ERISA PREEMPTION OF STATE MANDATED-PROVIDER LAWS

The Employee Retirement Income Security Act of 1974[1] ("ERISA" or "the Act") is a comprehensive federal statute which imposes minimum standards on employee benefit plans. To prevent conflicting state regulation, ERISA preempts state laws which "relate to" these plans.[2] ERISA's preemption, however, is not complete. Consistent with the federal policy embodied in the McCarran-Ferguson Act[3] of leaving the regulation of insurance to the states, Congress saved from ERISA preemption any state law which regulates "insurance."[4]

States have enacted legislation that requires insurers to pay for the services of a particular type of health care provider, even if the terms of the policy specify that payment will be made only to another type of provider.[5] These "mandated-provider" laws, as they are called,[6] "relate to" employee benefit plans because they change the terms of the insurance policies purchased by these plans.[7] Thus, unless mandated-provider laws regulate "insurance," such laws are preempted by ERISA as applied to employee benefit plans. The question whether mandated-provider laws are laws that regulate "insurance" is important because of the prevalence of such statutes,[8] the large number of individuals covered by in-

1. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (1982)) [hereinafter cited as ERISA].

2. *Id.* § 514(a), 29 U.S.C. § 1144(a).

3. Ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (1982)).

4. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982).

5. *See infra* notes 29-30 and accompanying text.

6. Mandated-provider laws are also referred to as "freedom-of-choice" laws, and "antidiscrimination" laws. Chupack, *Preferred Provider Organizations,* 6 AM. C. SURGEONS BULL. 36, 36 (1984). Although the term "mandated-provider laws," as used in this note, refers specifically to laws that require insurers to reimburse certain types of health practitioners, the analysis presented here is equally applicable to laws that require insurers to reimburse certain providers of other kinds of policy benefits, such as legal services. *See infra* note 47.

7. *See infra* text accompanying note 36 and note 52.

8. Mandated-provider laws regulating health insurance policies have been adopted in nearly every state. *See* ALA. CODE § 27-1-10 (1975) (chiropractors); *id.* § 27-1-11 (dentists); *id.* § 27-19-39 (optometrists); *id.* § 27-1-15 (Supp. 1985) (podiatrists); *id.* § 27-1-18 (Supp. 1985) (psychologists and psychiatrists); ALASKA STAT. § 21.42.355 (1984) (nurse midwives); *id.* § 21.89.040 (optometrists); ARIZ. REV. STAT. ANN. § 20-1406 (1975 & Supp. 1985) (optometrists, opthalmologists, podiatrists, nurse practitioners, and licensed providers); *id.* § 20-1406.01 (Supp. 1985) (psychologists and chiropractors); ARK. STAT. ANN. § 66-3212.2 (1980) (optometrists); *id.* § 66-3212.4 (podiatrists); *id.* § 66-3212.6 (psychologists); *id.* § 66-3212.8 (Supp. 1985) (dentists); CAL. INS. CODE § 10176 (West 1972 & Supp. 1986) (psychologists, social workers, counselors, speech pathologists, audiologists, registered nurses, psychiatric mental health nurses, chiropractors, dentists, podiatrists, opticians,

surance plans, and the significant effect such statutes have on the

optometrists, and occupational therapists); *id.* § 10176.2 (physical therapists); COLO. REV. STAT. § 10-8-103(3)(a) (1973) (osteopaths, dentists, optometrists, psychologists, chiropractors, and podiatrists); CONN. GEN. STAT. ANN. § 38-174d (West Supp. 1985) (psychologists, psychiatrists, and social workers for child guidance clinics); *id.* § 38-174h (dentists); *id.* § 38-174q (occupational therapists); *id.* § 38-174v (nurse midwives, nurse practitioners, and psychiatric mental health clinical nurse specialists); DEL. CODE ANN. tit. 24, § 2101(c) (1981) (optometrists); *id.* § 511 (Supp. 1984) (podiatrists); *id.* § 717 (chiropractors) (Supp. 1984); FLA. STAT. ANN. § 627.419 (West 1984) (dentists, optometrists, and podiatrists); *id.* § 627.6406 (nurse midwives); GA. CODE ANN. § 33-24-27(b) (1982) (psychologists and chiropractors); *id.* § 33-24-27.1 (optometrists); HAWAII REV. STAT. § 431-450 (1976) (optometrists); *id.* § 431-499 (dentists); *id.* § 431-500 (Supp. 1984) (psychologists); IDAHO CODE § 41-2103 (1977) (podiatrists and optometrists); ILL. ANN. STAT. ch. 73, § 364 (Smith-Hurd Supp. 1985) (dentists); *id.* § 370b (osteopaths and chiropractors); *id.* § 370c (psychologists); IND. CODE ANN. § 27-8-6-1 (Burns 1975 & Supp. 1985) (dentists, health service providers in psychology, podiatrists, osteopaths, optometrists, and chiropractors); IOWA CODE ANN. §§ 509.3, 514.7 (West Supp. 1985) (optometrists); KAN. STAT. ANN. § 40-2,100 (1981) (optometrists, dentists, and podiatrists); *id.* § 40-2,104 (psychologists); KY. REV. STAT. § 304.18-095 (1981) (optometrists and osteopaths); *id.* § 304.18-097 (dentists); LA. REV. STAT. ANN. § 22:662 (West 1978) (podiatrists); *id.* § 22:664 (optometrists); *id.* § 22:665 (psychologists); *id.* § 22:668 (chiropractors); *id.* § 22:213.1 (West Supp. 1985) (dentists); *id.* § 22:669 (social workers) (West Supp. 1985); ME. REV. STAT. ANN. tit. 24-A, § 2744 (1985) (psychologists, social workers, and psychiatric nurses); MD. ANN. CODE art. 48A, § 490 (1979) (podiatrists); *id.* § 477-0 (1979 & Supp. 1985) (social workers); *id.* § 477T (Supp. 1985) (nurse practitioners); *id.* § 489 (Supp. 1985) (chiropractors); *id.* § 490A (Supp. 1985) (psychologists); *id.* § 490A-2 (Supp. 1985) (nurse midwives); MASS. ANN. LAWS ch. 175, § 108B (Michie Law. Co-op. 1977) (dentists); *id.* § 110 (optometrists and podiatrists); *id.* § 108D (Michie Law. Co-op. Supp. 1985) (chiropractors); MICH. COMP. LAWS ANN. § 500.2243 (West 1983) (optometrists); *id.* § 500.3475 (psychologists, chiropractors, and podiatrists); *id.* § 500.2239 (West Supp. 1985) (dentists); MINN. STAT. ANN. § 62A.043 (West Supp. 1985) (dentists and podiatrists); *id.* § 62A.15 (optometrists, chiropractors, and registered nurses); *id.* § 62A.152 (psychologists); MISS. CODE ANN. § 83-41-203 (1972) (optometrists); *id.* § 83-41-209 (Supp. 1985) (dentists); *id.* § 83-41-211 (Supp. 1985) (psychologists); *id.* § 83-41-213 (Supp. 1985) (nurse practitioners); *id.* § 83-41-215 (chiropractors) (Supp. 1985); MO. ANN. STAT. § 375.936(11)(b) (Vernon Supp. 1986) (optometrists, chiropractors, dentists, psychologists, pharmacists, and podiatrists); *id.* § 354.027 ("person[s] duly licensed" to perform covered services); MONT. CODE ANN. § 33-22-111 (1985) (dentists, osteopaths, chiropractors, optometrists, chiropodists, psychologists, social workers, nurse specialists, and pharmacists); NEB. REV. STAT. § 44-513 (1984) (osteopaths, chiropractors, optometrists, psychologists, dentists, and podiatrists); NEV. REV. STAT. § 689A.380 (1985) (dentists, osteopaths, chiropractors, oriental medicine, podiatrists, and optometrists); *id.* § 689B.038 (psychologists); *id.* § 689B.039 (chiropractors); N.H. REV. STAT. ANN. § 415:18-a (1983) (licensed pastoral counselors, psychologists, and psychiatrists); N.J. STAT. ANN. § 17B:27-50 (West 1985) (psychologists); *id.* § 17B:27-51 (optometrists); *id.* § 17B:27-51.1 (chiropractors); *id.* § 17B:27-51.8 (dentists); N.M. STAT. ANN. § 59A-22-32 (Supp. 1985) (optometrists, psychologists, podiatrists, and nurse midwives); N.Y. INS. LAW § 3221 (McKinney 1985) (nurse midwives and social workers); *id.* § 4235 (physical therapists, podiatrists, optometrists, dentists, psychiatrists, psychologists, and chiropractors); N.C. GEN. STAT. § 58-260 (1982) (optometrists, podiatrists, dentists, chiropractors, and psychologists); OHIO REV. CODE ANN. § 3923.23 (Page Supp. 1984) (osteopaths, optometrists, chiropractors, and podiatrists); *id.* § 3923.231 (psychologists); *id.* § 3923.232 (dentists); *id.* § 3923.233 (nurse midwives); OKLA. STAT. ANN. tit. 36, § 6051 (West 1976) (optometrists); *id.* § 3634 (West Supp. 1985) (podiatrists, psychologists, and clinical social workers); *id.* § 6055 (West Supp. 1985) ("any practitioner licensed under the healing arts"); OR. REV. STAT. § 743.117 (1983) (optometrists); *id.* § 743.123 (psychologists); *id.* § 743.128 (nurse practitioners); *id.* § 743.132 (dentists and denturists); *id.* § 743.135 (clinical social workers); PA. STAT. ANN. tit. 40, § 1511 (Purdon Supp. 1985) (osteopaths, dentists, chiropractors, podiatrists, and physical therapists); *id.* § 3002 (nurse

