)(a) and notes 40-51.

77. Sharon J. Arkin, *Tort Actions Against Health Maintenance Organizations and Their Doctors*, 23 WHITTIER L. REV. 609, 609-12 (2002) (highlighting the importance that the choice of legal theory has on a plaintiff participant).

78. See generally 1 COUCH, *supra* note 8, § 7:34 (describing the types of state-law claims for emotional distress that have been preempted because they "relate to" an ERISA benefit plan). When the act which allegedly gave rise to the emotional distress claim is itself related to the benefit plan in any significant respect, these claims have been preempted. *Id.* Claims related to denial or processing of claims, misrepresenting that expenses would be covered under the plan, reduction and termination of benefits under the ERISA plan, terminating employment in order to terminate benefits or in retaliation for having discovered ERISA violations, and improper refusal to convert a group policy to individual coverage have all been preempted. *Id.* See also Steele & Saue, *supra* note 45, § 14:18 (noting that some of ERISA's most important parts as applied to employee benefit plans are the preemption provisions).

79. Arkin, *supra* note 77, at 609-10 (presenting alternative avenues with which a plaintiff may seek to extract his or her case from the strict limitations of ERISA). She also notes that without these alternatives, a plaintiff's "claim is reduced to what is essentially a contract claim—with all the cards stacked against" him or her. *Id.* at 610.

80. *Id.* at 612 (noting that consequential damages, emotional distress damages, and punitive damages are not recoverable). No matter how egregious the provider's misconduct, the plan still will be subject only to ERISA's limited liabilities. *Id.* at 611-12. See also TERRY O. TOTTENHAM, "ERISA and HMO Liability," 1 HEALTH L. PRAC. GUIDE § 9:68 (2003) (discussing state medical malpractice claims against HMOs); Paula A. Nelson, Note, *Pilot Life Ins. Co. v. Dedeaux: The Supreme Court's Federalization of Employee Benefit Law*, 23 TORT & INS. L.J. 507 (1988) (*Pilot Life* stands for the proposition that no extra-contractual damages are available in a suit by a participant or beneficiary against an insurance carrier which processes claims or makes benefit



from denying claims in bad faith<sup>81</sup> because ERISA does not authorize any other legal or equitable relief<sup>82</sup> outside of recovery of the benefit due under the plan.<sup>83</sup> The difference between a tort claim and a contract claim also has significant ramifications for a plaintiff.<sup>84</sup> Recovering in contract law<sup>85</sup> instead of tort law<sup>86</sup> severely restricts a patient's potential and actual damages.<sup>87</sup> However, as more Americans are covered by

determinations).

81. Jayne Elizabeth Zanglein, *Closing the Gap: Safeguarding Participants' Rights by Expanding the Federal Common Law of ERISA*, 72 WASH. U. L.Q. 671, 671 (1994) (exploring the current boundaries of the federal common law of ERISA and urging the expansion of these boundaries to protect plan participants who have been betrayed without a remedy). See 1 COUCH, *supra* note 8, § 7:15 (mentioning the simultaneous reduction of an insurer's incentive to behave reasonably and a wronged insured's ability to enforce their ERISA rights).

82. 29 U.S.C. § 1132(a)(1)(B) (2000). "Congress attempted to preserve the states' traditional role as the primary regulators of insurance companies" when they enacted ERISA. See ASHLEY, *supra* note 45, § 9:17. The regulation of group health insurance claim settlement practices should have been kept safely outside the reach of the federal courts. *Id.* However, in *Pilot Life*, the "Supreme Court demonstrated the wisdom of Congress' allocation of authority by unanimously misinterpreting the very provision by which Congress had intended to save the states' power to define the insurer's role in adjusting claims." ASHLEY, *supra*, § 9:17.

83. Zanglein, *supra* note 81, at 671 (noting that insurance companies have little incentive under current state or federal law to pay, in good faith, disputed medical or pension benefit claims). Those claims preempted by ERISA because they "relate to" an employee benefit plan are: state law improper denial of a claim, state law misrepresentation, breach of contract, negligence, emotional distress, outrageous and fraudulent denial of coverage, unfair insurance practices, tortious interference, and bad faith. *Id.* at 671-72. Such preemption would be logical if ERISA provided a remedy sufficient to deter bad faith claims denial and fraudulent misrepresentation. *Id.* at 671. But see ASHLEY, *supra* note 45, § 9:17 (noting that while ERISA does not provide plaintiffs the generous relief available to them under the common law of bad faith, it does provide some possibilities for recovering damages beyond mere policy proceeds, including damages not available in common law bad faith cases).

84. See PETER D. JACOBSON, *STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA*, Oxford University Press, 108-114 (2002) (describing the differences between tort and contract claims, and the resulting impact on health care claims).

85. *Id.* at 105. The most likely remedy for a breach of contract involves awarding damages to compensate an injured party for a loss (legal relief), but a court may require specific performance of the contract (equitable relief), which in a health care context, means that a plan would be required to provide a benefit that was denied. *Id.* at 107. Punitive damages, which are designed to punish the offending party and to deter similar conduct in the future, and exemplary damages, which are reserved for cases where the defendant's conduct is tantamount to fraud, malice, or oppression, are available for breach of contract in a small number of jurisdictions. *Id.*

86. *Id.* at 103. State courts usually resolve litigation between patients and physicians or hospitals over medical injuries. *Id.* Under agency and vicarious liability principles, an MCO may be indirectly liable for malpractice committed by independent contractor physicians. *Id.* Utilization-review arrangements that allow an MCO to override a physician's clinical judgment are good indicia of whether an MCO has sufficient control over the physician. *Id.* at 104. The question is whether and how courts will apply these principles to the ever-morphing managed care organizational forms and cost-containment innovations, both within and outside of the ERISA context. *Id.* at 103.

87. *Id.* at 98. Contract damage awards tend to be more limited, as pain and suffering are more

ERISA plans,<sup>88</sup> which are immune from state laws that relate to these benefit plans,<sup>89</sup> the chances that a patient will be able to recover in tort are less likely.<sup>90</sup> Percolating behind much of this debate is the fight for patients' rights.<sup>91</sup>

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difficult to get than in a negligence action. *Id.* Unequal bargaining power between plan and patient and the contract language may result in a more difficult challenge of delayed or denied health care under a contract theory because the plan contract may eliminate the possibility of individual challenges. *Id.*

88. In 1995, the General Accounting Office estimated that 114 million individuals, or 44 percent of the US population, were covered by an ERISA health plan. ISSUES, TRENDS, AND CHALLENGES, *supra* note 8, at 2. In 2001, an estimated 129 million Americans receive health insurance through their employer. *ERISA Hearing*, *supra* note 13, at 2 (Rep. Sam Johnson, Member, House Subcomm. on Employer-Employee Relations). Over eighty percent of U.S. workers are covered by ERISA. *Id.*

89. See text § II(A)(2)(b) and notes 52-63. See also 29 U.S.C. § 1144 (2000).

90. JACOBSON, *supra* note 84, at 98. The hybrid nature of managed care requires a new governing approach as the current legal rules were designed to respond to a system with separate financing and care-giving functions. *Id.* at 99. When contracts dominate the legal rules, large institutions, such as MCOs, wield their superior bargaining power during the contract-writing process to create favorable situations for them. *Id.* This market-based contract approach fails to protect patients when MCOs can avoid responsibility for adverse medical outcomes. *Id.* To that extent, government oversight and the regulatory functions of the tort system serve as deterrents and potential correctives to the market's excesses. *Id.* at 98-99.

91. See Matthew J. Binette, Comment, *Patients' Bill of Rights: Legislative Cure-All or Prescription for Disaster?*, 81 N.C. L. REV. 653, 657-58 (2003) (concluding that Congressional action is necessary to alleviate the confusion caused by overlapping state and federal judicial action on the issue of ERISA preemption and managed care liability, but that Congress should take a moderate approach); Sylvia A. Law, *Do We Still Need a Federal Patients' Bill of Rights?*, 3 YALE J. HEALTH POL'Y, L. & ETHICS 1 (2002) (despite the leeway for state remedies following *Pegram* and *Moran*, a federal patients' bill of rights is necessary); Ann H. Nevers, *ERISA Right to Sue: An Rx for Health Care that Places Forum over Substantive Consumer Rights*, 31 N.M. L. REV. 493, 493 (2001) (real reform lies in protecting substantive consumer rights through a variety of forums and providing for adequate redress for harm in whichever forum relief is sought); Eric M. Eusanio, Comment, *Control, Quality, and Cost: The Need for Federal Legislation Amending ERISA's Failure to Protect Consumers from Liability-Free MCOs*, 7 J.L. & POL'Y 627 (1999) (arguing for federal legislation to cure the defects in the private sector employer-provided health care market); Deborah S. Davidson, Note, *Balancing the Interests of State Health Care Reform and Uniform Employee Benefit Laws Under ERISA: A "Uniform Patient Protection Act,"* 53 WASH. U. J. URB. & CONTEMP. L. 203, 206 (1998) (proposes a Uniform Patient Protection Act and an amendment to ERISA that brings self-insured plans within the Uniform Act's provisions). *But see, e.g.*, Edward A. Zelinsky, *Against a Federal Patients' Bill of Rights*, 21 YALE L. & POL'Y REV. 443 (2003) (finding no justification for a Patients' Bill of Rights, which is just a response to a nonexistent problem, because ERISA did not create a regulatory gap); Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. CONTEMP. HEALTH L. & POL'Y 1 (1998) (distinguishing between patient rights and consumer rights and suggesting that managed care plans be viewed as a hybrid incorporating elements of standard form insurance contracts and elements of professional service agreements for personal medical care traditionally governed by tort standards).

## 2. “Any Willing Provider” Laws

An HMO arrangement turns the traditional fee-for-service upside-down.<sup>92</sup> Instead of the patient directly paying the independent health care provider, under an HMO arrangement, the patient pays a prearranged fixed fee to the HMO.<sup>93</sup> In return, the HMO bears the responsibility for arranging the care provided for the patient and paying for those services.<sup>94</sup> One way that health care providers have devised to control health care costs is “selective contracting,” where the MCO selects a limited number of a health care providers to provide services to the MCO’s membership in return for a reduced cost to the MCO.<sup>95</sup> While theoretically reducing the costs of health care,<sup>96</sup> such methods have caused substantial consumer dissatisfaction and discussion over the perceived ills of managed care.<sup>97</sup>

One response to managed care restrictions is “any willing provider” law.<sup>98</sup> While there are variations among them, the basic AWP law allows health care providers (usually physicians but also pharmacies)

92. Diana Joseph Bearden and Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 287 (1995) (providing an overview of the various theories of liability that have been pursued against managed care organizations).

93. *Id.* at 291.

94. *Id.*

95. James W. Childs, Jr., Comment, *You May Be Willing, But Are You Able?: A Critical Analysis of “Any Willing Provider” Legislation*, 27 CUMB. L. REV. 199, 207 (1997). “Providers are essentially guaranteed a steady volume of patients because the MCO will contract with only a select few providers.” *Id.*

96. *Id.* (noting that selective contracting is the one of the most successful methods that health care providers have created to control health care costs).

97. Larry J. Pittman, “Any Willing Provider” Laws and ERISA’s Savings Clause: A New Solution for an Old Problem, 64 TENN. L. REV. 409, 416 (1997). Barry R. Furrow describes the concern over managed care as follows:

Some groups fear this evolution within the health care system. They worry that managed care organizations will limit physician options and harm patients through systematic cost-cutting. They foresee cookbook medicine through imposed practice guidelines; bureaucratic controls through utilization review; and dissipation of physician-patient trust as a result. They fear that profound inequality within our health care system will result from any “rush” toward efficiency-based medicine. Primarily, however, they fear a corporatization of health care. Under such corporatization, they fear, doctors will come to resemble little more than production workers in a medical version of the assembly line, with corporate management tools and statistical process analysis micromanaging physician work.

Barry R. Furrow, *Incentivizing Medical Practice: What (If Anything) Happens to Professionalism?*, 1 WID. L. SYMP. J. 1, 3-4 (1996) (footnotes omitted).

98. Approximately half of the states have some form of AWP laws, with most (twenty) of those laws relating to pharmacies and pharmacists. Sara Hoffman Jurand, *High Court Ruling on ERISA Is Another Blow to HMOs*, TRIAL, June 2003, available at WL 39-JUN JTLATRIAL 17. Seven have AWP laws that apply to doctors. *Id.*

who have been denied access to a managed care network the opportunity to “opt in” to the network.<sup>99</sup> At work behind the AWP debate were two competing public policies: an individual’s right to choose a medical provider and the need to reduce health care costs.<sup>100</sup> There are non-cost related benefits to such laws, such as stronger doctor-patient relationships and improved patient continuity of care when employers change insurance plans.<sup>101</sup> Balanced against broad access is the overall ability of the market to provide basic, affordable coverage, which lies at the root of the country’s health care crisis.<sup>102</sup> HMOs also argue that such laws force them to carry excessive administrative costs while restricting their ability to ferret out questionable providers.<sup>103</sup> The consensus is that AWP laws drive up the cost of health care, erasing whatever reductions managed care was able to achieve using limited networks.<sup>104</sup> Before

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99. Andrew L. Jiranek & Susan Baker, *Any Willing Provider Laws*, 28 MD. BAR J. 27, 27 (1995). There are three basic categories of AWP laws. The first is “freedom of choice,” where insurers are required to reimburse a non-network provider if the provider agrees to accept the insurer’s level of reimbursement for the service. *Id.* The second is “mandatory admittance,” which requires insurers to include in the network any provider willing to abide by the terms and conditions of the network. *Id.* Kentucky’s AWP law falls in this second category. The third category is “due process,” which requires insurers to follow certain procedures in establishing and maintaining their network. *Id.*

100. Dianne McCarthy, Note, *Narrowing Provider Choice: Any Willing Provider Laws After New York Blue Cross v. Travelers*, 23 AMER. J.L. & MED. 97, 97 (1997).

