

SAVING THE SAVINGS CLAUSE: ADVOCATING A
BROADER READING OF THE *MILLER* TEST TO ENABLE
STATES TO PROTECT ERISA HEALTH PLAN MEMBERS
BY REGULATING INSURANCE

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INTRODUCTION

The Employee Retirement Income Security Act (“ERISA”) of 1974’s¹ preemption of state laws relating to employee benefit plans² has been described as being “conspicuous for its breadth.”³ With regard to health plans in particular, ERISA preemption prevents states from regulating these plans even though ERISA itself provides almost no substantive regulation of their provisions.⁴ This has permitted insurance companies to largely control the terms of ERISA health benefit plans that provide coverage through the purchase of insurance.⁵

While this nation’s newly enacted health care reform places some limits on insurers’ coverage practices,⁶ it largely addresses the uninsured prob-

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¹ Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1001-1461 (2006).

² ERISA § 514(a), 29 U.S.C. § 1144(a) (“[T]he provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .”).

³ *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *see also Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (“ERISA includes expansive pre-emption provisions . . .”); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (explaining that ERISA’s “pre-emptive scope was as broad as its language” and the “House and Senate sponsors emphasized both the breadth and importance of the pre-emption provisions” (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983))).

⁴ *E.g.*, *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985) (noting that while ERISA imposes requirements upon welfare plans relating to reporting, disclosure, and fiduciary responsibility, “[i]t does not regulate the substantive content of welfare-benefit plans”).

⁵ Plans that purchase health insurance to provide benefits to plan members are known as “insured” ERISA health plans. *See, e.g., Metro. Life Ins. Co.*, 471 U.S. at 732 (explaining that “insured plans” are “[p]lans that purchase insurance” (internal quotation marks omitted)); *Celentano v. Comm’r of Mass. Div. of Ins.*, No. 09-11112-DPW, 2010 WL 559121, slip op. at *1 n.1 (D. Mass. Feb. 2, 2010) (“In fully-insured employee benefit plans, the employer purchases commercial group health coverage from an insurance company, which, in turn, assumes the risk of paying claims.”).

⁶ *E.g.*, Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, § 2704, 124 Stat. 119, 154 (to be codified as amended at 42 U.S.C. § 300gg (2010)) (stating that by 2014, insurers may not deny coverage to anyone due to preexisting conditions); PPACA § 2711, 124 Stat. at 883 (stat-

lem by mandating the purchase of insurance coverage.⁷ Therefore, health care reform has actually magnified the importance of enabling states to regulate insurers' conduct.

While ERISA clearly precludes states from regulating self-insured⁸ health benefit plans,⁹ its "savings clause"¹⁰ saves from preemption states' regulation of insurance. Consequently, ERISA's savings clause is currently the only means by which states can step into the ERISA void by regulating the substantive terms of insured ERISA health plans and promulgating rules by which insurers will perform their contractual duties.¹¹ As these state insurance laws comprise the mainstay of protections available for ERISA

ing that insurers must eliminate lifetime and annual caps on coverage); *see generally* Tara Siegel Bernard, *For Consumers, Clarity on Health Care Changes*, N.Y. TIMES, Mar. 21, 2010, <http://www.nytimes.com/2010/03/22/your-money/health-insurance/22consumer.html>.

⁷ *See generally* Jill Jackson & John Nolen, *Health Care Reform Bill Summary: A Look at What's in the Bill*, CBS NEWS (Mar. 21, 2010, 6:31 PM), http://www.cbsnews.com/8301-503544_162-20000846-503544.html. Most Americans who do not maintain minimum essential coverage by 2014 would face a penalty. *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1002, 124 Stat. 1029, 1032 (to be codified as amended at 26 U.S.C. § 5000A (2010)). Larger employers (those with over 50 employees) must either provide coverage to employees or pay a penalty per employee (counting the entire number of employees minus some allowances) if any employee receives a federal subsidy to purchase health insurance. PPACA § 1513, 124 Stat. at 253.