Proponents of mandated-provider laws argue that these laws give insureds freedom of choice of provider and improve the quality of care by preventing insurers from refusing to reimburse health care providers other than those with whom the insurer has specifically contracted.[14] In addition, non-physician health care providers have tended to favor mandated-provider laws because non-physician providers, in particular, have tended to be excluded from reimbursement.[15]

Though ERISA's statutory language sheds little light on what Congress intended to save from preemption as laws that regulate "insurance,"[16] the Act's legislative history suggests that Congress intended to preempt mandated-provider laws.[17] Furthermore, the Supreme Court has clearly delineated what laws regulate "insurance" in a line of cases interpreting the scope of the McCarran-Ferguson Act.[18] This note argues that ERISA's insurance saving clause should be construed consistently with the McCarran-Ferguson Act, because both Acts serve the same federal policy and use similar language to describe what is left to the states.[19] This note concludes, through an application of the principles set forth in cases interpreting the scope of the McCarran-Ferguson

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HOSP. F., Nov.-Dec. 1984, at 7 (discussion of merits of California law that allows contracting with exclusive groups of providers).

A PPO may be sponsored by an insurer, a group of physicians, hospitals, or other health care providers, or it may be freestanding. Stromberg, Duncheon, and Goldman, *PPOs and the Antitrust Laws,* HOSPITALS, Oct. 16, 1983, at 65, 65. In an insurer-sponsored PPO, the insurer goes beyond the normal insurance function of insuring against specific casualty losses: the insurer acts as a purchasing agent for insureds in obtaining volume discounts from specific "participating providers." *Id.* PPOs offer financial incentives, such as lower deductibles, to subscribers who use providers who have agreed to participate in the PPO. Rothenberg, *PPOs: Critical Elements in Their Design,* HEALTHCARE FIN. MGMT. Oct. 1983, at 32, 32. In exchange for the assurance that they will receive more patients, the participating providers offer services at a discount from full charges and submit to the PPOs utilization review. *Id.* Mandated-provider laws, however, require insurers to reimburse non-participating providers on the same terms as the participating providers. Insurer-sponsored PPOs are thus unable to create financial incentives to encourage subscribers to use participating providers. *See id.* at 34. Without the assurance that they will receive more patients, providers have no incentive to offer discounts to insurers. *Id.* at 33.

14. *See, e.g.,* Hopkins & Davis, *Restricted Choice—A Liability of Alternative Delivery Systems,* 58 FLA. B. J. 145, 145 (1984). *See generally* Berger, *supra* note 13, at 8-11 (insurer's ability to contract selectively with exclusive group of providers affects quality of care); Davy, *Preferred Provider Organizations,* 38 AM. J. OCCUPATIONAL THERAPY 327, 328-29 (1984) (PPOs may fail to provide rehabilitative services such as occupational therapy); Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships,* 1985 DUKE L.J. 1071, 1155 n.274 (persons insured on group basis who would prefer coverage entitling them to patronize a particular class of providers may not have their preferences recognized if they constitute minority of group).

15. Pierce, *supra* note 11, at 57; *see, e.g.,* Griffith, *Who Will Become the Preferred Providers?,* 1985 AM. J. NURSING 539, 541.

16. *See infra* note 37 and accompanying text.

17. *See infra* notes 43-47 and accompanying text.

18. *See infra* notes 71-105 and accompanying text.

19. *See infra* notes 56-65 and accompanying text.

Act, that "mandated provider" laws do not regulate "insurance" and thus should be preempted by ERISA.[20]

I. ERISA'S INSURANCE-SAVING CLAUSE

ERISA regulates employee pension plans, which provide for retirement and deferred income,[21] and welfare benefit plans, which provide for medical, disability, and other non-pension benefits.[22] ERISA was enacted to protect the benefit rights and retirement security of plan participants and beneficiaries.[23] The Act achieves this by establishing minimum reporting, disclosure, participation, funding, and vesting standards for employee benefit plans and places fiduciary duties on plan managers.[24] To eliminate potential confusion caused by coextensive state regulation, ERISA contains a broad preemption provision declaring that the statute shall "supersede" state laws that "relate to" employee benefit plans.[25] The preemption provision is substantially qualified, however, by its "insurance saving clause," which saves from preemption any state law that "regulates insurance."[26]

Employee benefit plans may purchase insurance for their participants or they may self-insure. Those plans that purchase insurance, so-called "insured plans," are governed by state laws that regulate "insur-

20. *See infra* notes 106-110 and accompanying text.

21. ERISA § 3(2), 29 U.S.C. § 1002(2) (1982). An employee pension plan is defined as any fund or program maintained by an employer or employee organization, or by both, which results in a deferral of income or provides retirement income to employees. *Id.*

22. *Id.* § 3(1), 29 U.S.C. § 1002(1). An "employee welfare benefit plan" is defined as any fund or program maintained by an employer or employee organization, or by both, which provides for medical, disability, death, unemployment, prepaid legal service, or other non-pension benefits. *Id.* The term "employee benefit plan" can refer to an employee pension plan, an employee welfare benefit plan, or both. *Id.* § 3(3), 29 U.S.C. § 1002(3).

23. For a discussion of ERISA's objectives, see generally Hutchinson, *The Employee Retirement Income Security Act: Origins and Objectives,* 14 FORUM 611 (1979). The Act has been described as the "most comprehensive overhaul of the private employee benefit system to date." Brummond, *Federal Preemption of State Insurance Regulation Under ERISA,* 62 IOWA L. REV. 57, 59 (1976) (footnote omitted).

24. Title I of ERISA establishes regulatory standards for employee benefit plans subject to the Act in a five part scheme. ERISA §§ 2-514, 29 U.S.C. §§ 1001-1145 (1982). Part one imposes reporting and disclosure requirements for all employee benefit plans covered by the Act. *Id.* §§ 101-111, 29 U.S.C. §§ 1021-1031. Parts two and three apply only to pension plans, and create standards in such areas as vesting, participation, and funding. *Id.* §§ 201-211, 301-306, 29 U.S.C. §§ 1051-1061, 1081-1086. Part four establishes fiduciary standards for the management of employee pension and welfare benefit plans. *Id.* §§ 401-414, 29 U.S.C. §§ 1101-1114. Part five provides a scheme of administration and enforcement that applies to pension and welfare benefit plans. *Id.* §§ 501-515, 29 U.S.C. §§ 1131-1145.

25. *Id.* § 514(a), 29 U.S.C. § 1144(a).

26. *Id.* § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

ance" because of ERISA's insurance-saving clause.[27] In contrast, state insurance laws are preempted to the extent that they purport to regulate self-insured employee benefit plans.[28]

One way states have sought to regulate insured plans is through "mandated provider" laws, which require insurance companies to pay for the services of particular types of health-care providers if the services they provide are covered by the health insurance policy. Mandated-provider laws prevent health insurers from excluding certain types of health care providers (e.g., optometrists) from receiving payment for services covered under the insurer's policies, even if the terms of the policies authorize payment only to some other type of provider (e.g., ophthalmologists).[29] Some mandated-provider laws also prevent insurers from reimbursing some providers at a greater rate than other providers of the same type of service.[30]

The scope of ERISA's insurance-saving clause and the relationship of that clause to the general preemption provision have been a source of controversy and litigation.[31] Much of the difficulty in determining whether state laws that regulate insured plans are saved from preemption by ERISA stems from the "linguistic overlap" of these two clauses.[32]

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27. *See* Brummond, *supra* note 23, at 67-92 (discussing ways state insurance regulatory schemes may affect employee benefit plans).