101. Laura B. Benko, *Willing and Able: Supreme Court Ruling Forces HMOs to Open Networks to Any Willing Provider*, MODERN HEALTHCARE, Apr. 7, 2003, at 6 (statement by Andrew Pulito, Ky. Med. Ass’n). Without AWP laws, the employees of an employer who changed insurance plans would be forced to go to a provider on the employer’s approved list, which may or may not include the employee’s present provider. *Id.* If the provider was not on the list, an employee may have had the option of paying out-of-pocket to continue to see that particular provider, but under AWP laws, the particular provider need only join the new network. *Id.* AWP laws especially help patients in rural areas or small towns, where healthcare choices are limited. *Id.* (statement by Carol Ormay, Ky. Hospital Ass’n). Without the ability to see out-of-network providers in their small towns, many rural Kentuckians were forced to travel several hours to see an in-network provider. *Id.*

102. *Id.* (statement by Melodie Shrader, Ky. Ass’n of Health Plans) (“[t]he problem with our healthcare system is that we’re told, ‘You have to buy a Cadillac or you can’t drive’”).

103. *Id.* (statement by Don Young, Health Ins. Ass’n of America). AWP laws add requirements to the HMO’s responsibility, in addition to state mandates governing network structure, claims payment, external review, and required benefits. *Id.*

104. See Jill A. Marsteller *et al*, *The Resurgence of Selective Contracting Restrictions*, 22 J. HEALTH POL. POL’Y & L. 1133 (1997) (providing an analytical conclusion based on statistics and categorization, but not limited to AWP laws); William J. Bahr, Comment, *Although Offering More Freedom to Choose, “Any Willing Provider” Legislation Is the Wrong Choice*, 45 U. KAN. L. REV. 557, 590 (1997) (concluding that AWP laws are not the answer to health care problems, “but an avenue to reach the most beneficial solution”); Gary A. Francesconi, Note, *ERISA Preemption of “Any Willing Provider” Laws – An Essential Step Toward National Health Care Reform*, 73 WASH. U. L.Q. 227 (1995) (arguing that AWP laws should be preempted by ERISA because they are “health laws,” not “insurance laws”).

*Miller*, many commentators agreed with the circuit courts that held that ERISA preempted AWP laws.<sup>105</sup>

### III. STATEMENT OF THE CASE

#### A. Statement of the Facts and Procedural History

The Kentucky General Assembly enacted an “Any Willing Provider” provision in 1994,<sup>106</sup> followed by a chiropractor-specific law two years later.<sup>107</sup> The plaintiffs were several health maintenance

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105. See Alice T. Armstrong, Comment, *ERISA Preemption of “Any Willing Provider”*: Why the Eighth Circuit Got It Right, 7 GEO. MASON L. REV. 753 (1999) (even under the narrow preemptive reach following *Travelers*, AWP laws do not survive ERISA preemption); Theodore Einhorn, Note, *Reigning in ERISA Preemption? Any Willing Provider Statutes After New York Blue Cross Plans v. Travelers Ins. Co.*, 13 J. CONTEMP. HEALTH L. & POL’Y 265 (1996) (the Supreme Court’s limitation of *Travelers* regarding “indirect economic effects” leaves questions as to state regulation of health care, which the Court will need to address in the future). *But see* Colleen C. Donnelly, Note, *CIGNA Healthplan of Louisiana, Inc. v. Louisiana: Unwilling to Save Louisiana’s Any Willing Provider Statute from ERISA Preemption*, 42 VILL. L. REV. 1255 (1997) (arguing that the Fifth Circuit should have followed *Travelers*’ narrowing of ERISA preemption and saved Louisiana’s AWP law).

106. *Ky. Ass’n of Health Plans, Inc. v. Miller*, 227 F.3d 352, 355 (6th Cir. 2000). KY. REV. STAT. ANN. § 304.17A-110(3) (Banks-Baldwin 1995) states that “Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.” *Id.* A “health benefit plan” was defined as:

[Any] hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERIS; health maintenance organization contract; and standard and supplemental health benefit plan as established in KRS 304.17A-160.

*Miller*, 227 F.3d at 355. KY. REV. STAT. ANN. § 304.17A-100(4) (Banks-Baldwin 1995).

Effective July 1, 1999, §§ 304.17A-110(3) and 304.17A-100(4) were repealed. *Miller*, 227 F.3d at 356. The Kentucky General Assembly reenacted the provision by substituting the term “health insurer” for “health benefit plan” and keeping the rest of the provision, which was codified at KY. REV. STAT. ANN. § 304.17A-270 (Banks-Baldwin). *Id.* The definition of “insurer” was codified at KY. REV. STAT. ANN. § 304.17A-005(22) (Banks-Baldwin 1999). *Id.* “Insurer” is defined as:

Any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

*Id.* The Sixth Circuit and the Supreme Court analyzed the statute’s present form rather than the repealed versions. *Miller*, 227 F.3d at 356.

107. *Id.* at 355. KY. REV. STAT. ANN. § 304.17A-171 (Banks-Baldwin 1999). § 171 imposed eight requirements on health benefit plans that include chiropractic benefits, but the Sixth Circuit only ruled on § 304.17A-171(2), the “any willing provider” provision, which states:

A health benefit plan that includes chiropractic benefits shall: . . . (2) Permit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and

organizations (HMOs) and a Kentucky-based association of HMOs.<sup>108</sup> To control the quality and cost of health care delivery, the petitioners created exclusive “provider networks” with selectively-chosen doctors, hospitals, and other health care providers.<sup>109</sup> The contract between the HMO and these “participating providers” required the providers to charge discounted rates for health care services to the HMO’s subscribers.<sup>110</sup> Limited access to providers was the HMO’s way of controlling the cost to its subscribers.<sup>111</sup>

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standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.

KY. REV. STAT. ANN. § 304.17 A-171 (A). *Miller*, 227 F.3d at 355 n.2. The Sixth Circuit remanded the issue of preemption of the seven remaining provisions, § 304.17A.-171(1) and (3)-(8), for consideration by the district court because the district court “apparently limited its analysis to Kentucky’s ‘Any Willing Provider’ provisions,” including § 304.17A-110(3) and § 304.17A-171(2), and “never explicitly addressed” the remaining seven provisions. *Id.* at 355 n.3. The remaining provisions required health benefit plans that included chiropractic benefits to:

include all primary chiropractic providers who are selected by a person covered by the plan; allow participants direct access to chiropractors of their choice without referral from a gatekeeper; appoint a chiropractor as a gatekeeper for the provision of chiropractic services when the plan uses gatekeepers; refrain from discriminating in reimbursement rates between chiropractors; refrain from promoting or recommending any chiropractor to a covered person; assure adequate numbers of providers are included in the plan; and make listings of participating chiropractors available to covered persons on a regular basis.

*Id.* at 355 n.3. All of the chiropractor provisions remained intact when the legislature repealed the health benefit plan statutes in 1998. *Id.* at 356. § 304.17A-110(3) and § 304.17A-171(2) will be referred to collectively as Kentucky’s “AWP” laws, unless specifically cited.

108. *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332 (2003). Two of the original seven plaintiffs, Advantage Care, Inc. and FHP of Ohio, Inc., did not join in the petition for writ of certiorari to the Supreme Court. Petition for a Writ of Certiorari, *Ky. Ass’n of Health Plans, Inc. v. Miller*, 2001 WL 34125415 (2001) (No. 00-1471). The Kentucky Association of Health Plans, Inc. is a non-profit association established to promote its members’ business interest. *Miller*, 227 F.3d at 355.

109. Brief for Petitioner at 1, *Ky. Ass’n of Health Plans, Inc. v. Miller*, 2002 WL 31128122 (2002) (No. 00-1471).

110. *Id.* at 1-2. In exchange for their rate discount, participating providers received the advantage of access to the HMO’s subscribers and, hence, increased patient volume over non-network providers lacking such access. *Id.*

111. *Id.* at 3 (citing ROBERT G. SHOULDICE, INTRODUCTION TO MANAGED CARE 72 (1991)). The HMOs argued that the fewer the providers, the greater the patient volume for each provider. *Id.* They also argued that the AWP laws were designed to require them to “throw open their closed provider networks to any provider in the geographic area willing to abide by the terms of their network contracts.” *Id.* at 4. An HMO controls cost and quality by deciding for itself which providers will be included in the network, and, the petitioners contended, “the unavoidable consequence of the laws is to drive up the costs of the health care services managed by HMOs and to affect their ability to regulate efficiently the quality of care offered by network providers.” *Id.* at 4-5. The petitioners contended that the consumers would ultimately be denied the benefit of these cost-reducing arrangements. *Miller*, 538 U.S. at 332. For a discussion of the shortcomings of AWP laws as well as the inefficiencies of the free market in the health care industry, see Christine C.

The plaintiffs filed suit against the Commissioner of the Kentucky Department of Insurance<sup>112</sup> in the Eastern District of Kentucky in April 1997, requesting that the AWP laws be declared preempted by § 514(a) of ERISA, 29 U.S.C. § 1144(a).<sup>113</sup> Both parties moved for partial summary judgment.<sup>114</sup> The district court granted partial summary judgment in favor of the Commissioner, ruling that while the AWP laws were related to employee benefit plans under ERISA,<sup>115</sup> they were saved from preemption through ERISA's saving clause<sup>116</sup> because they regulated the business of insurance.<sup>117</sup> The plaintiffs appealed this decision to the United States Court of Appeals for the Sixth Circuit.<sup>118</sup>

The court of appeals affirmed the district court's summary judgment with respect to the AWP statute<sup>119</sup> and the chiropractic AWP statute,<sup>120</sup> but remanded the additional provisions in the chiropractic statute for the district court to decide if they were preempted by ERISA.<sup>121</sup> The Sixth Circuit agreed with the district court that the AWP

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Dodd, Comment, *The Exclusion of Non-Physician Health-Care Providers from Integrated Delivery Systems: Group Boycott or Legitimate Business Practice?*, 64 U. CIN. L. REV. 983, 1025 (1996) (concluding that AWP laws are too broad to have any meaningful change in the market). For a comprehensive nationwide overview of state selective contracting laws, see Jill A. Marsteller, *et al.*, *The Resurgence of Selective Contracting Restrictions*, 22 J. HEALTH POL. POL'Y & L. 1133 (1997).

112. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 227 F.3d 352, 355 (6th Cir. 2000). At the time of the filing, George Nichols held this position, and he was named the defendant in his official capacity. *Id.* Following the Sixth Circuit's decision, Janie Miller succeeded Nichols as Commissioner, and she was substituted as respondent beginning with the Petition for Writ of Certiorari. Petition for Writ of Certiorari at ii, 2001 WL 34125415 (2001) (No. 00-1471).

113. *Miller*, 227 F.3d at 356.

114. *Id.*

115. *Miller*, 227 F.3d at 356-57 (citing 29 U.S.C. § 1144(a), the preemption clause, *supra* note 12).

116. *Id.* at 357 (citing 29 U.S.C. § 1144(b)(2)(A), the savings clause, *supra* note 13).

117. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 227 F.3d 352, 356 (6th Cir. 2000). The district judge also determined the order to be final and appealable. *Id.* Plaintiffs then appealed. *Id.* Community Health Partners, Inc. filed suit challenging Kentucky's AWP laws in December 1996 in the Western District of Kentucky. Petition for Writ of Certiorari at 6 n.3, 2001 WL 34125415 (2001) (No. 00-1471). Plaintiff in that suit, *Community Health Partners, Inc. v. Ky. ex rel. Nichols*, 14 F. Supp. 2d 991 (W.D. Ky. 1998), also appealed, and the same Sixth Circuit panel heard separate arguments for both of the cases. Petition for Writ of Certiorari at 6 n.3, 2001 WL 34125415 (2001) (No. 00-1471). The Court incorporated its full majority and dissenting opinions into its Community Health Partners decision. *Id.* Community Health Partners' petition for certiorari was unanimously denied by the Supreme Court on the day that it reached its decision in *Miller*, April 7, 2003. *Community Health Partners, Inc. v. Ky.*, 538 U.S. 960, 960 (2003).

118. *Miller*, 227 F.3d at 356.