⁸ In contrast to fully insured ERISA health benefit plans, plans that opt to pay for the medical care of plan members directly—by setting aside funds in a trust or by paying for claims directly out of employers' operating funds—are known as "self-insured" or "self-funded" plans. *See, e.g.*, *Maciejczak v. Procter & Gamble Co.*, 246 F. App'x 130, 132 (3d Cir. 2007) (explaining that self-insured plans "pay[] benefits out of operating funds rather than from a separate ERISA trust fund" (quoting *Vitale v. Latrobe Area Hosp.*, 420 F.3d 278, 282 (3d Cir. 2005)) (internal quotation marks omitted)); *Post v. Hartford Ins. Co.*, 501 F.3d 154, 163 (3d Cir. 2007) (stating that administrators for self-insured plans may pay the claims out of the employer's "operating budget, rather than from segregated monies" that the employer sets by an actuarial formula). A self-insured ERISA health plan, unlike a fully insured plan, does not purchase a policy from an insurance company to provide coverage to its members. *See, e.g.*, *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990) ("[A self-funded plan] does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants."); *Metro. Life Ins. Co.*, 471 U.S. at 732 (distinguishing self-insured ERISA plans from insured plans that "purchase insurance for their participants"); *Celentano*, 2010 WL 559121, slip op. at *1 n.1 ("Self-funded employee benefit plans are those in which the employer bears the risk of paying claims, and generally a third-party plan administrator is hired to process and pay claims.").

⁹ ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (2006) ("Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts . . .").

¹⁰ ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . .").

¹¹ *Metro. Life Ins. Co.*, 471 U.S. at 729 ("The substantive terms of group-health insurance contracts . . . have been extensively regulated by the States.").

health plan members,¹² it is critical that the savings clause function as fully as possible to save state insurance regulations.

Whether particular state laws regulate insurance and are thereby rendered safe from preemption under ERISA's savings clause has been debated since ERISA's inception.¹³ In the 2003 case *Kentucky Association of Health Plans, Inc. v. Miller*,¹⁴ the United States Supreme Court devised a new test to determine savings, relaxing the requirements to preserve a greater range of state insurance laws.¹⁵ However, due to the test's rather confusing language,¹⁶ federal courts have continued to deliver inconsistent rulings as to whether particular state laws are saved from preemption.¹⁷ The unfortunate result is that state laws that legitimately regulate the relationship between ERISA insurers and insureds continue to be wrongfully preempted,¹⁸ depriving countless ERISA plan members of the state law protections that should be available to them.

This Essay argues for a broader reading of the *Miller* savings test, in keeping with the intent and expansive language of ERISA's savings clause.¹⁹ Applying *Miller* to give full effect to the savings clause will unbind the states to indirectly regulate insured ERISA health benefit plans via their traditional role of regulating insurance business conducted within the states' borders.

I. ERISA'S BROAD PREEMPTION OF STATE LAWS RELATING TO EMPLOYEE HEALTH BENEFIT PLANS

ERISA was promulgated to protect the members of employee benefit plans.²⁰ Congress passed ERISA in the wake of congressional investigations

¹² *Id.* (describing the variety of state laws that regulate insurance contracts purchased by ERISA health benefit plans).

¹³ *See id.* at 744 (concluding that state mandated-benefits laws are saved from ERISA preemption as the regulation of insurance).

¹⁴ 538 U.S. 329 (2003).

¹⁵ *See id.* at 341-42 (devising a new two-part test to determine whether a state law qualifies as a "law . . . which regulates insurance" (internal quotation marks omitted)).

¹⁶ *See infra* Part VI.

¹⁷ *See infra* Part V.

¹⁸ *See infra* Parts VII-VIII.

¹⁹ *See infra* Parts VI-VIII.

²⁰ ERISA § 2(b), 29 U.S.C. § 1001(b) (2006) ("It is hereby declared to be the policy of this chapter 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."); *see also, e.g., Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) ("Congress enacted ERISA to 'protect . . . the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appro-

that had revealed labor unions' mismanagement and looting of union-sponsored pension plans.²¹ In order to insulate employee benefit plans from corruption, ERISA deemed that all such plans were to be held in trust for the exclusive benefit of the plan members and their beneficiaries.²²

In order to achieve uniform protections for the members of employee benefit plans,²³ ERISA expressly preempts any state law that "relate[s] to" an ERISA benefit plan.²⁴ With regard to employee health benefit plans in particular, courts have applied ERISA's broad "relates to" standard²⁵ to preempt a large variety of state law claims, including state common law breach of contract and tort claims,²⁶ as well as more specific laws regulating

priate remedies, sanctions, and ready access to the Federal courts.'" (alteration in original) (quoting ERISA § 2(b), 29 U.S.C. § 1001(b)); *Hammond v. Fid. & Guar. Life Ins. Co.*, 965 F.2d 428, 429 (7th Cir. 1992) ("One of ERISA's purposes is to protect the financial integrity of pension and welfare plans . . .").