28. The insurance-saving clause is qualified by a "deemer clause," which states that no employee benefit plan shall be "deemed to be an insurance company or other insurer . . . for purposes of any law of any State purporting to regulate insurance companies." ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1982). The Supreme Court has subsequently, in dictum, interpreted the deemer clause to prohibit states from regulating self-insured employee benefit plans as a special type of insurance. *See* Metropolitan Life Ins. Co. v. Massachusetts, 105 S. Ct. 2380, 2390 (1985); *see also* Hewlett-Packard Co. v. Barnes, 571 F.2d 502, 504 (9th Cir.), *cert. denied,* 439 U.S. 831 (1978).

29. *See, e.g.,* ALA. CODE § 27-19-39 (1975). The statute provides:

> Whenever any policy of insurance . . . provides for reimbursement for any visual service in Alabama which is within the lawful scope of practice of a duly licensed optometrist . . . the insured or other person entitled to benefits under such policy shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly licensed optometrist, whichever the insured selects, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract.

Id.

30. *See, e.g.,* UTAH CODE ANN. § 31-27-24 (Supp. 1985). The statute provides in part:

> (1) No insurer shall make or permit any unfair discrimination *in favor of particular individuals or persons* or between any duly licensed professional groups who are authorized by law to render similar services, including physicians and optometrists licensed to perform similar ocular or optometric services.

Id. (emphasis added).

31. For a discussion of the scope of the insurance-saving clause and its relationship to the general preemption clause, see Brummond, *supra* note 23, at 93-122; Kilberg & Heron, *The Preemption of State Law Under ERISA,* 1979 DUKE L.J. 383, 394-403; Manno, *ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action,* 52 TEMP. L.Q. 51, 58-60 (1979); Okin, *Preemption of State Insurance Regulation by ERISA,* 13 FORUM 652, 655-67, 670-78 (1978).

32. Manno, *supra* note 31, at 58.

The preemption clause of ERISA broadly preempts state laws that "relate to" employee benefit plans.[33] The insurance-saving clause, however, saves from preemption state laws that regulate "insurance."[34] To the extent that many employee benefit plans are "insured plans," Congress appears to have restored to the states, through the insurance-saving clause, the ability to regulate as "insurance" much of the same activity it had excepted from state regulation through the preemption clause.[35]

Mandated-provider laws arguably "relate to" insured employee benefit plans because they dictate which providers will supply plan benefits, and ultimately affect the plan's cost, structure, and administration.[36] A more difficult question is whether mandated-provider laws are laws which regulate "insurance" within the meaning of ERISA's saving clause. The difficulty here is exacerbated by both the lack of a statutory definition of "insurance"[37] and the sparse discussion in the Act's legislative history of the relationship of the insurance-saving clause to the general preemption clause.

The scarcity of legislative history on this specific question is explained by the manner in which the preemption clause was added to the Act. The preemption clause was entirely redrafted shortly before ERISA was adopted.[38] The original House version of ERISA generally limited the scope of preemption of state regulation to areas expressly covered by the bill.[39] The more sweeping language of ERISA's preemption clause was adopted during the bill's final consideration in the House-Senate conference committee.[40] Statements made in the House and Senate debates indicate that Congress intended the preemption clause to occupy

33. The preemption provision provides that, with certain exceptions, ERISA shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a) (1982).

34. The insurance-saving clause provides that "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Id.* § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982).

35. Manno, *supra* note 31, at 58-59.

36. *See infra* note 52.

37. Metropolitan Life Ins. Co. v. Whaland, 119 N.H. 894, 901, 410 A.2d 635, 639 (1979).

38. Okin, *supra* note 31, at 653-55.

39. *See* H.R. 2, 93d Cong., 1st Sess. § 514, 120 CONG. REC. 4717, 4742 (1974). The Senate altered H.R. 2 to preempt state law insofar as it "relate[s] to subject matters regulated by this Act or the Welfare and Pension Plans Disclosure Act." H.R. 2, 93d Cong., 1st Sess. § 699(a), 120 CONG. REC. 5002 (1974) (as amended by Senate). For a discussion of the legislative history of ERISA's preemption provision, see Hewlett-Packard Co. v. Barnes, 425 F. Supp. 1294, 1298-1300 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978). *See also* Kilberg & Heron, *supra* note 31, at 390-92; Turza & Halloway, *Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 28 CATH. U.L. REV. 163, 166-69 (1979).

40. *See* S. Rep. No. 1090, 93d Cong., 2d Sess. § 514(a) (1974).

the entire field of employee benefit plan regulation.[41] The preemption clause was thus entirely redrafted at the last minute, with no specific consideration given to the consequences of the redrafted clause for state mandated-provider laws.[42] The reason behind the change in the preemption clause, however, suggests that Congress would have intended ERISA to preempt mandated-provider laws if it had specifically considered the question. The ERISA preemption clause was broadened largely because organized labor and consumer groups feared that states and bar associations would block the formation of "closed panel" prepaid legal plans, which provide legal services through a group of participating lawyers.[43] These interest groups wanted to prevent states and professional associations from enacting regulations favoring "open panel" prepaid legal plans, which allow all lawyers to participate.[44]

The floor debates on the preemption clause show that Congress intended to preempt state regulations which would prevent the formation of closed panel plans. Senator Javits, one of ERISA's floor managers, stated:

> Since plans subject to federal supervision would include plans providing prepaid legal services, it is intended that state regulation—but not bar association ethical rules, guidelines or disciplinary actions—in regard to such plans be preempted. But the State, directly or indirectly through the bar, is preempted from regulating the form and content of a legal service plan, for example, open versus closed panels, in the guise of disciplinary or ethical rules or proceedings.[45]

Following this statement, another of ERISA's floor managers, Senator Williams, concurred with Senator Javits's views on preemption, stating

41. *See, e.g.*, 120 CONG. REC. 29,933 (1974) (remarks of Senator Williams) (preemption "is intended to apply in its broadest sense to all actions of State or local governments"); *id.* at 29,197 (remarks of Rep. Dent) ("[T]he conferees, with the narrow exceptions specifically enumerated, applied this principle in its broadest sense to foreclose any non-federal regulation of employee benefit plans.")

42. Okin, *supra* note 31, at 654. Although the insurance-saving clause was included in its current form in bills introduced several years before ERISA's enactment, *see, e.g.*, S. 3589, 91st Cong., 2d Sess. § 18, 116 CONG. REC. 7280, 7284, 7288 (1970), the House and Senate conferees did not file their reports disclosing the change in the preemption clause until ten days before ERISA was passed, *see* 30 CONG. Q. ALMANAC 252, 252-53 (1974).

43. Okin, *supra* note 31, at 654; Turza & Halloway, *supra* note 39, at 205-06. The preemption provision was changed, at least in part, in reaction to the American Bar Association's amendments to the Code of Professional Responsibility, DR 2-101 and DR 2-103, both of which disfavored closed panel plans. Turza & Halloway, *supra* note 39, at 205 & n.248. Two votes taken in the conference committee supported preemption of state laws that regulated prepaid legal service plans in this manner. Pfennigstorf & Kimball, *Employee Legal Service Plans: Conflicts Between Federal and State Regulation*, 1976 AM. B. FOUND. RESEARCH J. 787, 802 n.71. For a discussion of ERISA preemption of legal service plans, see Pfennigstorf & Kimball, *supra*.

44. Okin, *supra* note 31, at 654; Pfennigstorf & Kimball, *supra* note 43, at 802-03, 828-29; Turza & Halloway, *supra* note 39, at 205 & n.248.

45. 120 CONG. REC. 29,949 (1974).

that Congress was "giving employers and unions the freedom to develop and operate legal service plans of their choice."[46]

Because Congress intended to preempt state regulations which require prepaid legal plans to reimburse nonparticipating lawyers, it is reasonable to infer that Congress would have intended to preempt similar state regulations which require other types of insured welfare benefit plans (e.g., medical and dental plans) to reimburse nonparticipating providers.[47]

II. THE McCARRAN-FERGUSON ACT DEFINITION OF "INSURANCE" AND *METROPOLITAN LIFE INSURANCE CO. V. MASSACHUSETTS*

In *Metropolitan Life Insurance Co. v. Massachusetts*,[48] the Supreme Court interpreted ERISA's insurance-saving clause in determining whether a Massachusetts statute that required insurance policies to provide certain mental health benefits was preempted as applied to policies purchased by employee benefit plans.[49] Such "mandated-benefit" statutes, as they are called, require insurers to include coverage for certain medical conditions, such as mental illness.[50] "Mandated-benefit" laws thus differ from "mandated-provider" laws in that the former add to the coverage, while the latter require an insurer to pay for the services of additional providers without broadening the scope of coverage.[51]

The ERISA question upon which the decision in *Metropolitan Life* turned was whether the mandated-benefit law was a law that regulated

46. *Id. See also id.* at 29,933 (remarks of Sen. Williams) ("State professional associations acting under the guise of State-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized—for example, prepaid legal services programs—whether closed or open panel . . . .").