119. *Id.* at 372. KY. REV. STAT. ANN. § 304.17A-270 (Banks-Baldwin 1999).

120. *Miller*, 227 F.3d at 372. KY. REV. STAT. ANN. § 304.17A-171(2) (Banks-Baldwin 1999).

121. *Miller*, 227 F.3d at 372. KY. REV. STAT. ANN. § 304.17A-171(1) and (3)-(8). (Banks-Baldwin 1999). *See supra* note 106.

laws “regulat[ed] insurance” and fell within ERISA’s savings clause.<sup>122</sup> The court of appeals first determined that the AWP provisions “relate[d] to” an employee benefit plan for purposes of ERISA § 514(a).<sup>123</sup> The court then held that the AWP laws were saved from preemption because they were “specifically directed toward ‘insurers’ and the insurance industry and [were] ones that from a ‘common sense view’ regulate[d] insurance.”<sup>124</sup> In considering the three McCarran-Ferguson factors,<sup>125</sup> the

122. Ky. Ass’n of Health Plans, Inc. v. Miller, 227 F.3d 352, 372 (6th Cir. 2000).

123. The court of appeals found that the AWP provisions “relate[d] to” employee benefits plans under both prongs of the test that the Supreme Court established in *Cal. Div. of Labor Standards Enforcement v. Dillingham Construction, N. A., Inc.*: “a law ‘relates to’ a covered employee benefit plan for purposes of § 514(a) if it [1] has a connection with or [2] reference to such plan.” 519 U.S. 316, 324 (1997) (internal quotations and citations omitted). If a law relates to a covered employee benefit plan, then ERISA preempts it, “unless [they are] found to be statutes that regulate insurance under the savings clause, § 514(b)(2)(A).” *Miller*, 227 F.3d at 363.

124. *Miller*, 227 F.3d at 366. The court of appeals felt that even though the laws included HMOs and traditional insurance companies within its reach, the laws could still fall within the state’s right to regulate insurance. *Id.* at 364. The court agreed with the reasoning of the Ninth Circuit in *Washington Physicians Service Association v. Gregoire*, 147 F.3d 1039, 1045-46 (9th Cir. 1998):

The Washington law is “specifically directed” toward the insurance industry [ ] because it operates directly on HMOs and HCSCs, entities that are engaged in the business of health insurance. “The primary elements of an insurance contract are the spreading and underwriting of a policyholder’s risk.” [ ] The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, [ ] but this is a distinction without a difference. [ ] In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

*Miller*, 227 F.3d at 364-65 (internal citations omitted). The court also agreed with the Seventh Circuit’s reasoning that “because HMOs spread risk – both across patients and over time for any given person – they are ‘insurance vehicles’ under” Kentucky law. *Id.* at 365 (citing *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994)).

Because ERISA’s “deemer” clause does not protect certain self-insured health care benefit plans that are excluded from ERISA coverage under 29 U.S.C. § 1003(b), e.g. self-insured government plans and self-insured church plans, the court acknowledged that Kentucky’s statutes would reach these plans. *Miller*, 227 F.3d at 365. The court did “not see this fact, however, as any barrier to a finding that a common sense view is that the statutes regulate insurance.” *Id.* The court saw no reason why States do not have the authority to include entities that act as self-insurers within their laws dealing with insurance. *Id.* Recognizing that courts and legislatures struggle over whether self-insurers should be the equivalent of an insurer, citing 1 COUCH, *supra* note 8, § 10:2, the court noted that states bypass this difficulty by “express statutory provisions specifying that a particular requirement does or does not apply to self-insured entities.” *Miller*, 227 F.3d at 365. Kentucky has followed this direction by including self-insurers, to the extent permitted by ERISA, within the statute, which is codified in Kentucky’s Insurance Code. *Id.*

The court also focused on the relationship between insurers and insureds under health benefit plans, holding that Kentucky’s AWP laws:

[A]ffect restrictions by the insurers on the number of health care providers available to the insureds under such plans; they increase benefits to the insureds by giving them



court of appeals found that all three applied to the Kentucky AWP laws.<sup>126</sup> The plaintiffs filed for, and were granted, a writ of certiorari by the United States Supreme Court.<sup>127</sup>

### *B. Supreme Court Decision*

Justice Antonin Scalia wrote a unanimous opinion affirming the Sixth Circuit's decision.<sup>128</sup> The Court noted that their prior decisions construing the savings clause have relied on their cases interpreting two subsections of the McCarran-Ferguson Act.<sup>129</sup> This use of the McCarran-Ferguson case law in the ERISA context "has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis."<sup>130</sup> The Court stated

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greater freedom to choose health care providers under the plans; and they are aimed at regulating this insurance relationship.

*Id.* at 368.

125. See text *supra* § II(A)(1). The appellate court noted that the McCarran-Ferguson factors are "checking points" or "guideposts" because they are of secondary importance and not essential elements. *Miller*, 227 F.3d at 364.

126. *Miller*, 538 U.S. at 333.

127. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 536 U.S. 956 (2002) (granting writ of certiorari). The petitioners contended in the petition that the Sixth Circuit's decision exacerbated conflicts in the federal circuits over whether AWP statutes are laws which regulate insurance. Petition for Writ of Certiorari, *Miller*, at 2-3, 2001 WL 34125415 (2001) (No. 00-1471). Compare *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir. 1993) (holding that Virginia's statute, which prohibited insurers and benefit plan administrators from entering into exclusive contracts with preferred providers, related to ERISA employee benefit plans but was saved from pre-emption because it regulates insurance as a matter of common sense); with *Prudential Ins. Co. of America v. Nat'l Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1998) (holding that the Arkansas law, which was "almost identical" to Kentucky's AWP law, failed both the common sense test and all three McCarran-Ferguson factors, and therefore was not saved from pre-emption by ERISA); and *Cigna Healthplan v. La.*, 82 F.3d 642 (5th Cir. 1996) (holding that a Louisiana AWP law that mandated that a licensed provider who agreed to the terms and conditions of the preferred provider contract shall not be denied the right to become a preferred provider was not a law which regulated insurance because the laws were not limited to entities within the insurance industry and it applied not only to insurers, but also to self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self-funded trusts or programs, as well as health care financiers, third party administrators, providers or other intermediaries).

128. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003).

129. *Id.* at 339. McCarran-Ferguson Act §§ 2(a)-(b), 15 U.S.C. § 1012.

130. *Miller*, 538 U.S. at 340 (declaring that it was unsurprised by this result since the statutory language of the savings clause differs substantially from the McCarran-Ferguson Act). The McCarran-Ferguson Act concerns itself with whether certain practices constitute "[t]he business of insurance," 15 U.S.C. § 1012(a), or whether a state law was "enacted . . . for the purpose of regulating the business of insurance," 15 U.S.C. § 1012(b) (emphasis added). The savings clause, on the other hand, asks merely whether a state law is a "law . . . which regulates insurance, banking, or securities." *Id.* 29 U.S.C. § 1144(b)(2)(A). In addition, the McCarran-Ferguson factors were developed in cases that characterized *conduct* by private actors, not state laws. *Id.* (referring to *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982), and *Group Life & Health Ins. Co. v.*

that when it held in *UNUM Life Ins. Co. of America v. Ward*<sup>131</sup> and *Rush Prudential HMO Inc. v. Moran*<sup>132</sup> that the state law may fail the first McCarran-Ferguson factor yet still be saved from pre-emption by the savings clause, it created more questions than answers and provided wide opportunities for divergent outcomes.<sup>133</sup> Because it had never held that the McCarran-Ferguson factors were essential to a savings clause inquiry,<sup>134</sup> the Court chose to make a clean break from them for that analysis.<sup>135</sup> For a state law to be deemed a “law . . . which regulates insurance” under the savings clause, it must satisfy two requirements: (1) the state law must be directed specifically directed toward entities engaged in insurance, and (2) the state law must substantially affect the risk pooling arrangement between the insurer and the insured.<sup>136</sup>

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Royal Drug Co., 440 U.S. 205, 210 (1979)).

131. *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999).

132. *Rush Prudential HMO Inc. v Moran*, 536 U.S. 355 (2002).

133. *Miller*, 538 U.S. at 340 (questioning whether a state law that satisfied any two of the factors could still fall under the savings clause or asking what happens if two factors are satisfied, but not “securely satisfied” or “clearly satisfied,” as in *Ward* and *Moran*). The Court acknowledged that there is even more confusion with whether the *state law itself* or the *conduct regulated by that law* is the proper subject to which the McCarran-Ferguson factors are applied. *Id.* (emphasis in original). See *ASHLEY*, *supra* note 45, § 9:17 (concluding that the only real connection between the McCarran-Ferguson “business of insurance” phrase and the ERISA “law . . . which regulates insurance” savings clause phrase is the word “insurance,” and that this is hardly a compelling reason to impose an interpretation of the McCarran-Ferguson Act on different language in ERISA).

134. *Miller*, 538 U.S. at 341 (recalling its prior decisions that referred to the McCarran-Ferguson factors as “considerations [to be] weighed” in determining whether a state law falls under the savings clause or “checking points” to be used *after* determining whether the state law regulates insurance from a “common-sense” understanding” or “guideposts” to “confirm our conclusion” that the state statute regulated insurance).

In oral arguments, Justice Scalia said that he did not like the common-sense, “I know it when I see it,” test. Transcript, U.S.S. Ct. at 41, 2003 WL 145394 (2003) (No. 00-1471). He worried that the Court would “approve those things that we like, and disapprove those things that we don’t like . . . I don’t trust common sense.” *Id.* Instead of the common-sense test, Justice Scalia wanted “some rule of law that [he] could adhere to.” *Id.* at 42. Justice Ginsburg highlighted that difficulty with the common-sense test, when she said,

I read the Sixth Circuit opinion, I said, yes, that makes common sense, and I read Judge Kennedy’s dissenting opinion and said, yes, that’s common sense, too . . . These are rational judges on both sides, they both made good arguments, and they both conformed to some sense of what goes on in the real world, so what is the common sense test?

*Id.* at 37.

135. *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341 (2003). *But see* *ASHLEY*, *supra* note 45, § 9:17 (noting the fundamental discrepancy between the McCarran-Ferguson “business of insurance” analysis and the purposes of ERISA’s savings clause). *Ashley* contends that the McCarran-Ferguson test should be reformulated to fit ERISA cases within the analysis of the phrase “business of insurance”: “(1) Does the law regulate the transferring or spreading of the risk? (2) Does the law regulate an integral part of the policy relationship between the insurer and the insured? (3) Is the law’s scope limited to entities within the insurance industry?” *Id.*

136. *Miller*, 538 U.S. at 342.

### 1. Specifically Directed Toward Entities Engaged in Insurance

The Court found that the AWP laws “regulated” insurance by imposing conditions on the right to engage in the business of insurance.<sup>137</sup> The Court first reiterated that ERISA’s savings clause only saves a state law that is “specifically directed toward” the insurance industry that regulates an insurance practice.<sup>138</sup> Addressing the petitioners’ first claim, the Court held that Kentucky did not fail to specifically direct its AWP laws toward the insurance industry simply because the laws restricted the actions of providers and insurers equally.<sup>139</sup> Nor do the laws lose their specificity when one of their consequences is that entities outside of the insurance industry will be unable to enter into certain agreements with Kentucky insurers.<sup>140</sup> The savings clause only requires a law to be one “which regulates insurance”.<sup>141</sup>

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137. *Id.* at 333 (only mentioning the court of appeals’ finding that the AWP statutes “relate to” employee benefit plans under § 1144(a) as part of the procedural history, and not in the discussion section).