²¹ See, e.g., John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1325 (2007).

²² *Id.* at 1325 ("In enacting ERISA," the Supreme Court has observed, "Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits . . .") (quoting *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989)). ERISA provides that "all assets of an employee benefit plan shall be held in trust." ERISA § 403(a), 29 U.S.C. § 1103(a). This provision, however, does not apply to insurance policies of plan assets held by an insurer. ERISA § 403(b)(1)-(2), 29 U.S.C. § 1103(b)(1)-(2) ("The requirements of subsection (a)[, holding assets of plans in trust,] shall not apply—(1) to any assets of a plan which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State; [or] (2) to any assets of such an insurance company or any assets of a plan which are held by such an insurance company.").

²³ See, e.g., *Davila*, 542 U.S. at 208 ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."); *Hammond*, 965 F.2d at 430 ("ERISA's preemption provision was designed to eliminate the 'threat of conflicting or inconsistent State and local regulation of employee benefit plans.'" (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987))).

²⁴ ERISA § 514(a), 29 U.S.C. § 1144(a) ("Except as provided in [the savings clause, discussed in Part III, *infra*,] the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."). A law "relates to" an ERISA plan if it has "a connection with or reference to such a plan." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)) (internal quotation marks omitted).

²⁵ Numerous courts have commented on the breadth of ERISA's preemption provisions. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) ("[T]he express pre-emption provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.'" (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981))). The *Pilot Life* Court quoted from the Congressional Record:

[T]he substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

481 U.S. at 46 (quoting 120 CONG. REC. 29,933 (1974)).

²⁶ See, e.g., *Pilot Life*, 481 U.S. at 57 (preempting a state common law cause of action for bad faith asserted to challenge alleged improper processing of a claim for benefits in an ERISA health plan); *Hammond*, 965 F.2d at 430 (preempting state rules of contract interpretation).

insurance practices.²⁷ These state laws were deemed to be preempted by ERISA even when the state laws implemented protections for the members of ERISA health plans.²⁸

II. THE ERISA GAP

Justice Ginsburg recognized in *Aetna Health Inc. v. Davila*²⁹ that due to ERISA's broad preemption, health plan members may sometimes be denied important protections afforded by state law.³⁰ In *Davila*, the Supreme Court ruled that ERISA completely preempted the Texas Health Care Liability Act,³¹ which made managed care plans liable for damages

²⁷ See, e.g., *Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.3d 460, 465-66 (10th Cir. 1997) (preempting OKLA. STAT. ANN. tit. 36, §§ 3629, 4405 (West 1990), which provided a policyholder with a cause of action for improper processing of an insurance claim); *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 938, 943 (6th Cir. 1997) (preempting a provision of the Ohio Code, OHIO REV. CODE ANN. § 3923.14 (West 1989), that prevented a health insurer from rescinding coverage due to the falsity of information provided by the insured in his application unless the statement was "willfully false," "fraudulently made," and material to the insurer's acceptance of the risk), *abrogated by* *Johnson v. Conn. Gen. Life Ins. Co.*, 324 F. App'x 459 (6th Cir. 2009); *DeBruyne v. Equitable Life Assurance Soc'y of U.S.*, 920 F.2d 457, 467-68 (7th Cir. 1990) (preempting N.Y. INS. LAW § 4226(a) (McKinney 1984), which prohibited insurers from misrepresenting the terms of their policies).

²⁸ See cases cited *supra* note 27 (describing state laws that were implemented to protect policyholders from unfair insurance practices).

²⁹ 542 U.S. 200 (2004).

³⁰ *Id.* at 222 (Ginsburg, J., concurring).