47. ERISA includes legal service plans in its coverage of welfare benefit plans. ERISA § 3(1), 29 U.S.C. § 1002(1) (1982). Some legal service plans provide services to groups on a prepaid basis. Brummond, *supra* note 23, at 75. Such plans transfer and spread the risk of the need for legal services, and hence, have been considered by most commentators as an insurance arrangement. *Id.* at 76. *See also* Pfennigstorf & Kimball, *Legal Service Plans: A Typology*, 1976 AM. BAR FOUND. RESEARCH J. 411, 423-25. Some states have attempted to regulate legal service plans under insurance laws. Pfennigstorf & Kimball, *supra* note 43, at 797-98. Hence, legal service plans encounter the same preemption conflicts as health care benefit plans with regard to state regulation of insurance. *See* Turza & Halloway, *supra* note 39, at 204.

48. 105 S. Ct. 2380 (1985).

49. *Id.* at 2383.

50. *Id.*

51. For example, a mandated-benefit law may require insurers to provide vision care coverage in all health insurance policies they issue. In contrast, a mandated-provider law may require the insurer to reimburse optometrists as well as ophthalmologists if the insurer elects to provide vision care coverage. The *Metropolitan Life* Court recoguized these differences, observing that mandated-benefit statutes are therefore "only one variety of a matrix of state laws that regulate the substantive content of health-insurance policies." *Id.* at 2384.

"insurance" so as to be excepted from preemption by ERISA's insurance-saving clause.[52] The Court held that the mandated-benefit law was saved from preemption by the insurance-saving clause.[53]

In reaching this conclusion, the Court ascribed the difficulty of discerning the scope of the insurance-saving clause to two factors: the complexity of the statutory language, which the Court lamented was "not a model of legislative drafting,"[54] and the lack of explanation in ERISA's legislative history as to the intended breadth of the insurance-saving clause.[55] The Court recalled, however, that it had interpreted virtually

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52. *Id.* at 2388-89.

The Court reached this question only after concluding that the mandated-benefit law "clearly 'relate[d] to' " employee benefit plans regulated by ERISA, and hence fell within the reach of the Act's preemption clause. *Id.* at 2389. The Court reaffirmed its decision in Shaw v. Delta Air Lines, 463 U.S. 85 (1983), where the phrase "relate to" was given "its broad common-sense meaning such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *Metropolitan Life,* 105 S. Ct. at 2389 (quoting Shaw v. Delta Air Lines, 463 U.S. 85, 96-97 (1983)). In *Shaw* the Court concluded that both New York's Human Rights Law and its Disability Benefits Law "relate[d] to" pension plans governed by ERISA. *Shaw,* 463 U.S. at 100. The Court rejected the notion that a statute must conflict with one of the subjects covered by ERISA in order to "relate to" benefit plans. *Id.* at 98-99. Rather, the Court reasoned that "[a] law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan." *Id.* at 97. Applying this definition, the Court concluded that "the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans." *Id.*

The *Metropolitan Life* Court also held that all state laws that fall within the scope of ERISA's preemption clause are displaced, even those that do not conflict with ERISA's substantive requirements. *Metropolitan Life,* 105 S. Ct. at 2389. Furthermore, a law need not directly regulate employee benefit plans to be subject to preemption by ERISA; even indirect state regulation of employee benefit plans is subject to preemption. *Id.* The Court cited its decision in Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 525 (1981), for the proposition that even indirect regulation of ERISA plans falls within the scope of ERISA's preemption. *Metropolitan Life,* 105 S. Ct. at 2389. In *Alessi,* the Court held that the New Jersey Workers Compensation Act was preempted by ERISA insofar as the state law prohibited workers' compensation payments from being set off against pension benefits payable by a pension plan regulated by ERISA. *Allesi,* 451 U.S. at 526. The *Alessi* Court concluded that the statute "relate[d] to" pension plans governed by ERISA. *Id.* at 524. It noted that its conclusion was not altered by the fact that the statute "intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called 'pension regulation.' " *Id.* at 525. Rather, "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern." *Id.*

Applying these principles, the *Metropolitan Life* Court concluded that Massachusetts's mandated-benefit law, although not denominated a benefit plan law, clearly "relate[d] to" such plans, because it bore "indirectly but substantially on all insured benefit plans" by requiring them to purchase specified benefits when they purchased an insurance policy. *Metropolitan Life,* 105 S. Ct. at 2389.

53. *Metropolitan Life,* 105 S. Ct. at 2390.

54. *Id.* at 2389.

55. *Id.* at 2392 & nn.22-23.

identical language in the McCarran-Ferguson Act.[56] It reasoned that because the McCarran-Ferguson Act and ERISA's insurance-saving clause serve the same federal policy and use similar language to define the scope of permissible state regulation, the two statutes should be interpreted in a consistent manner.[57]

The McCarran-Ferguson Act[58] vests in the states the primary authority for the regulation and taxing of the "business of insurance." The preamble to the McCarran-Ferguson Act provides that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business."[59] It further provides that federal laws shall not indirectly preempt state laws regulating the "business of insurance."[60] The *Metropolitan Life* Court maintained that "Congress' 'primary concern' in enacting McCarran-Ferguson was to 'ensure that the States would continue to have the ability to tax and regulate the business of insurance.' "[61]

The Court recognized that ERISA "appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States."[62] It observed that the ERISA insurance-saving clause and the McCarran-Ferguson Act use similar language to define what is left to the states: the McCarran-Ferguson Act preserves state laws that "regulate the business of insurance"; ERISA preserves any

56. *Id.* at 2391 (citing the McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (1982)).

57. *Metropolitan Life*, 105 S. Ct. at 2392 n.21.

58. Ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (1982)).

59. 15 U.S.C. § 1012 (1982).

60. *Id.* Section 1012(b) states: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business . . . ." *Id.* § 1012(b).

61. *Metropolitan Life*, 105 S. Ct. at 2392 n.21 (quoting Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 217-18 (1979)). *See also* SEC v. National Sec., Inc., 393 U.S. 453, 458 (1969); Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 429 (1946). Although most litigation concerning the McCarran-Ferguson Act has focused on insurance's qualified exemption from the antitrust laws, Congress's concern with this aspect of federal regulation was "secondary." *See Royal Drug*, 440 U.S. at 218.

The McCarran-Ferguson Act was enacted in response to the Supreme Court's decision in United States v. South-Eastern Underwriters Ass'n., 322 U.S. 533 (1944). For many years, insurance was thought not to be subject to federal regulation under the commerce clause, the Supreme Court having held in Paul v. Virginia, 75 U.S. (8 Wall.) 168, 183 (1868), that "[i]ssuing a policy of insurance is not a transaction of commerce." In *South-Eastern Underwriters*, however, the Court reversed *Paul v. Virginia* and held that the business of insurance was interstate commerce, subject to federal regulation under the commerce clause. *South-Eastern Underwriters*, 322 U.S. at 553. For a discussion of the purposes of the McCarran-Ferguson Act, see Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L.J. 587, 640 (in adopting McCarran-Ferguson, Congress was primarily concerned with preserving state taxation and regulation of insurance).

62. *Metropolitan Life*, 105 S. Ct. at 2392 n.21.

state law that "regulates insurance."[63] The similarity of the relevant portions of ERISA and the McCarran-Ferguson Act, the Court observed, suggests that Congress may have had the McCarran-Ferguson Act in mind when drafting ERISA's insurance-saving clause. The Court found further support for this interpretation in section 514(d) of ERISA, which provides that ERISA's preemption provision may not be construed to "alter, amend, modify, invalidate, impair or supersede any law of the United States."[64] Thus, section 514(d) prevents ERISA from impairing the McCarran-Ferguson Act and other federal laws.[65]

The *Metropolitan Life* Court relied upon three criteria, articulated in earlier cases construing the McCarran-Ferguson Act, that are relevant in determining whether a particular practice is 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."[66] Applying these three criteria, the Court held that mandated-benefit laws regulate insurance and are thus excepted from ERISA preemption by the insurance-saving clause.[67] First, the Court concluded, mandated-benefit laws are intended to regulate the transfer and spreading of risk between insurer and policyholder.[68] Second, mandated-benefit laws directly regulate an integral part of the relationship between insurer and policyholder by prescribing the type of insurance benefits the insurer must sell to the policyholder.[69] Third, mandated-benefit laws are intended to regulate the insurer's relationship with the policyholder directly, and only indirectly to affect providers or others outside the insurance industry.[70]

III. CASES INTERPRETING THE MCCARRAN-FERGUSON ACT "BUSINESS OF INSURANCE" EXCEPTION

An examination of cases interpreting the scope of the McCarran-Ferguson Act reveals that, unlike mandated-benefit laws, mandated-pro-

63. *Id.*

64. *Id.* (quoting 29 U.S.C. § 1144(d)).