138. *Miller*, 538 U.S. at 334 (citing *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366 (2002)). Laws of general application that have some bearing on insurers do not qualify. *Id.* (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). The petitioners contended that the AWP laws fell outside the scope of the savings clause for two reasons: (1) Kentucky failed to “specifically direc[t]” its AWP laws towards the insurance industry and (2) the AWP laws did not regulate an insurance practice. *Id.*

139. *Miller*, 538 U.S. at 334 (noting that providers are prevented from entering into limited network contracts, and insurers are prevented from creating exclusive networks). The Court also stated that neither of the AWP statutes imposed any prohibition or requirement on health-care providers, and that Kentucky health-care providers are able to enter exclusive networks with insurers who conduct business outside Kentucky or who are otherwise not covered by the AWP statutes. *Id.* at 335. Only when a “health insurer” or “health benefit plan that includes chiropractic benefits” excludes a provider who is willing and able to meet its terms is the particular AWP statute violated. *Id.*

140. *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 335 (2003) (stating that similar consequences resulted from state laws that were saved from pre-emption in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), and *Rush Prudential*). In *FMC Corp.*, 498 U.S. at 55 n.1, Pennsylvania prohibited insurers from exercising subrogation rights against an insured’s tort recovery and prevented insureds from entering into enforceable contracts with insurers allowing subrogation. *Miller*, 538 U.S. at 335. In *Rush Prudential*, 536 U.S. at 372, Illinois required HMOs to provide independent review of whether services were “medically necessary,” and likewise excluded insureds from joining an HMO that would have withheld the right to independent review in exchange for a lower premium. *Miller*, 538 U.S. at 335. Even though the effect of those laws on noninsurers may have been significant, the Court found that the effect of the laws was not inconsistent with the requirement that they be “specifically directed toward” the insurance industry. *Id.* Regulations “directed toward” certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such regulation outside the scope of the savings clause. *Id.*

141. *Miller*, 538 U.S. at 336 n.1 (emphasis added in opinion) (distinguishing the savings clause from language requiring a state law to regulate “insurance companies” or from section 2 of the

## 2. Substantially Affect the Risk Pooling Arrangement between the Insurer and the Insured

The Court also rejected the petitioners' second claim that the AWP laws did not regulate insurers with respect to an insurance practice because the laws did not control the actual terms of insurance policies.<sup>142</sup> First, the Court distinguished between § 2(b) McCarran-Ferguson Act—an interpretation of which (*Royal Drug*) the petitioners relied upon in their argument—and ERISA's savings clause, saying that the savings

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McCarran-Ferguson Act). Petitioners contended that the general AWP law, KY. REV. STAT. ANN. § 304.17A-270, was not “specifically directed toward” insurers because it applied to “self-insurer or multiple employer welfare arrangement[s] not exempt from state regulation by ERISA.” *Id.* KY. REV. STAT. ANN. § 304.17A-005(3) (preempting the law as a result of it not being saved). The Court disagreed because self-insured plans engaged in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan. *Miller*, 538 U.S. at 336 n.1. A contrary view would render the “deemer clause” superfluous, since that clause only comes into play once the savings clause “saves” a state law from preemption because the law regulates insurance. *Id.* The “savings” is revoked by the deemer clause if the law would allow the State to regulate a self-insured employee benefit plan by deeming the plan to be an insurance company, other insurer, or one engaged in the business of insurance. *Id.* 29 U.S.C. § 1144(b)(2)(B). Implicit in the deemer clause's construction was the determination that a law regarding *all* self-insured employee benefit plans, including ERISA-protected plans, was initially “saved” because it *did* regulate insurance, otherwise the law would not have been saved in the first place. *Miller*, 538 U.S. at 336 n.1. In the end, only those self-insured employee benefit plans that are protected by ERISA are exempt from state regulation. *Id.* Thus, the petitioners' contention that the law was not “specifically directed toward” insurers simply because it applied to “self-insurer or multiple employer benefit welfare arrangements not exempt from state regulation by ERISA” failed because such laws would never be saved from preemption in the first place. *Id.* In this case, all HMOs, including those that do not act as insurers but provide only administrative services to self-insured plans, are regulated by both of the AWP laws. *Id.* The Court did not agree that applying the laws to non-insuring HMOs forfeits the laws' status as “laws[s] . . . which regulat[e] insurance.” *Id.* § 1144(b)(2)(A). First, it felt that for the purposes of § 1144(b)(2)(A), the “activity of insurance” encompassed the administration of self-insured plans by a non-insuring HMO. *Miller*, 538 U.S. at 336 n.1. Second, *Rush Prudential* foreclosed this argument because in that case, the independent-review law in question contained “some overbreadth in the application of [the law] beyond orthodox HMOs,” yet the Court held that “there is no reason to think Congress would have meant such minimal application to noninsurers to remove a state law entirely from the category of insurance regulation saved from preemption [sic].” *Id.* (citing *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 372 (2002)). See Rafael Gely, *Supreme Court's 2002 Term Employment Law Cases: Is This the Scalia Court?*, 7 EMPL. RTS. & EMPLOY. POL'Y J. 253, 260 (2003) (noting that Justice Scalia not only relied on the statutory text as a basis for his interpretation, but he also placed the savings clause in the context of other ERISA provisions).

142. *Miller*, 538 U.S. at 337 (alleging that the AWP laws focused upon the relationship between an insurer and third-party providers, which did not constitute an “insurance practice”). The petitioners relied on *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210 (1979), in which the Court held that third-party provider arrangements between insurers and pharmacies were not “the ‘business of insurance’” under § 2(b) of the McCarran-Ferguson Act. *Miller*, 538 U.S. at 337.

clause is “not concerned with how to characterize *conduct* undertaken by private actors, but with how to characterize *state laws* in regard to what they ‘regulate’”<sup>143</sup> Then, by the way of an example involving lawyers and mandatory continuing legal education hours,<sup>144</sup> the Court found that Kentucky’s AWP laws, which prohibit any “health insurer” from discriminating against any willing provider, “‘regulat[e]’ insurance by imposing conditions on the right to engage in the business of insurance.”<sup>145</sup> However, ERISA’s savings clause covers only those “conditions on the right to engage in the business of insurance [that] also substantially affect the risk pooling arrangement between the insurer and the insured.”<sup>146</sup> AWP laws “expan[d] the number of providers from

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143. *Miller*, 538 U.S. at 337 (emphasis in original) (noting that the McCarran-Ferguson Act provision is concerned with how to characterize conduct undertaken by private actors). The Court noted that *Royal Drug* did not lead to the conclusion that a law mandating certain insurer-provider relationships fails to “regulate insurance.” *Id.* See generally ASHLEY, *supra* note 45, § 9:17 (arguing that *Pilot Life* was full of flaws, the first of which involved the connection with the McCarran-Ferguson factors, which was finally severed in *Miller*). The cases deciding what is the “business of insurance” for McCarran-Ferguson purposes arise in significantly different contexts from cases deciding what laws “regulate insurance” for ERISA purposes. *Miller*, 538 U.S. at 337. “Business of insurance” cases normally arise when an administrative agency or private party attempts to assert a federal statute, usually an antitrust statute, against an insurance company and the insurance company defends the action by arguing that the McCarran-Ferguson Act preempts the application of federal law to the insurance company’s activities because those activities are part of the “business of insurance” within the meaning of the McCarran-Ferguson Act. *Id.* For ERISA purposes, the question is not whether an enterprise has engaged in the business of insurance, but whether the state statute asserted against an insurer is a law that regulates insurance. *Id.* E.g., Troger v. New York Life Ins. Co., 633 F. Supp. 503 (D. Md. 1986), *overruled*, *Pilot Life*, 481 U.S. 41 (refusing to apply the McCarran-Ferguson factors because they do not determine what laws regulate the business of insurance).

144. *Miller*, 538 U.S. at 337. The Court felt that the AWP laws operated in a similar manner with respect to the insurance industry. *Id.*

A state law required all licensed attorneys to complete 10 hours of continuing legal education (CLE) each year. This statute “regulates” the practice of law—even though sitting through 10 hours of CLE classes does not constitute the practice of law—because the state has *conditioned* the right to practice law on certain requirements, which substantially affect the product delivered by lawyers to their clients.

*Id.* (emphasis in original).

145. Ky. Ass’n of Health Plans, Inc. v. *Miller*, 538 U.S. 329, 337 (2003) (deciding that whether or not an HMO’s contracts with providers constitute “the business of insurance” under *Royal Drug* is beside the point).

146. *Id.* at 338 (noting that without the substantial affect on the risk pooling arrangement, any state law aimed at insurance companies could be deemed a law that “regulates insurance,” which is contrary to the Court’s interpretation of the savings clause in *Rush Prudential*). The petitioners contended that the AWP laws failed this test because they did not alter or affect the terms of insurance policies, but concern only the relationship between insureds and third-party providers. *Id.* Rejecting this argument, the Court said that it has never held that state laws must alter or control the actual terms of insurance policies to be deemed “laws . . . which regulat[e] insurance” under the savings clause. *Id.*

whom an insured may receive health services.”<sup>147</sup> Thus, the laws “alter the scope of permissible bargains between insurers and insureds in a manner similar” to the laws that the Court upheld in three prior cases.<sup>148</sup> Having found that the Kentucky AWP laws satisfied both of these requirements, the Supreme Court affirmed the judgment of the Sixth Circuit.<sup>149</sup>

#### IV. ANALYSIS

Since the Supreme Court decided that common law bad faith claims were preempted by ERISA in 1987,<sup>150</sup> the tenor of its ERISA decisions has prompted substantial discussion regarding how far the Court will allow the states to “regulate” employee benefit plans.<sup>151</sup> From mandated mental health benefits<sup>152</sup> to independent utilization review,<sup>153</sup> and now

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147. *Id.*

148. *Miller*, 538 U.S. at 338-39 (referring to the mandated-benefit laws upheld in *Metropolitan Life*, the notice-prejudice rule sustained in *UNUM*, and the independent-review provisions approved in *Rush Prudential*). Kentucky insureds no longer must trade off lower premiums for access only to a closed network or health-care providers, and this prohibition, the Court said, substantially affects the type of risk pooling arrangements that insurers may offer. *Id.* at 339.

149. *Id.* at 341-42.

150. *Pilot Life*, 481 U.S. at 52 (finding that a bad faith cause of action rooted in Mississippi’s common law was preempted by ERISA). For a contemporaneous analysis of *Pilot Life*, see Aldisert, *supra* note 15, at 1367-83; Nelson, *supra* note 80, at 507.

151. See Pittman, *supra* note 97, at 416 (through their construction of ERISA’s preemption clause, recent Supreme Court and lower federal court decisions have given more protection to state law regulation of MCOs and their cost-cutting strategies); James Saya, Note, *Removing a Roadblock to Reforming Health Care: Ny. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 3 CONN. INS. L.J. 127 (1996) (viewing *Travelers* as allowing the states greater freedom to design and implement health care legislation, restoring the states to their traditional role as formulators of health care policy); Deborah S. Davidson, Note, *Balancing the Interests of State Health Care Reform and Uniform Employee Benefit Laws Under ERISA: A “Uniform Patient Protection Act,”* 53 WASH. U. J. URB. & CONTEMP. L. 203 (2003) (discussing the Court’s shift to a more restrained application of the preemption clause); Phyllis C. Borzi, *Distinguishing Between Coverage and Treatment Decisions Under ERISA Health Plans: What’s Left of ERISA Preemption?*, 49 BUFFALO L. REV. 1219, 1267-71 (2001) (noting that after twenty years of broadly interpreting the sweep of ERISA preemption, the Court has narrowed ERISA’s reach). *But see* Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity vs. Quality Lead to ERISA’s Inequitable Preemption of Claims*, 34 AKRON L. REV. 571 (2001) (only Congress can clarify the rights of patients against MCOs and rectify the inequities that plague plaintiffs in MCO litigation).

152. *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 758 (1985) (finding that a Massachusetts statute setting forth mandatory minimum health care benefits for inclusion in general insurance policies was not preempted by ERISA).

153. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (finding that Illinois law requiring HMOs to provide independent review of disputes between primary care physician and HMO, and to cover services deemed medically necessary by that independent reviewer, regulated insurance within meaning of saving clause).

Any Willing Provider statutes,<sup>154</sup> the Court has expanded the definition of a state insurance regulation.<sup>155</sup> In *Miller*, Justice Scalia, for a unanimous court, refused to pigeonhole the definition of “insurance” and instead chose to analyze the relationship between the parties.<sup>156</sup>

#### A. *The Perceived Impact of Miller*

Immediately following the Court’s decision, reaction to the ruling was mixed. The perceived consensus was that *Miller*’s expansiveness would permit the states greater room to regulate MCOs.<sup>157</sup> State regulators and providers viewed the ruling as a victory in their efforts to enforce HMO accountability and consumer access to care.<sup>158</sup> But the

154. *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003) (finding that Kentucky’s Any Willing Provider statute was saved from ERISA preemption).

155. Larry J. Pittman, *ERISA’s Preemption Clause: Progress Towards a More Equitable Preemption of State Laws*, 34 IND. L. REV. 207, 229-232 (2001) (arguing that the *Pegram* case is an extension of the Supreme Court’s efforts to narrow the scope of ERISA preemption). *But see* Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457 (arguing that the Supreme Court missed opportunities to rationalize the body of law encompassing negligence claims against and benefit regulation of managed care organizations, further entrenching a failed jurisprudence of managed care).

156. *Miller*, 538 U.S. at 337-38 (holding that the savings clause looks at the state law, not the conduct of private individuals, *i.e.*, in relation to the “business of insurance” test used under the McCarran-Ferguson Act).

157. Marie Suszynski, *Attorney: Supreme Court Ruling Boosts States’ Power over HMOs*, BESTWIRE, Apr. 21, 2003. Mark Gallant, chairman of the health law department at Cozen O’Connor, said that “[u]nder older case law, it was a harder test to demonstrate whether a law regulated insurance. Here, the Supreme Court blew the lid off the older test and took a broad view.” *Id.* But Anthony F. Shelley, an attorney at Miller & Chevalier in Washington, D.C., considered the clearer test “more favorable to ERISA.” Lee, *supra* note 5. He commented that “[b]efore, the courts used the ‘I know it when I see it’ criteria, but now the test narrows the inquiry somewhat.” *Id.* *Miller* still adversely affects fully-insured plans, he said, because it subjects them to “many more state regulations,” and in the end, that could drive up premiums. *Id.* Penelope Lemov, in GOVERNING MAGAZINE, noted *Miller*’s importance, but stated that “in a practical sense, the victories may be less than meets the eye” since budget crises may cause states to “capitalize on their power to inhibit managed-care strategies—at least not right now.” Penelope Lemov, *Blocking ERISA*, GOVERNING, May 1, 2003, at 74. *See also* Jurand, *supra* note 98 (“[t]he Court’s willingness to take a fresh look at the savings-clause prong of the preemption test indicates that they may be willing to take a fresh look at the other portions of the statute and possibly interpret them favorably for plaintiffs.”).