³¹ A theory of "complete" preemption is distinct from a theory of express preemption under the "relate to" clause of ERISA. Under a complete preemption theory, a state law is deemed preempted by federal law "[w]hen the federal statute wholly displaces the state-law cause of action." *Id.* at 207 (quoting *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 8 (2003)) (internal quotation marks omitted); see also *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 413 F.3d 897, 907 (8th Cir. 2005) ("Complete preemption occurs whenever Congress 'so completely [preempts] a particular area that any civil complaint raising this select group of claims is necessarily federal in character.'" (alteration in original) (quoting *Metro Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987))). The *Davila* Court declared that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Davila*, 542 U.S. at 209; see also *Prudential Ins. Co.*, 413 F.3d at 907 ("Claims arising under the civil enforcement provision of Section 502(a) of ERISA, 29 U.S.C. § 1132(a), including a claim to recover benefits or enforce rights under the terms of an ERISA plan, implicate one such area of complete preemption." (quoting *Neumann v. AT & T Commc'ns, Inc.*, 376 F.3d 773, 779 (8th Cir. 2004))). The *Davila* Court ruled that the Texas Act was completely preempted because it was, in effect, a claim for benefits due under the ERISA plan, which could have been brought under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and because it offered the policyholder remedies that went beyond the remedies available under ERISA's civil enforcement provisions. *Davila*, 542 U.S. at 217-18. "[A] state cause of action that provides an alternative remedy to those provided by the ERISA civil enforcement mechanism conflicts with Congress' clear intent to make the ERISA mechanism exclusive." *Id.* at 214 n.4; see also *Prudential Ins. Co.*, 413 F.3d at 907 ("Because of complete preemption, any claim filed by a plan participant for the same relief provided under ERISA's civil enforcement

proximately caused by their failure to exercise ordinary care when making health care-treatment decisions.³² Respondent Juan Davila had suffered a severe reaction to Naprosyn that required extensive treatment and hospitalization after Aetna refused to cover his physician's prescription for Vioxx unless Davila first try Naprosyn, a less expensive alternative.³³ Co-respondent Ruby Calad had experienced serious post-surgery complications after she left the hospital early following Aetna's refusal to cover an extended hospital stay recommended by her physician.³⁴ Both respondents, members of ERISA health plans that had purchased coverage from Aetna, sued Aetna under the Texas Act, alleging that Aetna's failure "to exercise ordinary care when making health care treatment decisions" had caused their injuries.³⁵

Due to the Supreme Court's finding that ERISA completely preempted the Texas Act,³⁶ the respondents could not recover damages for their injuries that otherwise would have been available under the state law.³⁷ Instead, they were limited to claiming the value of their denied benefits,³⁸ the only damages that ERISA § 502(a)(1)(B) permits for aggrieved plan members.³⁹

provision, even a claim purportedly raising only a state-law cause of action, arises under federal law and is removable to federal court.").

Prior to the decision in *Davila*, other courts had recognized that ERISA's civil enforcement provisions demonstrated an "overpowering federal policy" to completely occupy the field and preempt any inconsistent remedies. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 375 (2002) (5-4 decision). Justice Thomas, in *Rush Prudential HMO, Inc. v. Moran*, stated that "[t]his Court has repeatedly recognized that ERISA's civil enforcement provision . . . provides the exclusive vehicle for actions asserting a claim for benefits under health plans governed by ERISA, and therefore that state laws that create additional remedies are preempted." *Id.* at 388 (Thomas, J., dissenting). Thus, the appropriate inquiry is whether the challenged state laws "'supplem[en]t or supplan[t]' the federal scheme by allowing beneficiaries 'to obtain remedies under state law that Congress rejected in ERISA.'" *Id.* at 378 (majority opinion) (alterations in original) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)).

³² *Davila*, 542 U.S. at 214 ("We hold that respondents' state causes of action fall 'within the scope of' ERISA § 502(a)(1)(B), and are therefore completely pre-empted by ERISA § 502" (citation omitted) (quoting *Taylor*, 481 U.S. at 66)).

³³ *Id.* at 205; *Roark v. Humana, Inc.*, 307 F.3d 298, 303 (5th Cir. 2002), *rev'd on other grounds sub nom.* *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).

³⁴ *Davila*, 542 U.S. at 205.

³⁵ *Id.* (internal quotation marks omitted).