65. *Id.*

66. *Id.* at 2391 (quoting Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982)) (emphasis omitted).

67. *Id.* at 2391.

68. *Id.*

69. *Id.*

70. *Id.*

vider laws do not regulate the "business of insurance."[71]

A. Group Life & Health Insurance Co. v. Royal Drug Co.: *Narrowing the Scope of the "Business of Insurance."*

In *Group Life & Health Insurance Co. v. Royal Drug Co.*,[72] the Supreme Court considered an antitrust challenge to agreements between an insurer and certain participating pharmacies and was presented with the question whether these agreements constituted the "business of insurance" within the meaning of the McCarran-Ferguson Act.[73] In *Royal Drug*, a Blue Shield plan provided drugs to policyholders through a pharmacy PPO it had established.[74] Blue Shield entered into participating provider agreements with a number of pharmacies, whereby the pharmacies undertook to sell prescription drugs to policyholders for a two dollar markup above costs. Policyholders using the participating pharmacies paid only two dollars per prescription, with the balance being billed directly to Blue Shield. Blue Shield discouraged use of nonparticipating pharmacies by reimbursing policyholders who used these pharmacies at a lower rate.[75]

In rejecting the McCarran-Ferguson Act defense, the Court held that the challenged agreements did not involve the "business of insurance."[76] The Court reasoned that the agreements did not meet the first criterion for insurance in that they did not spread or underwrite the policyholder's risk,[77] which is an "indispensible characteristic of insurance."[78] The participating provider agreements did not transfer risk, because the risk of loss had already been transferred to Blue Shield in its

71. For a discussion of Supreme Court cases interpreting the scope of the McCarran-Ferguson Act, see Kennedy, *The McCarran Act: A Limited "Business of Insurance" Antitrust Exemption Made Ever Narrower: Three Recent Decisions*, 18 FORUM 528 (1983).

72. 440 U.S. 205 (1979).

73. *Id.* at 210.

74. *Id.* at 209.

75. *Id.*

76. *Id.* at 212-14.

77. Blue Shield had accepted in its policies the risk that policyholders would be "unable to pay for prescription drugs during the period of coverage." *Id.* at 213. The Court explained that the spreading and underwriting of risk is part of the textbook definition of insurance. *Id.* at 211 (citing 1 G. COUCH, CYCLOPEDIA OF INSURANCE LAW § 1:3 (2d ed. 1959); R. KEETON, INSURANCE LAW § 1.2(a) (1971); 1 G. RICHARDS, THE LAW OF INSURANCE § 2 (5th ed. 1952)).

78. *Id.* at 212, 214. The Court cited for support of this proposition their decision in SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65 (1959). In *Variable Annuity*, the Court held that the offering of variable annuity contracts that placed all investment risk on the purchaser of the contract was not within the business of insurance as defined by the McCarran-Ferguson Act. *Variable Annuity*, 359 U.S. at 71-73. The Court reasoned that "the concept of 'insurance' involves some investment risk taking on the part of the company." *Id.* at 71.

contracts with insureds.[79] Rather, Blue Shield's agreements with participating pharmacies were wholly separate from the insurance contracts between Blue Shield and its policyholders, and merely served to lower the cost Blue Shield incurred in purchasing drugs.[80] Thus, these participating provider agreements were "legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low."[81]

The Court concluded that the participating provider agreements also did not meet the second criterion for the "business of insurance" in that they did not involve the relationship between insurers and their policyholders.[82] The challenged agreements defined Blue Shield's relationship, not with its policyholders, but with the participating pharmacies. Thus, the agreements were only peripheral to the relationship between insurer and insured.[83] In reaching this conclusion, the Court adopted a narrower view of what constitutes the "relationship between insured and policyholder" than the Court's previous decisions would have sug-

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79. *Royal Drug,* 440 U.S. at 213-14.

80. *Id.* at 213.

81. *Id.* at 215. The Court noted that the decision of the United States Court of Appeals for the District of Columbia Circuit in Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939), illustrated the distinction between an insurance company's function as an insurer of risks and its non-insurance functions, which merely lower its costs. *Royal Drug,* 440 U.S. at 225-30. The *Jordan* court had held that a health service plan that contracted with specified groups of doctors, hospitals, and other participating providers to supply medical services to its members was not "insurance." *Jordan,* 107 F.2d at 248, stating:

> Although Group Health's activities may be considered in one aspect as creating security against loss from illness or accident, more truly they constitute the quantity purchase of well-rounded, continuous medieal service by its members. . . . The functions of such an organization are not identical with those of insurance or indemnity companies. The latter are concerned primarily, if not exclusively, with risk . . . . On the other hand, the cooperative is concerned principally with *getting service rendered to its members and doing so at lower prices* made possible by quantity purchasing and economics in operation.

Royal Drug, 440 U.S. at 228 (emphasis in original) (quoting *Jordan,* 107 F.2d at 247).

82. *Royal Drug,* 440 U.S. at 215-16. The Court cited for support its decision in SEC v. National Sec., Inc., 393 U.S. 453, 460 (1969), which established that not all laws that regulate insurance companies regulate the "business of insurance." In that case, the Court considered whether a state law governing the relationship between insurance companies and their shareholders was a law regulating the business of insurance as the phrase is used in the McCarran-Ferguson Act. *Id.* at 457. The Court, in holding that the statute did not regulate insurance, *id.*, reasoned that the McCarran-Ferguson Act did not make states supreme in regulating "all the activities of insurance *companies,*" but only in regulating those activities that comprise the "*business* of insurance." *Id.* at 459 (emphasis supplied).

The "focus" of the business of insurance is on the "relationship between the insurance company and the policyholder." *Id.* at 460. Thus laws that regulate the various other activities of insurance companies, such as their relationship to stockholders, do not regulate the " 'insurance' relationship." *Id.*

83. *Royal Drug,* 440 U.S. at 216.

gested.[84] The Court indicated that although arrangements that affect the benefit an insurer confers upon policyholders are the "business of insurance," not all aspects of an insurer's relationship with insureds are the "business of insurance."[85] The Court acknowledged that the pharmacy agreements were referred to in the insurer's contracts with insureds, and that the agreements affected the insureds' premiums,[86] choice of pharmacy, and amount and method of reimbursement for the prescription drug benefit.[87] These factors, however, did not affect the "wholly separate nature" of the two categories of agreements.[88]

The Court further concluded that the pharmacy agreements failed the third criterion for the "business of insurance" because they involved parties who were wholly outside the insurance industry.[89] The Court noted that the McCarran-Ferguson Act exemption typically applies only to entities that are within the insurance industry.[90] Although the participating pharmacies were engaged in business with an insurer, they were not themselves insurers or part of the insurance industry.[91]

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84. The Court's prior decisions suggested a broader view. As noted by the United States Court of Appeals for the Second Circuit in Pireno v. New York State Chiropractic Ass'n, 650 F.2d 387 (2d Cir. 1981), *aff'd sub. nom.* Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982), when the Supreme Court held in SEC v. National Sec., Inc., 393 U.S. 453 (1969), that the business of insurance concerns the insurer-policyholder relationship, the Court sought merely to exclude the "markedly different" relationship of insurer to stockholder. *Pireno,* 650 F.2d at 394 (citing *National Securities,* 393 U.S. at 460). Thus, the *National Securities* Court did not consider what aspects of the insurer-policyholder relationship constituted "insurance." *Pireno,* 650 F.2d at 394.