158. Benko, *supra* note 101. The American Medical Association, which has submitted *amici* briefs to the Supreme Court in recent years, also applauded the decision. *AMA Commends Supreme Court Decision that Reduces Confusion Surrounding Laws Regulating Health Insurers*, AMERICAN MEDICAL ASS’N, Apr. 3, 2003, available at <http://www.ama-assn.org/ama/pub/print/article/9255-7495.html>. Elizabeth Johnson, counsel for the Kentucky Department of Insurance, agreed that the “broader” interpretation of ERISA exemptions allows states to address health care issues that Congress has yet to resolve. Benko, *supra* (“[w]hile the [C]ourt has consistently leaned toward giving states more power [to address health care issues that Congress has not resolved], this landmark ruling really drives that idea home”). This decision is also seen as a continuation of the

health care industry feared that greater state regulation will translate into higher costs, which they say they will be forced to pass on to their plan participants.<sup>159</sup> Such a combination—increasing state authority to interfere with HMOs as they bargain with providers and expanding the savings clause umbrella—may prove to be a lethal combination for the managed care industry.<sup>160</sup> Others worried about the greater impact on the larger companies that self-insure.<sup>161</sup> Ultimately, only time will tell what *Miller*'s real impact on insurers will be.<sup>162</sup>

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Court's defederalization "policy" that has given more power to the states. Lorraine Schmall and Brenda Stephens, *ERISA Preemption: A Move Towards Defederalizing Claims for Patients' Rights*, 42 BRANDEIS L.J. 529, 572 (2004) ("Court further defederalized state claims which lower courts might tend to find preempted"); *but see* Carol S. Weissart, *Promise and Perils of State-Based Road to Universal Insurance in the U.S.*, 7 J. HEALTH CARE L. & POL'Y 42, 51 (2004) ("[w]hile these cases seem to be narrowing ERISA's preemption, ERISA continues to impede comprehensive state action").

159. Leo T. Crowley, *Supreme Court Narrowly Construes ERISA Preemption*, N.Y.L.J., Apr. 29, 2003, at 3, col. 1. Benko, *supra* note 101 (statement by Melodie Shrader, *Ky. Ass'n of Health Plans*) ("[g]overnment interferences masquerading as patient protections are actually having the opposite effect as healthcare costs increase and more Americans go uninsured").

160. Crowley, *supra* note 159 ("[*Miller*] appears likely to open the doors to higher health care costs through allowing states to pass regulations that prevent HMOs from bargaining with providers for lower costs at the same time that it broadens the ERISA savings clause in the insurance area by a considerable margin"). *See also* Benko, *supra* note 101 ("[t]his could prove to be a final nail in the coffin of managed care") (statement by Chip Kahn, Federation of American Hospitals). But one industry insider saw *Miller* as the end of ERISA. Mark A. Hofmann, *Supreme Court Rules Any Willing Provider Law Not Pre-Empted by ERISA; Health Plans Fear Cost Increase*, BUSINESS INSURANCE, Apr. 7, 2003, at 4 (statement by Neil Trautwein, Nat'l Ass'n of Manufacturers) ("[t]his is a horrible decision—yet another nail in the coffin of ERISA"). An insurance analyst with Standard & Poor's disagreed with the dire predictions by the industry. Benko, *supra* note 101. He stated that most health plans have found other ways to retain their bargaining power and that the ruling will "probably cause a small deterioration in (profit) margins, but certainly nothing that would severely disrupt operations or throw insurers into insolvency." *Id.* (parenthetical text in original). *But see* Weissart, *supra* note 158, at 51 (narrowing of ERISA preemption has not opened the door for comprehensive state action).

161. John Carroll, *AWP Reimbursement Ruling May Be More Than Meets Eye*, MANAGED CARE, May 2003, available at <http://www.managedcaremag.com/archives/0305/0305.regulation.html> (quoting industry analysts worried that the states will read *Miller* as their green light to regulate insurance, self-insured or not); Alden J. Bianchi, *Ky. Ass'n of Health Plans v. Miller—The Expanding Scope of the ERISA Saving Clause and the Future of State Regulation of Managed Care Organizations*, 44 BNA TAX MANAGEMENT MEMORANDUM 15, July 28, 2003, available at [http://www.bnatax.com/tm/jc\\_memorandum\\_vol44no15.htm](http://www.bnatax.com/tm/jc_memorandum_vol44no15.htm) (noting the potential Pandora's Box in one of the Court's lengthy footnotes for self-funded plans with insurers or HMOs providing administrative-services-only). Bianchi concludes that "[w]hile there is nothing on the face of *Miller* that should change the ERISA treatment of alternative remedies, its tone and tenor make it easier for states to move in this direction." *Id.* Presently, the "deemer" clause, 29 U.S.C. § 1144(b)(2)(B) (2000) prevents the states from considering self-insured benefit plans for state regulation of insurance. *See* text § II(A)(2)(d) and notes 71-74.

162. Benko, *supra* note 101 (statement by Karen Ignagni, American Ass'n of Health Plans) (*Miller* "changes little in the current healthcare delivery system"). Kentucky's AWP law had been



Looking at the legal aspects of the decision, reaction focused mainly on Justice Scalia's new test. Some commentators were shocked, while others appreciated the Court's attempt to clarify a very murky area of law.<sup>163</sup> A handful criticized the Court's holding from a legal perspective,<sup>164</sup> as they feared that the relatively stagnant ERISA waters would be stirred as new court challenges would seek to expand this holding to areas previously held to be preempted.<sup>165</sup>

Similar to a good bottle of wine, the kinks in any new test work themselves out—and hence get better—with time. A recent example of the Supreme Court announcing a new test in a non-criminal setting involved the admissibility of expert scientific evidence under Federal Rule of Evidence (FRE) 702.<sup>166</sup> The District of Columbia Circuit Court

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in effect for nine years prior to the ruling, and insurers outside of Kentucky responded to the demands of consumers and regulators in that time. *Id.* As a result, insurers offered more product choices and built a higher-quality healthcare system, with the majority of health plans already opening their networks to include 90% of providers. *Id.*

The greatest effect most likely will be on health plans that operate in states that do not have AWP laws, since HMOs in states with AWP laws have already factored the cost impact into their operations. Benko, *supra* note 101 (statement by Dick Brown, Humana). But the National Community Pharmacists Association believed that *Miller* is more important in those states that do have AWP laws on the books, as this decision will “stiffen the spines of state insurance commissioners when it comes to enforcing” AWP laws. Carol Ukens, *Supreme Court Hands Pharmacy a Victory*, DRUG TOPICS, no. 9, vol. 147, May 5, 2003, at 25 (“[w]e’ll get better enforcement because there won’t be ERISA hanging over proper enforcement”). For those states without AWP laws, the disappearance of the ERISA “specter” will take away from HMOs the “singular argument they have used in the states” to prevent legislatures from enacting such laws. *Id.* (pharmacy benefit managers “and insurance companies scare the bejesus out of folks with ERISA. They come in at the last minute and say, ‘There’s no use passing this bill; it’ll be preempted by ERISA’”).

163. Lee, *supra* note 5 (statement by Anthony F. Shelley). The unanimity of the decision increased fodder for discussion. Mark Gallant, chairman of the health law department at Cozen O’Connor, believed that this demonstrated a “strong desire on the Court’s part to let states regulate health-care delivery.” Suszynski, *supra* note 157. *E.g.*, Hofmann, *supra* note 160 (“[t]he court seems to be sending a very strong signal that the days of expansive ERISA pre-emption are long over”). *But see* Robert W. McCann, MANAGED HEALTHCARE EXECUTIVE, no. 6, vol. 13, at 14, June 1, 2003 (“The ruling marked a turnabout in judicial opinion concerning the states’ ability to regulate health plan operations”).

164. Joseph Beachwood, editor-in-chief of the CALIFORNIA EMPLOYMENT LAW LETTER, referred to the unanimous decision as a “pretty remarkable joke.” Lee, *supra* note 5. While referring to the other ERISA case decided in the 2002-03 term [*The Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003)], Mr. Beachwood said, “[t]he Court decided not to create a rule where there is no statutory or regulatory basis for it.” *Id.*

165. McCann, *supra* note 163. With a test less stringent than McCarran-Ferguson, a law may regulate insurance without necessarily regulating the “business of insurance,” calling into question a variety of state laws that previously had been assumed to be pre-empted. *Id.* McCann proposes that “any state law that might be categorized as regulating operations or dealing with unfair insurance practices is probably up for reconsideration.” *Id.*

166. *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 585-590 (1993) (rejecting the *Frye*

of Appeals first used the “general acceptance” test in *Frye v. United States*.<sup>167</sup> When the FRE came into effect in 1975, the federal courts were divided over *Frye*’s continued validity since the FRE contained a rule concerning the admissibility of scientific expert evidence.<sup>168</sup> In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, the Supreme Court rejected the “general acceptance” test as a precondition for the admissibility of scientific evidence under FRE 702.<sup>169</sup> *Daubert*’s impact was uncertain because the Court had disregarded a familiar test<sup>170</sup> valued for its simplicity in favor of an indeterminate rule and four factors that the court should consider.<sup>171</sup> One school of thought perceived *Daubert* as “open[ing] the courts to scientific evidence that was [previously] excluded under *Frye*,” while another saw it as “bar[ring] evidence that [had] been generally accepted but [now could not] meet the new

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“general acceptance” test for the admissibility of expert testimony). The Supreme Court requires a proponent who proffers a witness as a scientific expert to establish that the witness’ underlying theory or technique qualifies as reliable “scientific . . . knowledge.” *Id.* FRE 702 says:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

Fed. R. Evid. § 702. While not technically a new “test” per se (the FRE had been in force for eighteen years prior to *Daubert*), the Supreme Court reversed seventy years of jurisprudence by removing the “general acceptance” threshold from the federal courts and reinforcing Rule 702 as the only standard for the admissibility of expert scientific evidence. *Id.* This was an abrupt and significant shift in the Court’s jurisprudence on the matter; this is the situation with the new test for when a state law regulates insurance for ERISA purposes. *Id.*

167. *Frye v. United States*, 293 F. 1013, 1014 (D.C. Cir. 1923) (“sufficiently established to have gained general acceptance in the particular field in which it belongs”), *superseded by FRE 702 as stated in Daubert*, 509 U.S. 579 (1993).

168. PAUL C. GIANNELLI, UNDERSTANDING EVIDENCE § 24.04[C] (2003).

169. *Daubert*, 509 U.S. at 597. The Court ultimately found that the “Rules’ permissive backdrop and their inclusion of a specific rule on expert testimony that does not mention ‘general acceptance,’” made the “assertion that the Rules somehow assimilated *Frye*” unconvincing. *Id.* at 589.

170. Most jurisdictions and circuits had followed the *Frye* test for more than half-a-century. ROGER C. PARK, DAVID P. LEONARD, & STEVEN H. GOLDBERG, EVIDENCE LAW § 10.04 (1998) (noting that the *Frye* test dominated admission of and discussion about expert scientific testimony). Not all jurisdictions adopted it, nor did all the judges and commentators support it. *Id.*

171. *See Daubert*, 509 U.S. at 593-94. The courts appreciated the deference that the *Frye* test gave to those educated in the scientific field at issue. PARK, *supra* note 170, § 10.04; David O. Stewart, *A New Test: Decision Creates Uncertain Future for Admissibility of Expert Testimony*, 79 A.B.A. J. 48 (Nov. 1993) (Prof. Edward J. Imwinkelried, University of California at Davis School of Law) (“[o]ne of the reasons *Frye* survived so long . . . is that judges and lawyers were comfortable with it, since it liberated you from having to determine the reliability of scientific evidence”).

'scientific validity' test."<sup>172</sup> Similar ambivalence has appeared after *Miller*.<sup>173</sup>

### *B. Subtle Differences between "Risk Shifting" and "Risk Pooling"*

There are two conceptual schemes related to the definition of insurance: "risk shifting" and "risk pooling."<sup>174</sup> The process of risk transferring or shifting is narrow, covering only those arrangements that affect the risk between the insured and insurer.<sup>175</sup> By transferring risk from the insured to the insurer, the insured's uncertainty is reduced by the knowledge that its economic loss will be restored either in whole or in part.<sup>176</sup> "Risk pooling" deemphasizes the "risk transfer" aspect by focusing on the spreading of the insured's risk with that of similarly exposed individuals.<sup>177</sup> As such, "risk-pooling" is broader concept than "risk spreading."<sup>178</sup>

In *Miller*, the Court specifically chose "risk pooling arrangement" to characterize those relationships under the "insurance" umbrella in which the state would be allowed to regulate.<sup>179</sup> The state law is not

172. Stewart, *supra* note 171. For a general discussion of the cases following *Daubert* and leading up to *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137 (1999), see Leslie Morsek, *Get on Board for the Ride of Your Life! The Ups, Downs, the Twists, and the Turns of the Applicability of the "Gatekeeper" Function to Scientific and Non-Scientific Expert Evidence: Kumho's Expansion of Daubert*, 34 AKRON L. REV. 689 (2001).