³⁶ *Id.* at 214.

³⁷ *Id.* at 214-15.

³⁸ *Id.* at 214.

³⁹ ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (2006) ("A civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."). ERISA also authorizes a plan member to bring an action to receive information from an administrator, for relief for breach of fiduciary duty, or to enjoin an act that violates ERISA or the terms of the plan or to obtain other "appropriate equitable relief" to redress violations or enforce any provision of

While recognizing that the decision in *Davila* was consistent with prior ERISA case law on preemption, Justice Ginsburg noted in a concurring opinion the injustice of the result.⁴⁰ She pointed out the “regulatory vacuum” that ERISA preemption has created, whereby “[v]irtually all state law remedies are preempted but very few federal substitutes are provided.”⁴¹

This regulatory “gap” exists because—despite its broad preemption of state laws—ERISA itself provides little in the way of substantive protections for health plan members against insurers’ negligence or bad faith.⁴² Recoveries for ERISA plan members, like the *Davila* respondents, are limited to their “benefits due . . . under the terms of [their] plan[s].”⁴³ The dismissal of state law claims due to ERISA preemption thus “has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief.”⁴⁴ This “gap” between ERISA’s broad preemption of state laws regulating health plans and ERISA’s own failure to protect health plan members from serious personal injuries that may result from negligent or bad faith insurance coverage denials has been criticized by legal scholars.⁴⁵

III. THE SAVINGS CLAUSE: ERISA’S EXCEPTION TO PREEMPTION

The only significant exception to ERISA’s broad preemption of state laws that relate to employee benefit plans is ERISA’s savings clause, which expressly exempts from preemption any state laws that “regulate[] insur-

ERISA or the terms of the plan. ERISA §§ 502(a)(1)(A), (a)(2)-(3), 29 U.S.C. §§ 1132(a)(1)(A), (a)(2)-(3).

⁴⁰ *Davila*, 542 U.S. at 222 (Ginsburg, J., concurring) (“I also [urge this] ‘Court [to] revisit what is an unjust and increasingly tangled ERISA regime.’” (quoting *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003))).

⁴¹ *Id.* (alteration in original) (quoting *DiFelice*, 346 F.3d at 456) (internal quotation marks omitted).

⁴² *Id.* at 222-23 (noting the “limited remedies under ERISA”); see also *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985) (“[ERISA] does not regulate the substantive content of welfare-benefit plans.”).

⁴³ ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

⁴⁴ *Davila*, 542 U.S. at 222 (Ginsburg, J., concurring). Justice Ginsburg urged a “fresh consideration of the availability of consequential damages under § 502(a),” referring to the “‘gaping wound’ caused by the breadth of [ERISA] preemption and limited remedies under ERISA.” *Id.* at 223 (quoting *Cicio v. Does*, 321 F.3d 83, 107 (2d Cir. 2003) (Calabresi, J., dissenting in part)).

⁴⁵ E.g., John H. Langbein, *What ERISA Means by “Equitable”*: *The Supreme Court’s Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1365 (2003) (“The Supreme Court needs . . . to realign ERISA remedy law with the trust remedial tradition that Congress intended in the grant of ‘appropriate equitable relief’ [in § 502(a)(3)].”).

ance.”⁴⁶ Courts have recognized the breadth of the savings clause, observing that to a large extent, it gives back to the states many of the laws that would otherwise be preempted by ERISA.⁴⁷ By virtue of the savings exemption, states have been able to indirectly regulate insured ERISA health benefit plans by regulating the health insurance coverage that such plans purchase.⁴⁸ While state insurance laws, consistent with the finding of *Davila*, may not provide remedies that are inconsistent with ERISA’s comprehen-

⁴⁶ ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (“[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”).

⁴⁷ See, e.g., *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 363 (1999) (stating that ERISA’s savings clause is “phrased with similar breadth” as its preemption provision); *Metro. Life Ins. Co.*, 471 U.S. at 733, 739-40 (observing that “pre-emption is substantially qualified by an ‘insurance saving clause’” and that “while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States’ lawmaking power over much of the same regulation”); *Standard Ins. Co. v. Morrison (Morrison I)*, 537 F. Supp. 2d 1142, 1149 (D. Mont. 2008) (“[The] very purpose of ERISA’s Savings Clause [is to] mak[e] room for a state to regulate.”), *aff’d*, 584 F.3d 837 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010). Moreover, the term “State law” is broadly defined to include “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.” ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1) (internal quotation marks omitted).