In affirming the narrow view of the "relationship between insurance company and policyholder" adopted by the Fifth Circuit in *Royal Drug,* the Supreme Court noted that its decision was "in conflict with" the broader view of this relationship adopted by the Third Circuit, *see* Frankford Hosp. v. Blue Cross, 554 F.2d 1253, 1254 (3d Cir.) (per curiam), *cert. denied,* 434 U.S. 860 (1977), the Fourth Circuit, *see* Anderson v. Medical Serv., 551 F.2d 304 (4th Cir. 1977) (mem.), and the District of Columbia Circuit, *see* Proctor v. State Farm Mut. Auto. Ins. Co., 561 F.2d 262, 268 (D.C. Cir. 1977), *vacated and remanded mem.,* 440 U.S. 942 (1979). *See Royal Drug,* 440 U.S. at 208 n.2, *aff'g* 556 F.2d 1375 (5th Cir. 1977). Courts taking a broad view of the insurer-insured relationship had concluded that agreements between insurance companies and non-policyholders were within the scope of the business of insurance because of the substantial effects these agreements had on areas such as the limitation of costs, settlement of claims, and rates charged to subscribers. *See, e.g.,* Manasen v. California Dental Serv., 424 F. Supp. 657, 666-67 (N.D. Cal. 1976), *rev'd on other grounds,* 638 F.2d 1152 (9th Cir. 1979); Frankford Hosp. v. Blue Cross, 417 F. Supp. 1104, 1109 (E.D. Pa. 1976), *aff'd per curiam,* 554 F.2d 1253 (3d Cir.), *cert. denied,* 434 U.S. 860 (1977).

85. *Royal Drug,* 440 U.S. at 216-17 & n.14.

86. *Id.*

87. *Id.* at 209.

88. *Id.* at 216 n.14.

89. *Id.* at 231.

90. *Id.* at 221.

91. *Id.* at 224.

B. Union Labor Life Insurance Co. v. Pireno: *Further Defining "Insurance."*

In *Union Labor Life Insurance Co. v. Pireno,*[92] the Court used the same definition of "insurance" to determine whether an insurer's use of a peer review arrangement was exempt from antitrust challenge under the McCarran-Ferguson Act.[93] In *Pireno,* an insurer offered insurance policies covering chiropractic treatment that limited the insurer's liability to the reasonable charges for necessary medical care.[94] The insurer used an outside panel of chiropractors to review cases and advise them whether treatments were necessary and charges reasonable.[95]

The Court held that the peer review practice failed to meet the three criteria for "insurance," and was therefore not exempt from antitrust scrutiny.[96] First, the Court found that the peer review practice had no role in transferring or spreading of risk.[97] The risk of loss for necessary medical care had already been transferred to the insurer in its contracts with insureds. Transfer of risk, the Court explained, is complete at the time the insurance contract is formed. Peer review, however, takes place only after the policy is formed to determine whether the care the insured had received was necessary and within policy limits.[98]

Second, the insurer's use of a peer review committee was not an integral part of the policy relationship between the insurer and insured.[99] The insurer's peer review practice involved an arrangement with an outside panel of chiropractors that was separate from its agreements with its policyholders.[100] The agreements did not affect the benefit the insurer promised to provide its policyholders, which was to cover the reasonable costs of necessary chiropractic treatments up to policy limits.[101] Rather, a peer review committee was merely a device employed by the insurer to determine whether the claims were covered by its policies. Thus, the peer review practices were peripheral to the insurer-insured relationship,

92. 458 U.S. 119 (1982).
93. *Id.* at 129.
94. *Id.* at 122-23.
95. *Id.* at 123.
96. *Id.* at 129.
97. *Id.* at 129-30.
98. *Id.* at 130. A policyholder who patronizes a more expensive or inefficient provider may be required by the insurer to pay for services and charges that the peer review committee determines are unreasonable and unnecessary. The Court explained that the insurer's refusal to reimburse the policyholder does not transfer risk from insurer to insured, because the risk of incurring unnecessary treatments and unreasonable charges was never transferred to the insurer, but was instead a risk the insured had retained when the policy was formed. *Id.* at 130-31.
99. *Id.* at 131.
100. *Id.*
101. *Id.* at 132.

and a "matter of indifference to the policyholder, whose only concern is *whether* his claim is paid, not *why* it is paid."[102]

Third, the insurer's peer review practices were not limited to entities within the insurance industry.[103] The peer review was conducted, not by the insurer itself, but by an independent panel of chiropractors.[104] Thus, the insurer's peer review practices involved persons wholly outside the insurance industry.[105]

IV. MANDATED-PROVIDER LAWS AND THE DEFINITION OF "INSURANCE"

Application of the principles developed in *Royal Drug* and *Pireno* demonstrates that mandated-provider laws do not regulate "insurance" under the McCarran-Ferguson Act.

First, mandated-provider laws do not regulate the spreading and transfer of risk. The risk of loss is transferred in the insurance contracts with insureds, and the transfer of risk is complete at the time the contract is formed.[106] Mandated-provider laws, however, operate after this risk is transferred to require insurers to reimburse particular providers if those providers supply goods or services that the insurer is already obligated to pay for under its policies. Thus mandated-provider laws are like the pharmacy agreements in *Royal Drug* and the peer review practice in *Pireno*—they act only after the insurer is already obligated to provide the benefits under the policies.[107] Mandated-provider laws do not regulate the transfer or spreading of risk, but merely regulate an insurer's subsequent arrangements with providers for the purchase of goods and

102. *Id.* (emphasis in original).

103. *Id.*

104. *Id.* at 132-33.

105. Following the Supreme Court's decisions in *Royal Drug* and *Pireno,* courts have held that similar agreements between insurers and other types of providers were not "insurance" within the meaning of the McCarran-Ferguson Act. *See* Ratino v. Medical Serv., 718 F.2d 1260, 1266-67 (4th Cir. 1983) (Blue Shield plan's agreements with physicians); Proctor v. State Farm Mut. Auto Ins. Co., 675 F.2d 308, 336 (D.C. Cir.) (insurer's participating provider agreements with auto body repair shops), *cert. denied,* 459 U.S. 839 (1982); Portland Retail Druggists Ass'n v. Kaiser Found. Health Plan, 662 F.2d 641, 647 (9th Cir. 1981) (health maintenance organization's agreements with drug manufacturers); Quality Auto Body, Inc., v. Allstate Ins. Co., 660 F.2d 1195, 1201 (7th Cir. 1981) (insurer's agreements with automobile repair shops), *cert. denied,* 455 U.S. 1020 (1982); National Gerimedical Hosp. v. Blue Cross, 628 F.2d 1050, 1057 (8th Cir. 1980) (Blue Cross plan's agreements with hospitals), *rev'd on other grounds,* 452 U.S. 378 (1981); St. Bernard Hosp. v. Hospital Serv. Ass'n, 618 F.2d 1140, 1145 (5th Cir. 1980) (Blue Cross plan's agreements with hospitals); Workman v. State Farm Mut. Auto. Ins. Co., 520 F. Supp. 610, 624-25 (N.D. Cal. 1981) (insurer's agreements with automobile repair shops); Hoffman v. Delta Dental Plan, 517 F. Supp. 564, 568 (D. Minn. 1981) (insurer's agreements with dentists).

106. *Pireno,* 458 U.S. at 130-31.

107. *Cf. Pireno,* 458 U.S. at 130-31; *Royal Drug,* 440 U.S. at 213-15.

services.[108]

Second, the mandated-provider laws do not regulate the relationship between insurer and policyholder. Rather, they regulate the relationship between the insurer and certain categories of providers. As was the case with the pharmacy agreements in *Royal Drug* and the peer review procedures in *Pireno,* the mandated-provider laws do not change the benefits the insurer is obligated to provide under its policies. They simply regulate factors that are peripheral to the relationship between insurer and insured, such as the insured's choice of provider and the amount that an insured who uses a non-participating provider is required to pay.[109]

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108. It could be argued that mandated-provider laws do affect the "spreading" of loss because they affect the ascertainment and settlement of the amount of the indemnity which the insured who chooses a particular provider is entitled to receive. Although risks are transferred from insured to insurer at the time the policy is formed, losses are not "spread" among policyholders until they are ascertained through claims adjustment. *See* Kennedy, *supra* note 71, at 536. Arguably, mandated-provider laws regulate the spreading of loss by regulating claims adjustment.

This argument must be rejected because the *Pireno* Court held that the transferring or "spreading of . . . a policyholder's *risk*" is complete at the time the policy is formed. *See* 458 U.S. at 130 (emphasis added). As one commentator has noted, the *Pireno* Court, in defining insurance, did not refer to the normal insurance phrase "spread of loss"; instead, the Court referred to the "awkward" phrase "spreading of risk." Kennedy, *supra* note 71, at 536. The Court's reference to the "spreading of risk" is technically incorrect; it is not the risk—meaning "chance of loss"—that is spread by insurance, rather, it is the loss itself that is spread. *Id.* Thus, one result of the *Pireno* Court's narrowing of the scope of "insurance" to events occurring at or before policy issuance is to exclude claims-settlement activities from the scope of "insurance," since these activities must necessarily occur after the policy is issued. *Id.* at 536-37.