173. Mazer, *supra* note 18, at 14 (noting that *Miller* provides little principled guidance to the lower courts); but see Daniel Alter, *Another View of Miller*, 78 FLA. BAR J. 4 (March 2004) (stating that *Miller* does not change the status quo).

174. Bianchi, *supra* note 161; APPLEMAN, *supra* note 15, § 1.3 (discussing risk-sharing as a transfer of risk to others and a distribution of the risk among the others).

175. See *Miller*, 538 U.S. at 342; Bianchi, *supra* note 161.

176. Bianchi, *supra* note 161.

177. *Id.* As a result of the pooling of these many risks, an insured's uncertain risk of loss is reduced. *Id.* See also *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 128 n7, 102 S.Ct. 3002 (1982) ("a number of risks are accepted, some of which involve losses"; "losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it") (internal quotations omitted); *Hollaway v. UNUM Life Ins. Co. of Am.*, 89 P.3d 1022, 1029 (Okla. 2003) (risk pooling groups "those with greater and lesser risks together to better account and minimize the unpredictable risk for everyone" and "results in spreading the cost of risks of loss for which an insurer must pay across the span of insureds").

178. See, e.g., *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1145 (9th Cir. 2003) (noting that "risk pooling" is broader than "risk spreading").

179. *Miller*, 538 U.S. at 338. The petitioners had argued that the AWP laws did not "substantially affect the risk pooling arrangement undertaken by insurer and insured . . . since they [did] not alter or affect the terms of insurance policies, but concern[ed] only the relationship between insureds and third-party providers." *Id.* The Court disagreed, specifically saying that it had "never held that state laws must alter or control the actual terms of insurance policies to be deemed 'laws . . . which regulat[e] insurance' under § 1144(b)(2)(A); it suffices that they substantially affect the risk pooling arrangement between insurer and insured." *Id.*

required to actually spread or transfer risk to be saved from preemption.<sup>180</sup> Instead, the state law need only affect the relationship or the bargain between the insurer and the insured.<sup>181</sup> Given the Court's willingness to find that a state law governing the relationship between the insurer and a third-party affects the risk-pooling arrangement, this standard may not be too difficult to satisfy.<sup>182</sup>

*C. Another Look at the Supreme Court's Savings Clause Philosophy under Pilot Life and Metropolitan Life*

To recognize the jurisprudential change in the savings clause analysis after *Miller*, it is important to see how the Supreme Court initially analyzed state laws under the savings clause.

1. Pilot Life Ins. Co. v. Dedeaux

Mr. Dedeaux's complaint alleged three causes of action, all of which were rooted in common law.<sup>183</sup> The Court noted that the Mississippi Supreme Court recognized punitive damages in contract cases where "the act or omission constituting the breach of the contract amounts also to the commission of a tort."<sup>184</sup> The state supreme court

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

181. *Id.*

182. Crowley, *supra* note 159 ("The Kentucky court has adopted a test so broad as to potentially remove much of the analytical work in determining if a state law falls under the clause"). But see Mazer, *supra* note 18, at 14 (commenting that *Miller*'s second part is equally elastic and opaque, providing little principled guidance). It is not certain whether these laws must affect premium calculations, impose additional obligations on insurers, or prohibit certain insurance practices in order to "affect" risk pooling. *Id.* While this requirement is clearer than the McCarran-Ferguson factors, it is not clear enough to erase the Court's obligation to clarify this prong on a case-by-case basis. Larry J. Pittman, *A Plain Meaning Interpretation of ERISA's Preemption and Savings Clauses: In Support of a State Law Preemption of Section 1132(A) of ERISA's Civil Enforcement Provisions*, 41 S. DIEGO L. REV. 593, 601 (2004).

183. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Mr. Dedeaux alleged tortious breach of contract, breach of fiduciary duties, and fraud in the inducement. *Id.* at 43. He did not assert any of the causes of action provided by ERISA. *Id.* at 44. He sought damages for benefits due, mental and emotional distress, and punitive damages. *Id.* at 43-44.

184. *Id.* at 49 (citing *Hood v. Moffett*, 109 Miss. 757, 767 (Miss. 1915)). This claim is similar to a first-party bad faith claim. The Court noted that the Mississippi Supreme Court relied on its prior common law breach of contract rulings when it upheld awards of punitive damages against insurance companies for failure to pay a claim under an insurance contract. *Id.* (citing *Standard Life Ins. Co. v. Veal*, 354 So. 2d 239 (Miss. 1977)). The Court also noted that the Mississippi Supreme Court had "used the identical formulation" for such claims against insurance companies that it "first stated in [*American Railway Express Co. v. Bailey*, 142 Miss. 622, 631 (Miss. 1915),] of what must 'attend' the breach of contract in order for punitive damages to be recoverable." *Pilot Life*, 481 U.S. at 49-50.

eventually phrased the bad faith claim in relation to the insurance carrier, but it did not limit the availability of punitive damages for breach of contract to only insurance contracts.<sup>185</sup>

The Supreme Court began its analysis using the “common-sense” test,<sup>186</sup> first commenting that a law must be “specifically directed toward the insurance industry,” and “not just have an impact on” it.<sup>187</sup> Even though the law of bad faith in Mississippi was identified with the insurance industry, the Court saw the roots of the law “firmly planted in the general principles of Mississippi tort and contract law.”<sup>188</sup> This led the Court to conclude that the savings clause did not save causes of action based on these principles.<sup>189</sup>

The McCarran-Ferguson factors were not a separate step or element in the Court’s pre-*Miller* analysis,<sup>190</sup> but the Court used them for “reassurance” that Mississippi’s bad faith law did not regulate insurance.<sup>191</sup> There were not that many cases with which the Court could compare the Mississippi claim, so it compared the common law bad faith law to the mandated-benefits law it saved from preemption in *Metropolitan Life*.<sup>192</sup> As the Court’s first interpretation of the savings clause, *Metropolitan Life*’s formulation of a “test” and the Court’s application of that test to a state statute established the benchmark from which all future analyses arose.

185. *Id.* at 50 (citing *Blue Cross & Blue Shield of Miss., Inc. v. Campbell*, 466 So. 2d 833, 842 (Miss. 1984)) (“[w]e have come to term an insurance carrier which refuses to pay a claim when there is no reasonably arguable basis to deny it as acting in ‘bad faith,’ and a lawsuit based upon such an arbitrary refusal as a ‘bad faith’ cause of action”). This bolstered the Court’s view that the common law roots of the bad faith law could not be ignored. *Id.*

186. *See Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985) (common-sense view of the language of the saving clause itself provides guidance as to whether a state law falls under the saving clause).

187. *Pilot Life*, 481 U.S. at 51. The first step in the new test propounded by the *Miller* Court also includes the “specifically directed” language. *Miller*, 538 U.S. at 334. In *Miller*, the Court cited *Pilot Life* for this proposition. *Id.*

188. *Pilot Life*, 481 U.S. at 51. The Court also noted that “[a]ny breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.” *Id.*

189. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987).

190. In various cases, the McCarran-Ferguson factors have been used as “considerations [to be] weighed” in determining whether a state law falls under the savings clause, *Miller*, 538 U.S. at 341 (citing *Pilot Life*, 481 U.S. at 49), “checking points” used after determining whether the state law regulates insurance from a “common-sense” understanding, *id.* (citing *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 374 (1999)), and “guideposts” to “confirm [the Court’s] conclusion, *id.* (citing *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 373 (2002)).

191. *Pilot Life*, 481 U.S. at 50 (“[n]either do the McCarran-Ferguson Act factors support the assertion that the Mississippi law of bad faith ‘regulates insurance’”).

192. *Pilot Life*, 481 U.S. at 50-51 (citing *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985)).

## 2. Metropolitan Life Ins. Co. v. Massachusetts

A Massachusetts statute required insurance carriers to provide specified minimum mental-health-care benefits to its residents.<sup>193</sup> Throughout its opinion, the Court consistently referred to the statute and the “substantive terms” of insurance contracts,<sup>194</sup> initially noting that states subject group health insurance to extensive regulation.<sup>195</sup> The Court felt that “[m]andated-benefit laws,” which “require an insurer to provide a certain kind of benefit to cover a specified illness or procedure whenever someone purchases a certain kind of insurance, are a subclass of such content regulation.”<sup>196</sup> Massachusetts’ law also met all three of the McCarran-Ferguson factors: it regulated the spreading of risk,<sup>197</sup> it regulated an integral part of the relationship between the insurer and the policyholder,<sup>198</sup> and it was limited to entities within the insurance

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193. *Metropolitan Life*, 471 U.S. at 727.

194. *Id.* at 726-28.

195. *Id.* at 727-28. Categorizing the types of state regulation of group insurance as “regulation of the carrier, regulation of the sale and advertising of the insurance, and regulation of the content of the contracts,” *id.*, the Court noted the three varieties of common insurer regulations: solvency or the qualification of management, aspects of transacting the business of group insurance (including claim practices or rates), and content of group policies. *Id.* at 728 n.2.

196. *Id.* at 728. The Court rejected Metropolitan Life’s contention that laws that regulate the substantive terms of insurance contracts are health laws, not insurance laws, disagreeing on two counts. *Id.* at 741-42. First, this distinction reads the saving clause out of ERISA entirely, “because laws that regulate only the insurer, or the way in which it may sell insurance, do not ‘relate to’ benefit plans.” *Id.* at 741. Since they would not be preempted by ERISA § 514(a), there would be no reason for the saving clause to “save” them. *Id.* Second, Congress gave no indication that the saving clause was to be read broadly so as “to guard against too expansive readings of the general pre-emption clause that might have included laws wholly unrelated to plans,” *e.g.*, laws that do not “relate to” benefit plans. *Id.* at 741-42. The Court cited seven cases to support the statement that “nearly every court that has addressed the question has concluded that laws regulating the substantive content of insurance contracts are laws that regulate insurance and thus are within the scope of the insurance saving clause.” *Id.* at 742 n.18.

197. *Id.* at 743 (mandated-benefit law was “intended to effectuate the legislative judgment that the risk of mental-health care should be shared”). Massachusetts wanted to protect it and its working citizens from the high cost of treatment for mental illness, recognizing that “the voluntary insurance market was not adequately providing mental-health coverage, because of ‘adverse selection’ in mental-health insurance.” *Id.* at 731. Adverse selection occurs when the people who sign up for an insurance plan have costs that are greater than the expected costs that the insurance plan used to calculate the premium. *Adverse Selection and Cream Skimming* (2002), available at <http://www.healthinsurance.info/HISEL.HTM>. Massachusetts also wanted to correct the insurance market “by mandating minimum-coverage levels, effectively forcing the good-risk individuals to become part of the risk pool, and enabling insurers to price the insurance at an average market rather than a market retracted due to adverse selection.” *Metropolitan Life*, 471 U.S. at 743.

198. *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 743 (1985) (“[i]t is also evident that mandated-benefit laws directly regulate an integral part of the relationship between the insurer and the policyholder by limiting the type of insurance that an insurer may sell to the policyholder”).

industry.<sup>199</sup> Thus, the mandated-benefit laws were saved from ERISA preemption.<sup>200</sup>

### 3. The Substantial Burden of *Metropolitan Life*

The lingering effects of *Metropolitan Life* and its almost-redundant emphasis on “substantive terms” appear in the Court’s analysis in *Pilot Life*.<sup>201</sup> The Court clearly analogizes Mississippi’s common law bad faith claim to Massachusetts’ mandated-benefits law.<sup>202</sup> The bad faith law stood no chance of survival when compared to a strong and “obvious” state law that regulated insurance by regulating the substantive terms of an insurance contract.<sup>203</sup>

Massachusetts set out to force insurance carriers to carry individuals that they would not otherwise carry, and in the end, everyone’s premiums were affected.<sup>204</sup> Mississippi’s common law certainly did not “effect a spreading of policyholder risk” by forcing adverse selection on insurers.<sup>205</sup> Contrasting the bad faith law to the mandated-benefits law, the Court specifically said that the “common law of bad faith does not *define the terms* of the relationship between the insurer and the insured.”<sup>206</sup> Instead, the Court characterized the law as one that provides punitive damages in certain circumstances for breach of an insurance contract, regardless of whatever terms the parties may have agreed upon in that contract.<sup>207</sup>

The rest of the opinion merely emphasizes that the Court was looking at the bad faith law as one concerned mainly with remedies and not the actual relationship between the parties.<sup>208</sup> Instead of relying upon the “factors by which [they] were guided in *Metropolitan Life*” as the sole interpretation of the savings clause, the Court felt obliged to

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199. *Id.* at 743 (the mandated-benefit statutes impose requirements only on insurers). Here, the Court added that the mandated-benefit laws had “the *intent of affecting* the relationship between the insurer and the policyholder.” *Id.*

200. *Id.* at 758.