⁴⁸ The regulation is “indirect” because state insurance laws cannot regulate ERISA plans directly due to ERISA preemption. See ERISA § 514(a), 29 U.S.C. § 1144(a) (preempting state laws that “relate to” ERISA plans). States can, however, indirectly regulate the plans by regulating the insurance companies that sell insurance coverage to these plans. See, e.g., *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) (“[I]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts . . .”).

However, a state’s ability to affect ERISA plans indirectly through the regulation of insurance is limited in two ways. First, ERISA’s “deemer” clause prohibits state insurance laws from being applied to self-insured plans. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). The deemer clause provides that no self-insured plan “shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies[or] insurance contracts.” *Id.* As these plans do not purchase health insurance from an insurance company, they are unaffected by state insurance laws that apply to such insurance contracts. And because the deemer clause prohibits the state from regulating self-insured plans directly as species of insurance, the state has virtually no authority over such plans at all. See *FMC Corp.*, 498 U.S. at 61 (“We read the deemer clause to exempt self-funded ERISA plans from state laws that ‘regulat[e] insurance’ within the meaning of the saving clause.” (alteration in original)).

Second, even when a state law may be saved as the regulation of insurance, the law may not provide remedies to ERISA plan members that are not provided by ERISA’s comprehensive remedial scheme. *Davila*, 542 U.S. at 217-18 (“ERISA § 514(b)(2)(A) must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a). . . . [E]ven a state law that can arguably be characterized as ‘regulating insurance’ will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.”); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 388 (2002) (Thomas, J., dissenting) (“ERISA’s civil enforcement provision, § 502 of [ERISA], 29 U.S.C. § 1132, provides the exclusive vehicle for actions asserting a claim for benefits under health plans governed by ERISA, and therefore that state laws that create additional remedies are pre-empted.”); see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (“[O]ur understanding of the saving clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a) . . .”).

sive regulatory scheme,⁴⁹ the laws may nevertheless help to close the ERISA “gap” by requiring health insurance companies to provide benefits and determine claims in a fair and equitable manner.⁵⁰

Historically, in determining whether a particular state law was saved from preemption as a law that regulated insurance, courts started with a “common-sense view.”⁵¹ This approach required the law to “be specifically directed toward” the insurance industry in order to be saved.⁵² Generally, the commonsense test required the state law to be an insurance regulation and not just a broad common law principle that could be applied in numerous contexts besides insurance.⁵³

⁴⁹ See *Davila*, 542 U.S. at 217-18 (“[A] state law . . . will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.”); see also *Rush Prudential*, 536 U.S. at 375, 377 (stating that congressional intent to preempt state laws that were inconsistent with ERISA’s comprehensive remedial scheme was “so clear that it overrides a statutory provision designed to save state law from being preempted” and that “state insurance regulation los[es] out if it allows plan participants ‘to obtain remedies . . . that Congress rejected in ERISA’” (quoting *Pilot Life*, 481 U.S. at 54)); *Pilot Life*, 481 U.S. at 52 (“[O]ur 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).”). In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. *Id.* at 54.

⁵⁰ See, for example, the state insurance regulations discussed at Part V *infra*, including state insurance laws prohibiting insurers’ discretionary clauses, limiting insurers’ ability to rescind coverage due to an insured’s misstatements on the application, and imposing liability for insurers’ bad faith claims denials, all of which regulate insurers’ conduct for the protection of policyholders.

⁵¹ See, e.g., *Pilot Life*, 481 U.S. at 48 (stating that the first step in determining whether a state law falls under the saving clause is to take “what guidance was available from a ‘common-sense view’ of the language of the saving clause itself” (quoting *Metro. Life Ins. Co.*, 471 U.S. at 740 (applying a “common-sense view of the matter” in concluding that a state law that regulated the terms of certain insurance contracts seemed to be saved from preemption by the saving clause as a law “which regulates insurance” (internal quotation marks omitted)))).