A resulting difficulty with accepting the *Pireno* Court's definition of insurance is that other well-established state laws that regulate the claims and adjustment process, such as laws that require insureds to file suit within a set time limit after an insured event in order to be indemnified for their claim, would not constitute "insurance" regulation.

109. Despite the fact that mandated-provider laws ultimately affect whether the claim of an insured will be paid, mandated-provider laws do not affect an integral part of the relationship between an insurer and insured. In the analogous context of peer review practice, Justice Rehnquist, dissenting in *Pireno,* argued that peer review was an integral part of the insurer-insured relationship because peer review ultimately determined whether an insured's claim would be paid. *Pireno,* 458 U.S. at 137-38 (Rehnquist, J., dissenting). Under the peer review practice at issue in *Pireno,* an insured who consulted an unreasonably expensive chiropractor was required to pay more than if he consulted one whose charges were reasonable. *Id.* at 131.

The majority in *Pireno,* in rejecting this argument, reasoned that the peer review practice did not affect the benefit the insurer promised to the insured: payment of the reasonable charges of chiropractors for necessary treatments. *Id.* at 132. Rather, the peer review practice merely aided the insurer in determining whether a chiropractor's treatments fell within policy limits. *Id.* The Court thus found the situation in *Pireno* to be directly analogous to that in *Royal Drug,* where the Court held that the benefit promised to insureds was not affected by provider agreements that required any insured who selected a nonparticipating pharmacy to pay more for drugs than if he had selected a participating pharmacy. *Id.*

The Supreme Court's analysis requires rejection of the argument that mandated-provider laws are an integral part of the insurer-insured relationship because they directly affect the benefit conferred upon the insured. Like the peer review practice in *Pireno* and the participating provider agreements in *Royal Drug,* mandated-provider laws do not affect the benefit promised to insureds

Third, mandated-provider laws involve entities that are usually wholly outside the insurance industry. By regulating the relationship between insured and provider, mandated-provider laws have a direct and

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that particular medical conditions will be covered. Rather, mandated-provider laws merely affect which practitioners may provide policy benefits to insureds.

A few courts have held that an insurer's policy agreements with insureds to limit full reimbursement to services provided by speeific practitioners are within the "business of insurance" exception to the McCarran-Ferguson Act. *See, e.g.*, Hahn v. Oregon Physicians' Servs., 508 F. Supp. 970, 975 (D. Or. 1981), *rev'd*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983); Health Care Equalization Comm. v. Iowa Medical Soc'y, 501 F. Supp. 970, 995 (S.D. Iowa 1980) (insurer's decision not to reimburse chiropractors was "business of insurance" under McCarran-Ferguson Act); Virginia Academy of Clinical Psychologists v. Blue Shield, 469 F. Supp. 552, 562 (E.D. Va. 1979), *aff'd in part and rev'd in part*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981). *Cf.* Blue Cross and Blue Shield v. Bell, 596 F. Supp. 1053, 1059 (D. Kan. 1984) (Kansas mandated-provider statute held permissible under commerce clause because Kansas law regulated "business of insurance" within meaning of the McCarran-Ferguson Act). These courts have attempted to distinguish the situation in *Royal Drug* on the basis that *Royal Drug* involved a challenge to an insurer's agreements with participating providers, while policy provisions to limit full reimbursement to specific practitioners involve insurers' agreements with insureds. Most courts that have considered the matter, however, have correctly interpreted *Royal Drug* and *Pireno* in holding that agreements to limit reimbursement to services of specific providers are not the "business of insurance" because such agreements are tangential to the insurer-insured relationship. *See* Klamath-Lake Pharmacy v. Klamath Medical Serv. Bureau, 701 F.2d 1276, 1285 (9th Cir.) (dictum), *cert. denied*, 464 U.S. 822 (1983); Hahn v. Oregon Physicians' Serv., 689 F.2d 840, 842-44 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983); Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield, 568 F. Supp. 1474, 1483 (D.S.C. 1983).

For example, the district court in *Virginia Academy of Clinical Psychologists v. Blue Shield*, 469 F. Supp. 552, 562 (E.D. Va. 1979), *aff'd in part and vacated in part*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), held a Blue Shield plan's policy of reimbursing psychologists only when their services were billed through a physician to be the "business of insurance." This holding was based on a finding that the policy provisions in question involved the relationship between insurer and insured. *Virginia Academy*, 469 F. Supp. at 562. The court reasoned that the situation in *Royal Drug* was distinguishable because "[t]he contracts in question here are not between providers and Blue Shield," as was the case in *Royal Drug*, "but between subscribers and Blue Shield." *Id.* at 562.

The United States Court of Appeals for the Fourth Circuit, however, reversed, rejecting the district court's attempt to distinguish *Royal Drug*. Virginia Academy v. Blue Shield, 624 F.2d 476, 483 (1980), *cert. denied*, 450 U.S. 916 (1981). The court of appeals recognized that Blue Shield's refusal to reimburse psychologists directly was analogous to the pharmacy agreements in *Royal Drug*: both were "tangential" to the relationship between insurer and insured because neither affected the benefit conferred upon the subscriber. *Id.* at 483-84. "Their decision regarding psychologists was not whether to underwrite the risk of those disorders or even the need for psychotherapy; rather it was a question of who they would pay for such services. The coverage remained the same." *Id.* at 484.

The decision of the United States Court of Appeals for the Ninth Circuit in Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau, 701 F.2d 1276 (9th Cir.), *cert. denied*, 464 U.S. 822 (1983), is not contrary to this conclusion. The situation in *Klamath* was similar to *Royal Drug* in that it involved an insurer that offered an optional pharmacy benefit to subscribers of its major medical policies. *See id.* at 1279. Unlike *Royal Drug*, however, the insurer in *Klamath* owned the pharmacies where the drugs were distributed. *Id.* at 1279-80. Independent pharmacies brought an antitrust action against the insurer, alleging a tie between the major medical policy and the optional pharmacy benefit, since the latter could only be obtained if the subscriber had the major medical policy. *Id.* at 1280-81. The *Klamath* court held that the alleged tying arrangement was

intended impact on providers. Like the pharmacies in *Royal Drug* and peer review committee in *Pireno,* these providers are parties wholly outside the insurance industry.[110]

V. Cases Considering ERISA Preemption of Mandated-Provider Laws

Courts that have considered ERISA preemption of mandated-provider laws are divided over the question whether such statutes "regulate insurance" within the meaning of the insurance-saving clause.[111] In *Metropolitan Life Insurance Co. v. Insurance Commissioner,*[112] a Maryland court of special appeals held that a state mandated-provider statute was preempted as applied to an insured benefit plan regulated by ERISA.[113] The court, applying the criteria for "insurance" of *Royal Drug,* held that the mandated-provider statute did not regulate insurance.[114] Focusing on the criterion that "insurance" must involve the insurer-insured relationship, the court concluded that the mandated-provider law was tangential to this relationship.[115]

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shielded from antitrust scrutiny because the agreement was the "business of insurance" within the meaning of the McCarran-Ferguson Act. *Id.* at 1286.

The situation in *Klamath* can be distinguished from that in *Royal Drug* in that the tying claim did not challenge the insurer's arrangements to provide the pharmacy benefit, as did the antitrust claim in *Royal Drug.* Rather, the tying claim in *Klamath* challenged the pharmacy benefit in the insurance policy itself.

Hence, the situation in *Klamath* is analogous to those cases where an insurer's decisions regarding policy benefits are at issue. *Cf.* Metropolitan Life Ins. Co. v. Massachusetts, 105 S. Ct. 2380, 2392 (1985); Anglin v. Blue Shield, 693 F.2d 315, 321 (4th Cir. 1982) (insurer's refusal to offer plaintiff a policy that did not include his wife was the "business of insurance"); Feinstein v. Nettleship Co., 714 F.2d 928, 933 (9th Cir. 1983) (insurer's decision to offer malpractice insnrance only to members of medical association was the "business of insurance"), *cert. denied,* 104 S. Ct. 2346 (1984).

110. *Cf. Pireno,* 458 U.S. at 132; *Royal Drug,* 440 U.S. at 231.

111. *Compare* Blue Cross v. Peacock's Apothecary, Inc., 567 F. Supp. 1258, 1277 (N.D. Ala. 1983) (state mandated-provider law regulating insurer's pharmacy agreements was preempted by ERISA) *with* Blue Cross Hosp. Serv. v. Frappier, 681 S.W.2d 925, 931 (Mo. 1984) (en banc) (state mandated-provider law reqniring reimbursement for chiropractors and psychologists was saved from preemption by insurance-saving clause), *vacated and remanded mem.,* 105 S. Ct. 3471 (1985) *and* Insurance Comm'r v. Metropolitan Life Ins. Co., 296 Md. 334, 339, 463 A.2d 793, 798 (1983) (state mandated-provider law requiring payment for services of social workers was exempted from preemption by insnrance-saving clause).