201. *See Pilot Life*, 481 U.S. at 51.

202. *Id.* (“Unlike the mandated-benefits law at issue in *Metropolitan Life*,” and “[i]n contrast to the mandated-benefits law in *Metropolitan Life*”).

203. *See Metropolitan Life*, 471 U.S. at 740 (“[t]o state the obvious, [the mandated-benefit law] regulates the terms of certain insurance contracts”).

204. *See id.* at 731.

205. *Pilot Life*, 481 U.S. at 50. The Court also found the connection to the insurer-insured relationship “attenuated at best.” *Id.* at 51.

206. *Id.* at 51 (emphasis added).

207. *Id.*

208. *Id.* at 52-56 (discussing the exclusive remedies in § 502 that ERISA provides to plan participants).

place the savings clause in the context of ERISA as a whole.<sup>209</sup> Once again, the state cause of action is cast as one seeking “remedies for the improper processing of a claim for benefits under an ERISA-regulated plan.”<sup>210</sup> From this discussion of ERISA’s civil enforcement provisions flows the concept of complete preemption.<sup>211</sup>

*D. What Remains after Miller’s Rebottling of the “Savings” Analysis?*

What emerges from *Metropolitan Life* and *Pilot Life* is the conclusion that the regulation of the substantive terms of an insurance contract—a true spreading of the risk—was part-and-parcel to the preemption analysis using the McCarran-Ferguson factors.<sup>212</sup> As discussed above, the Court decided both of these cases with this emphasis in mind.<sup>213</sup> Those courts that relied on *Pilot Life* for the precedent that ERISA preempts *any* bad faith claim against an employee benefit plan failed to recognize that the Court has moved away from reliance on the McCarran-Ferguson factors’ emphasis on the substantive terms of the contract.<sup>214</sup> In fact, the Court expressly rebuked the position

209. *Id.* at 51 (“We are obliged in interpreting the saving clause to consider not only the factors by which we were guided in *Metropolitan Life*, but also the role of the saving clause in ERISA as a whole”).

210. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (“Our understanding of the saving clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)”).

211. See text *supra* § II(A)(2)(a). 29 U.S.C. § 1132(a) (2000). When analyzing state bad faith claims against ERISA providers, some district courts, before *Davila*, viewed the preemption and savings clause analysis as superfluous, since they followed *Pilot Life*’s analysis that state bad faith statutes will be completely preempted for providing an extra remedy.

212. See *Miller*, 538 U.S. at 338-39.

213. See text *supra* § IV(C) and notes 183-211.

214. While the proposition that the Court is moving away from this dependence on the substantive terms of the contract finds support in Justice Scalia’s opinion, the oral argument would appear to give a contrary impression. Transcript, U.S.S. Ct. (No. 00-1471), *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), available at 2003 WL 145394. Oral arguments began with Justices Souter and Scalia focusing on the AWP law’s practical effect on the policy:

MR. ECCLES: [They] change the network, that’s correct, Your Honor. [They] potentially change the network. The law itself creates no change. If the provider elects to join the network, and is willing to accept the terms—

QUESTION: But isn’t that a change in the policy? Doesn’t it give the patient a right he otherwise would not have?

...

QUESTION: Well, there’s nothing in the policy term that is changed [in] the literal sense of a change in language, but it seems to me that it does mean that under a policy subject to a law like Kentucky’s the person who joins the HMO, in effect the person who obtains the insurance, has a far greater choice, [in] the expenditure of benefits under the policy than he otherwise has. He’s getting something under a policy subject to the [Kentucky] law, that he does not get under a policy without that law, and that is a breadth of choice



that “state laws must alter or control the actual terms of insurance policies to be deemed ‘laws . . . which regulat[e] insurance’ under § 1144(b)(2)(A).”<sup>215</sup> Rather than look to the terms of the policy, the Court turned to the agreement between the parties, emphasizing that the “AWP laws alter[ed] the scope of permissible bargains between insurers and insureds.”<sup>216</sup>

The Court removed from the new analysis any consideration of whether the state law in question forms an integral part of the insurance policy.<sup>217</sup> The Court also recast the mandated-benefits law from *Metropolitan Life* in this light.<sup>218</sup> It rationalized the notice-prejudice rule from *Ward*<sup>219</sup> by saying that that rule “govern[ed] whether or not an

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about who is going to treat him.

...

QUESTION: . . . [e]ven if nobody elected to join, what has happened by reason of this law, is it not the case that the term of the policy is changed, that originally the policy said, we will pay for your treatment by a limited number of individuals whom—whom we—whom we approve, and that policy is now changed to, by reason of this law, we will pay for your treatment by any individuals who want to join our plan. Isn’t—isn’t that a different policy?

...

QUESTION: It’s not rewritten, but doesn’t the law . . . effectively change the term of the policy?

Transcript, at \*6-\*8. Later in the argument, the justices’ perspective on the matter became very apparent:

QUESTION: I hear you, I just don’t see that—that you—you make much headway in saying that isn’t a change.

...

QUESTION: I don’t—you—you’re really asserting that—that two insurance policies are exactly the same, their terms haven’t changed, or their terms aren’t different, where one says you can get your automobile fixed by these companies, blah, blah, blah, blah, blah, and the other one says, we will pay to get your automobile fixed by any company that is willing to do the job up to our standards, and—and you think those two insurance policies are saying exactly the same thing, that there’s only a hypothetical difference between the two.

*Id.* at \*12-\*13.

215. *Ky. Ass’n of Health Plans, Inc., v. Miller*, 538 U.S. 329, 338 (2003). Instead, the Court held that “it suffices that they substantially affect the risk pooling arrangement between insurer and insured.” *Id.* See *Kidneigh v. UNUM Life Ins. Co. of America*, 345 F.3d 1182, 1197 (10th Cir. 2003) (Henry, J., concurring in part, dissenting in part) (“*Miller*, in contrast [to Mississippi’s common law of bad faith], specifically disavowed the McCarran-Ferguson factors, including the test of ‘whether the practice has the effect of transferring or spreading a policyholder’s risk,’ the test relied on in *Pilot Life*”).

216. *Miller*, 538 U.S. at 338-39.

217. Horst & Rosenberg, *supra* note 20, at 41.

218. *Miller*, 538 U.S. at 338-39. The court also found the effect of the AWP laws similar to the notice-prejudice rule in *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999), and the independent-review provisions in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), both of which were saved from preemption. *Miller*, 538 U.S. at 340.

219. *Ward*, 526 U.S. at 358 (saving California’s notice-prejudice rule from preemption).

insurance company must cover claims submitted late, which dictate[ed] to the insurance company the *conditions* under which it *must pay* for the risk it has assumed.”<sup>220</sup> This, the Court felt, “certainly qualifie[d] [it] as a substantial effect on the risk pooling arrangement between the insurer and insured.”<sup>221</sup>

Though it appears that *Davila* foreclosed any further discussion of bad faith claims, the state laws upon which those claims were based provide an illustration of how *Miller*'s analysis is substantively different from the previous test.<sup>222</sup> If the *Miller* Court was correct when it said that it had “never held that the McCarran-Ferguson factors [were] an essential component of the” savings clause inquiry,<sup>223</sup> then the analysis in *Pilot Life*, which analyzed the common law bad faith claim in comparison to the mandated-benefit law, should have been limited to common law bad faith claims.<sup>224</sup> *Pilot Life*'s holding should also have been reexamined given that *Miller* expressly disavowed the McCarran-Ferguson factors that the Court in *Pilot Life* relied upon to find the bad faith claim preempted.<sup>225</sup> For the courts, this should have meant that

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220. *Miller*, 538 U.S. at 339 n.3 (emphasis added).

221. *Id.* One of the arguments in favor of saving bad faith laws was that they, too, dictated to the insurance company the conditions under which the insurance company *must pay* for the risk that the insurance company assumed. See *Kidneigh*, 345 F.3d at 1198 (Henry, J., concurring in part, dissenting in part) (Colorado bad faith statute “changes the conditions under which an insurer will ‘pay for the risk that it has assumed,’ by making the law decisively clear that the risk of nonperformance in settlement negotiations lies with the insurer”); *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1145 (9th Cir. 2003) (noting that “it is entirely plausible to find that the [Montana unfair trade practices act] allocates risk ‘by obligating insurers to make advance payments before the duty to indemnify under the policy is triggered’ and ‘by requiring insurers to pay excess judgments against their insureds’ in the case of a[n unfair trade practices act] violation”). *Davila* never addressed the savings clause aspect of preemption but held Texas’ patient rights statute preempted based on the theory of complete preemption. *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2493, 159 L.Ed. 2d 312 (2004).

222. Even before *Davila* was decided, some commentators, while acknowledging that *Miller* was different from common sense and McCarran-Ferguson, believed that *Miller* continued to preempt bad faith laws. Horst & Rosenberg, *supra* note 20, at 38-42.

223. *Ky. Ass'n of Health Plans, Inc., v. Miller*, 538 U.S. 329, 341 (2003).

224. The *Miller* Court characterized *Pilot Life*'s inquiry as: “whether Mississippi’s *law of bad faith* has the effect of transferring or spreading the risk, whether *that law* is integral to the insurer-insured relationship, and whether *that law* is limited to the insurance industry.” *Miller*, 538 U.S. at 340-41 (emphasis in original) (citations omitted). It is interesting to note that the *Pilot Life* Court did not use the word “transfer” in its decision, but used “spreading” instead. *Pilot Life*, 481 U.S. at 50 (“the Mississippi common law of bad faith does not effect a *spreading* of policyholder risk”) (emphasis added).

225. Mazer, *supra* note 18, at 10. See *Miller*, 538 U.S. at 341 (“We make a clean break from the McCarran-Ferguson factors”). See also Eric P. Weitz, *Does ERISA Still Pre-empt Bad Faith Claims?*, THE LEGAL INTELLIGENCER, Apr. 28, 2003, at 5, available at LEXIS, Legal News, LGINT. In *Metropolitan Life*, the Court stated that “the saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States.”

they needed to evaluate all state laws, including bad faith statutes, under the new test, instead of basing their decisions on *Pilot Life*'s weakened holding or the disavowed McCarran-Ferguson factors.<sup>226</sup> But one term later, the Supreme Court failed to even cite *Miller* in its *Davila* decision.<sup>227</sup>

#### E. *Miller Breaks Away*

An important difference between *Pilot Life* and *Miller* is the type of impact that the Court required the state law to impart upon the risk. In *Pilot Life*, the common law of bad faith did “not *effect a spreading of policyholder risk.*”<sup>228</sup> In contrast, Kentucky's AWP law needed only to “*substantially affect the risk pooling arrangement between the insurer and the insured.*”<sup>229</sup> As shown below, the syntax in both decisions, while

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*Metropolitan Life*, 471 U.S. at 744 n.21. The *Miller* Court rejected this premise, saying, “ERISA’s savings clause, however, is not concerned (as is the McCarran-Ferguson Act provision) with how to characterize *conduct* undertaken by private actors, but with how to characterize *state laws* in regard to what they ‘regulate.’” *Miller*, 538 U.S. at 337 (emphasis in original). Where the McCarran-Ferguson Act “concern[ed] itself with whether certain practices constitute[d] ‘[t]he business of insurance,’ or whether a state law was ‘enacted . . . for the purpose of regulating the business of insurance,’ [the savings clause] asks merely whether a state law is a ‘law . . . which regulates insurance, banking, or securities.’” *Id.* at 340. With regard to the “similar language” claim in *Metropolitan Life*, the *Miller* Court stated that “the statutory language of [the savings clause] differs substantially from that of the McCarran-Ferguson Act.” *Id.* The Third Circuit, in a post-*Davila* decision, found the Supreme Court’s analysis in *Pilot Life* instructive and still valid on the point that the “common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever the terms have been agreed upon in the insurance contract, a breach of that contract may in certain circumstances allow the policyholder to obtain punitive damages.” *Barber v. UNUM Life Ins. Co. of Am.*, 383 F.3d 134, 143 n.12 (3d. Cir. 2004) (citing *Pilot Life*, 481 U.S. at 49-51).

226. Mazer, *supra* note 18, at 14 (suggesting that the extension of *Pilot Life* to bad faith statutes in state insurance codes fails to meaningfully address whether a particular state law is specifically directed at the insurance industry, much less whether it regulates insurance); Horst & Rosenberg, *supra* note 20, at 40 (commenting that *Miller* will require courts to approach the preemption issue from a different perspective by focusing on the risk pooling arrangement). Horst and Rosenberg note that before *Miller*, most courts sidestepped the issue of whether bad faith laws substantially affected the risk pooling arrangement between an insurer and insured. *Id.* Instead, these courts focused on whether the bad faith cause of action became an integral part of the insurance policy. *Id.* After *Miller*, some courts analyzed whether the state bad faith law substantially affected the risk pooling arrangement in essentially the same manner as they had analyzed the “integral part of the policy relationship” factor. *Id.* at 41. See also *Kidneigh*, 345 F.3d at 1182.

227. *Aetna Health Inc. v. Davila*, 124 S.Ct. 2488 (holding state causes of action against HMOs for negligence completely preempted). See Horst & Rosenberg, *supra* note 20 (noting that any mention of *Miller* was conspicuously absent from *Davila*).

228. *Pilot Life*, 481 U.S. at 50 (emphasis added).

229. *Miller*, 538 U.S. at 342 (emphasis added). The Court specifically noted that they “have never held that state laws must alter or control the actual terms of insurance policies to be deemed ‘laws . . . which regulat[e] insurance’ under § 1144(b)(2)(A).” *Id.* at 338.

subtle, further demonstrates the Court's concerted retreat from the strictness of *Metropolitan Life* and the McCarran-Ferguson factors.<sup>230</sup>

A critical aspect of the McCarran-Ferguson factors was the first factor: whether the practice has the *effect* of transferring or spreading a policyholder's risk.<sup>231</sup> The word "effect" is a noun, meaning "something accomplished, caused, or produced; a result, consequence."<sup>232</sup> In the context of the McCarran-Ferguson factor, this means that the transferring or spreading of the policyholder's risk is the result or consequence of the state law.<sup>233</sup> Unless the risk is transferred or spread, the law did not regulate insurance.<sup>234</sup> On the other hand, the word "affect" is a verb, meaning "to have an influence on or effect a change."<sup>235</sup> This requires one to ask whether the subject influenced the decision, and in the context of the savings clause, whether the state law substantially influences "the risk pooling arrangement between the insurer and the insured."<sup>236</sup> Whether they are used as verbs or nouns, "affect" and "effect" have subtle differences that play an important role in understanding the Court's gradual shift from—and now break with—the narrow confines of the McCarran-Ferguson Act.<sup>237</sup>

It is not difficult to say that the mandated-benefits or AWP laws changed the substantive terms of the insurance contracts at issue, but it is harder to prove that a law influenced the decision-maker without looking to the result. By moving away from the McCarran-Ferguson factors and introducing a new test, the Court has signaled that it no longer focuses solely on whether the contract terms have changed, but whether the *law* "substantially affects the risk pooling arrangement between the insurer

230. See text § IV(E), *infra* and notes 228-45.

231. *Metropolitan Life*, 471 U.S. at 743 (emphasis added).

232. 5 THE OXFORD ENGLISH DICTIONARY 78 (2d ed. 1989). In the collective and abstract, "effect" refers to the "results in general," *id.*, as well as "a contemplated result, a purpose," *id.* at 79. "Effect" may also be a verb, meaning "to bring about (an event, a result); to accomplish (an intention, a desire)." *Id.* at 79.

233. See, e.g., *Metropolitan Life*, 471 U.S. at 743.

234. See, e.g., *id.* at 742-44.

235. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE (4th ed. 2000).

236. *Miller*, 538 U.S. at 342.

237. Compare the following sentences, which distinguish the two. Affect: *The boss's attitude affected the efficiency of the employees; The weather should not affect our plans, as billiards is played indoors.* LAURENCE URDANG, THE DICTIONARY OF CONFUSABLE WORDS 12 (1998). Effect: *The arbitrator effected a compromise; We easily effected the changeover from electric to gas heat.* *Id.* As these examples make clear, "effect" looks to the end product. The arbitrator produced a compromise just as the mandated-benefits law produced a change in the policy terms; the arbitrator may have influenced the parties to compromise, but in the end, a compromise was reached. "Using *affect* (= to influence) for *effect* (= to bring about) is an old error." BRYAN A. GARNER, A DICTIONARY OF MODERN AMERICAN USAGE 24 (1998).

and the insured.”<sup>238</sup> *Miller* does not ask, nor does it require, that the state law regulate the substantive terms of the contract.<sup>239</sup> Nor must the state law actually spread risk.<sup>240</sup> Instead, the emphasis is on the risk pooling arrangement,<sup>241</sup> which is conceptually different from the ink and paper constraints of the written policy terms.

For many district courts, *Miller* did little to change how they interpreted bad faith claims. Some hardly analyzed these claims using the new test,<sup>242</sup> and many simply failed to appreciate the differences

238. *Miller*, 538 U.S. at 342; Horst & Rosenberg, *supra* note 20, at 40 (noting that *Miller* removes any consideration of whether the state law forms an integral part of the insurance policy from the new analysis). *E.g.*, Rosenbaum v. UNUM Life Ins. Co. of America, No. 01-6758, 2003 WL 22078557 (E.D. Pa., Sept. 8, 2003) (second part of the *Miller* test “differs significantly from the first of the McCarran-Ferguson factors which asks ‘whether the [law] has the effect of transferring or spreading a policyholder’s risk’”). *See* Mazer, *supra* note 18, at 14 (suggesting that later higher authority has eclipsed prior decisions that held state bad faith statutes preempted under *Pilot Life*); *contra* Alter, *supra* note 173, at 4 (refuting Mazer’s conclusion that the *Miller* test opens the door to state law regulation of ERISA plan insurers); Gregory Primstone and Michele Johnson, Rush Prudential: *Savior of Pilot Life?*, 15 HEALTH LAWYER 7, 8 (2002) (*Rush Prudential* reaffirms *Pilot Life*).

239. *Miller*, 538 U.S. at 338 (“[w]e have never held that state laws must alter or control the actual terms of insurance policies to be deemed ‘laws . . . which regulat[e] insurance’ under § 1144(b)(2)(A)”).

240. Ky. Ass’n of Health Plans, Inc., v. Miller, 538 U.S. 329, 339 n.3 (2003). The Court noted that the Ninth Circuit, in *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939, 945-946 (9th Cir. 1998), *aff’d in part, rev’d and remanded in part*, UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999), held that California’s notice-prejudice rule did not spread the policyholder’s risk within the meaning of the first McCarran-Ferguson factor. *Miller*, 538 U.S. at 339 n.3. But in *Miller*, the Court held that notice-prejudice rule would satisfy the new two-pronged test, stating that the new test only requires “that the state law substantially affect the risk pooling arrangement between the insurer and insured.” *Id.* (emphasis in original).

241. *Miller*, 538 U.S. at 342. There are three categories of state laws that should satisfy the “substantially affect the risk pooling arrangement requirement.” Pittman, *supra* note 182, at 601. First, those laws that have a “substantial impact on insurers’ and insureds’ abilities to negotiate for different types of insurance arrangements than the one that the state law mandates.” *Id.* Second, the state law could mandate the terms and conditions of insurance arrangements. *Id.* Third, because they limit the types of insurance arrangements into which insurers and insureds can enter, *id.* at 601 n.24, those state laws that “impose utilization review requirements, establish external review obligations, mandate other procedures and conditions on the types of benefits that insurers must offer the insured, and regulate the manner in which insurers must provide medical benefits” would also satisfy the second prong. *Id.* at 601.

242. Mazer, *supra* note 18, at 14 (noting that most courts that have addressed the issue of risk-spreading with regard to a state law have favored conclusion over analysis). *See* Revells v. Metropolitan Life Ins. Co., 261 F. Supp. 2d 1359, 1366 (M.D. Al. 2003). The state statute in *Davila*, which affects medical decision-making, affects risk spreading, and, therefore, it may be “possible that a statute like the Texas law could be used to discipline the decision-making of ERISA plans.” McLean & Richards, *supra* note 20 (noting that because *Davila* did not address *Miller*, “the extent of the state power to regulate ERISA plans run by third-party administrators remains in limbo”). *Cf.* Barber v. UNUM Life Ins. Co. of Am., 383 F.3d 134, 143 n.11 (3d Cir. 2004) (*Miller* “demands more than whether a law substantially affects the insurance arrangements between the insurer and

between the common sense-McCarran-Ferguson test and the *Miller* test.<sup>243</sup> Some courts simply skipped over the “regulates insurance” step, using complete preemption to deny bad faith claims against employee benefit plans.<sup>244</sup> While this approach to bad faith may have been vindicated by *Davila*,<sup>245</sup> those courts neglected the Supreme Court’s

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insured”) (emphasis in original).

243. *E.g.*, *Dolce v. Hercules Inc. Ins. Plan*, No. COV/A/03-CV-1747, 2003 WL 22992148 (E.D. Pa. Dec. 15, 2003) (equating the first McCarran-Ferguson factor to the second part of the *Miller* test in a parenthetical) (“examining Pennsylvania’s bad faith statute under the then applicable first McCarran-Ferguson factor, which is virtually identical to the second prong of the *Miller* test). *Cf.* *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1143 (9th Cir. 2003) (“[b]ecause of the similarities between the *Metropolitan Life* and *Kentucky Association* approaches, it is well worth considering the substantial body of case law applying the older test”). *But see Allison v. UNUM Life Ins. Co. of Am.*, 381 F.3d 1015, 1027 (10th Cir. 2004) (“we must now determine if the recent decision in *Miller* has somehow affected its prior analysis of whether Oklahoma’s bad faith law regulated insurance within the meaning of ERISA’s savings clause preemption provision”). In *Allison*, the Tenth Circuit held that Oklahoma’s bad faith law met the first prong of *Miller*’s test, but decided that since the law did not “affect the substantive terms of the insurance contract,” the law did not meet the second prong of *Miller*. *Id.* at 1027-28.

244. *Kidneigh*, 345 F.3d at 1185-86 (holding that “Colorado bad faith claims are preempted by ERISA because they conflict with ERISA’s remedial scheme,” and in the alternative that such claims do “not fall within ERISA’s savings clause, and as such [are] expressly preempted); *Elliot*, 337 F.3d at 1147 (“[b]ecause the present case ‘involve[s] the sort of additional claim or remedy exemplified in *Pilot Life*,’ it falls within § 1132 preemption”); *Bonnell v. Bank of America*, 284 F. Supp. 2d 1284, 1288 (D. Kan. 2003) (“[t]he court is not inclined to engage in a detailed analysis of whether the Kentucky Act regulates insurance within the meaning of ERISA’s savings clause under the new legal standard announced in *Miller*, . . . when it is patently clear that, *regardless of the outcome* of that inquiry, plaintiff’s claims under the Kentucky Act are conflict preempted under a well-established body of case law that dates back to 1987 [*Pilot Life*].”) (emphasis added).

The Eastern District of Pennsylvania exemplified the disparity between the analyses in these cases that were written by the different judges within the district. One judge in particular, Judge Clarence C. Newcomer, has painstakingly analyzed Pennsylvania’s statute prior to, *Booz v. UNUM Life Ins. Co.*, No. Civ. A. 93-2326, 1993 WL 313372 (E.D. Pa. July 29, 1993) (holding a claim made under Pennsylvania’s bad faith statute to be preempted by ERISA), and immediately following, *Rosenbaum v. UNUM Life Ins. Co.*, No. 01-6758, 2003 WL 22078557 (E.D. Pa. Sep. 08, 2003), *Miller*. Judge Newcomer recognized that nine other Eastern District judges ruled contrary to his position in a 2002 decision in the *Rosenbaum* case. *Id.* at \*3-\*4. Beyond his own analysis, Judge Newcomer also pointed out what he perceived to be the flaws in those other decisions. *Id.* at \*7-\*18. Over the course of ten years and a handful of Supreme Court ERISA decisions, Judge Newcomer has reversed his analysis from finding preemption, *Booz, supra* (holding a claim made under Pennsylvania’s bad faith statute to be preempted by ERISA), to now finding “savings,” *Rosenbaum, supra* (saving Pennsylvania’s bad faith statute from ERISA preemption while applying the *Miller* test). In *Rosenbaum*, Judge Newcomer rejected the analysis of two contrary cases, saying that, “[w]hile both of these cases correctly recite the second prong of the *Miller* test, neither actually applies the standard as presented by *Miller*. Rather, both revert to the very different standard provided in the first of the McCarran-Ferguson factors.” *Rosenbaum*, 2003 WL 22078557, at \*5.

245. *Davila*, 124 S. Ct. at 2493 (holding state causes of action against HMOs for negligence completely preempted). *But see Barber v. UNUM Life Ins. Co. of Am.*, 383 F.3d 134, 144 (3d Cir. 2004) (holding that the risk of punitive damages is too attenuated to be deemed to substantially affect the risk pooling arrangement).

shift in savings clause jurisprudence.

#### V. CONCLUSION

The McCarran-Ferguson Act codified the rights of the states to regulate the insurance industry while ERISA stripped the states of any ability to regulate employee benefit plans. Despite the different philosophy in the two pieces of legislation, the Supreme Court borrowed the test for state insurance regulation and adapted it for employee benefit plan regulation. Thus, the McCarran-Ferguson factors, which were created to protect states' rights to regulate insurance, were being used to deny states the right to regulate employee benefit plans. *Miller* changed this uneasy and uncomfortable dichotomy by finally giving ERISA its own test, one that is free from the constraints of a competitive history and also substantively different from its predecessor. It is not just a new label with the same old result.

*Matthew G. Vansuch*