112. 51 Md. App. 122, 441 A.2d 1098 (1982), *rev'd,* 296 Md. 334, 463 A.2d 793 (1983).

113. *Id.* at 133, 441 A.2d at 1105.

114. *Id.* at 130-31, 441 A.2d at 1103-04 (citing Group Life & Hcalth Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979)). The court also cited Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476, 483-84 (4th Cir. 1980), for support. *See Metropolitan Life Ins.,* 51 Md. App. at 130, 441 A.2d at 1103.

115. *Metropolitan Life Ins.,* 51 Md. App. at 130, 441 A.2d at 1103. The court also concluded that the mandated-provider law "relate[d] to" the insured benefit plan and was thus subject to pre-

The Maryland Court of Appeals reversed the court of special appeals decision and held that the Maryland mandated-provider law is a law that "regulate[s] insurance," and is therefore not preempted by ERISA.[116] The court of appeals correctly recognized that ERISA's insurance-saving clause reflects the federal policy of state primacy in insurance regulation embodied in the McCarran-Ferguson Act.[117] The court asserted, however, that the "plain and ordinary meaning of the language" of ERISA's insurance-saving clause indicates that Congress intended mandated-provider laws to be preserved from preemption as laws regulating insurance.[118] For support of its position that Maryland's mandated-provider law regulates insurance, the court cited a number of cases which held that state mandated-*benefit* laws regulate insurance within the meaning of the saving clause.[119]

In analyzing whether the challenged mandated-provider statute regulates insurance, the court of appeals failed to recoguize the critical distinction between mandated-benefit laws and mandated-provider laws. Mandated-benefit laws, by requiring that specified risks be covered, operate to shift the risk of loss from policyholder to insurer.[120] In contrast, mandated-provider laws, by requiring that insurers pay for services of specified providers, do not shift the risk of loss.[121] Mandated-benefit laws directly regulate the insurer's relationship with insureds, and only indirectly affect providers.[122] Mandated-provider laws regulate the relationship between insurers and certain providers, and thus directly affect enti'ies which are wholly outside of the insurance industry.[123] By thus failing to distinguish between mandated-benefit and mandated-provider laws, the court reached tlie erroneous conclusion that mandated-provider laws regulate insurance.

More recently, the Supreme Court of Missouri, in *Blue Cross Hospi-*

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emption because it "change[d] a term or condition with regard to the payment of a benefit under the plan." *Id.* at 131, 441 A.2d at 1104.

116. Insurance Comm'r v. Metropolitan Life Ins. Co., 296 Md. 334, 345, 463 A.2d 793, 798 (1983).

117. *Id.* at 341, 463 A.2d at 796.

118. *Id.* at 339-40, 463 A.2d at 795-96.

119. *Id.* at 341-45, 463 A.2d at 797-98. The court cited as primary support Wadsworth v. Whaland, 562 F.2d 70, 77 (1st Cir. 1977), *cert. denied,* 435 U.S. 980 (1978), and Metropolitan Life Ins. Co. v. Whaland, 119 N.H. 894, 901-02, 410 A.2d 635, 640 (1979), both of which held that statutes mandating mental health benefits regulate "insurance" and are thus preserved from ERISA preemption by the saving clause.

120. *See supra* notes 67-68 and accompanying text.

121. *See supra* notes 106-108 and accompanying text.

122. *See supra* notes 69-70 and accompanying text.

123. *See supra* notes 109-110 and accompanying text.

tal Service v. Frappier,[124] held that a Missouri mandated-provider statute was not preempted by ERISA, on the ground that the law was insurance regulation subject to the saving clause.[125]

The Missouri court, in deciding that the mandated-provider law "regulates insurance," held that the McCarran-Ferguson Act exemption for insurance "is not identical to" ERISA's exemption for state laws regulating insurance.[126] The court further concluded that the mandated-provider law regulates insurance because it regulates insurance companies.[127]

The United States Supreme Court in *Metropolitan Life Insurance Co. v. Massachusetts,* however, clearly indicated that the ERISA saving clause and the McCarran-Ferguson Act exemption should be read consistently, because they serve the same federal policy and utilize similar language.[128] Cases interpreting the scope of the McCarran-Ferguson Act have identified essential criteria relevant to determining whether a particular practice constitutes insurance. Under this approach, a state law does not regulate insurance simply because it purports to regulate insurance companies.[129] Rather, states may regulate only those activities of insurers that comprise the essential elements of insurance.[130]

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124. 681 S.W.2d 925, 932 (Mo. 1984) (en banc), *vacated and remanded mem.,* 105 S. Ct. 3471 (1985).

125. *Id.* The decision also rested, in part, on a finding that the mandated-provider law did not "relate to" ERISA plans. *Id.* at 931. Here the court reached two conclusions in conflict with the decisions of the Supreme Court. The Missouri court concluded that ERISA preempts state regulation of employee benefit plans only in areas that are also specifically regulated by ERISA. *Id.* at 932. The court also concluded that "indirect regulation of employee benefit plans is permissible provided the regulation does not interfere with the purposes of ERISA." *Id.*

The Supreme Court in Metropolitan Life Ins. Co. v. Massachusetts, 105 S. Ct. 2380 (1985), and in previous decisions, however, rejected this narrow view of ERISA preemption. The *Metropolitan Life* Court, affirming its previous decision in Shaw v. Delta Air Lines, 463 U.S. 85 (1983), held that ERISA preempts even those state laws falling "within its sphere" that do not conflict with its substantive requirements. *Metropolitan Life,* 105 S. Ct. at 2389 (citing *Shaw,* 463 U.S. at 98-99). *See supra* note 52. The *Metropolitan Life* Court further noted that even indirect state regulation of ERISA plans may be preempted. *Metropolitan Life,* 105 S. Ct. at 2389.

126. *Frappier,* 681 S.W.2d at 931.

127. *Id.*

128. 105 S. Ct. 2380, 2391-92 & n.21 (1985). *See supra* notes 56-65 and accompanying text. Furthermore, from a policy perspective it would be illogical to find that ERISA's saving clause contained a broader exemption for state insurance regulation than Congress had granted to the states through the McCarran-Ferguson Act.

129. Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979) (quoting SEC v. National Sec., Inc., 393 U.S. 453, 459-60 (1969)). *See supra* notes 82-84 and accompanying text.

130. Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979).

The Missouri Supreme Court's decision in *Frappier* was vacated and remanded by the Supreme Court for further consideration in light of the Court's decision in *Metropolitan Life. See* Blue Cross Hosp. Serv. v. Frappier, 105 S. Ct. 3471 (1985) (mem.), *vacating* 681 S.W.2d 925 (Mo. 1984) (en banc). On remand, the Missouri Supreme Court in a supplemental opinion, Blue Cross Hosp. Serv. v. Frappier, 698 S.W.2d 326 (Mo. 1985) (en banc), readopted its previous decision, *id.* at 326, finding

VI. CONCLUSION

Mandated-provider laws, by changing the terms of insurance policies purchased by ERISA plans, clearly "relate to" these plans and thus fall within ERISA's sphere of preemption. A more difficult question is whether these laws are saved from ERISA preemption as laws that regulate "insurance" within the meaning of the Act's saving clause. ERISA's statutory language and legislative history fail to define adequately the bounds of state regulation of insurance.

In a series of cases, however, the Supreme Court has precisely defined the zone of permissible state regulation of insurance in the context of the McCarran-Ferguson Act. The Court has recoguized that ERISA's insurance-saving clause and the McCarran-Ferguson Act should be construed consistently with one another because both acts effectuate the same federal policy of maintaiming state primacy in the regulation of insurance. Application of the principles of these cases demonstrates that mandated-provider laws do not regulate insurance. Thus, mandated-provider laws should be preempted as applied to insurance policies purchased by employee benefit plans regulated by ERISA.

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"no viable distinction" between mandated-provider statutes and the mandated-benefit statute in *Metropolitan Life*. *Id.* at 327.

The Missouri Supreme Court failed to recognize the critical distinction between mandated-benefit laws and mandated-provider laws. *See supra* notes 67-70, 106-10 and accompanying text. The court thus made the same error that the Maryland Court of Appeals made in *Insurance Comm'r v. Metropolitan Life Ins. Co.*, 296 Md. 334, 463 A.2d 793 (1983). *See* text accompanying notes 119-23.