⁵² *Rush Prudential*, 536 U.S. at 366 (quoting *Pilot Life*, 481 U.S. at 50 (“A common-sense view of the word ‘regulates’ would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.”)) (internal quotation marks omitted); *Ward*, 526 U.S. at 368 (concluding that a state law regulates insurance because it “‘is directed specifically at the insurance industry and is applicable only to insurance contracts’” (quoting *Cisneros v. UNUM Life Ins. Co. of Am.*, 134 F.3d 939, 945 (9th Cir. 1998))). The commonsense inquiry has also been described as regulating insurers “with respect to their insurance practices,” and focusing on the “‘primary elements of an insurance contract[, which] are the spreading and underwriting of a policyholder’s risk.’” *Rush Prudential*, 536 U.S. at 366 (alteration in original) (quoting *Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979) (5-4 decision)).

⁵³ See, e.g., *Pilot Life*, 481 U.S. at 50 (“[T]he roots of this [common] law [breach of contract and tort claims] are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.”); see also *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 334 (2003)

If a state law passed the commonsense test, the court next tested the law by considering the three factors utilized to spare insurance laws from federal preemption under the McCarran-Ferguson Act⁵⁴: “*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.”⁵⁵ While courts considered all three factors, they generally agreed that “[a] state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption.”⁵⁶

With the rapid growth of managed care⁵⁷ in the 1980s and 1990s, a substantial activity of health insurance companies creating managed care products involved contracting with a network of providers to render treat-

(“It is well established in our case law that a state law must be ‘specifically directed toward’ the insurance industry in order to fall under ERISA’s saving clause; laws of general application that have some bearing on insurers do not qualify.” (quoting *Pilot Life*, 481 U.S. at 50)).

⁵⁴ *Rush Prudential*, 536 U.S. at 366. The McCarran-Ferguson Act provides that the business of insurance be subject to state regulation and, subject to certain exceptions, mandates that “no Act of Congress shall be construed to invalidate . . . any law enacted by any State for the purpose of regulating the business of insurance.” 15 U.S.C. § 1012(b) (2006). The “*primary* purpose of the McCarran-Ferguson Act was to preserve state regulation of the activities of insurance companies” and also “to assure that the States are free to regulate insurance companies without fear of Commerce Clause attack.” *Grp. Life*, 440 U.S. at 218 n.18.

⁵⁵ *Metro. Life Ins. Co.*, 471 U.S. at 743 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)) (internal quotation marks omitted) (stating the McCarran-Ferguson factors); *see also* *Rush Prudential*, 536 U.S. at 373-74 (applying the three McCarran-Ferguson factors); *Ward*, 526 U.S. at 367 (stating the McCarran-Ferguson criteria). The McCarran-Ferguson test has been described as determining “when insurers are regulated with respect to their insurance practices.” *Rush Prudential*, 536 U.S. at 366.

⁵⁶ *Rush Prudential*, 536 U.S. at 373 (declaring that McCarran-Ferguson factors are only “guideposts”); *see also* *Ward*, 526 U.S. at 373-74 (“[N]one of these [McCarran-Ferguson] criteria is necessarily determinative in itself, . . . [but courts look to them] as checking points or ‘guideposts, not separate essential elements . . . that must each be satisfied’ to save the State’s law” (quoting *Pireno*, 458 U.S. at 129; *Cisneros v. UNUM Life Ins. Co. of Am.*, 134 F.3d 939, 946 (9th Cir. 1998))); *Pilot Life*, 481 U.S. at 49 (referring to the McCarran-Ferguson criteria merely as “considerations weighed” in the saving analysis); *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 940 (6th Cir. 1997) (“[The McCarran-Ferguson] criteria must be considered in combination, and, standing alone, no single one is dispositive.”), *abrogated by* *Johnson v. Conn. Gen. Life Ins. Co.*, 324 F. App’x. 459 (6th Cir. 2009). *But see* *CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 650 (5th Cir. 1996) (“[I]f a statute fails . . . to satisfy any one element of the three-factor [McCarran-Ferguson] test, then the statute is not exempt from preemption by the ERISA insurance savings clause.”).

⁵⁷ Generally, managed care organizations combine health care delivery with its financing. The traditional form of managed care is the health maintenance organization (“HMO”), defined as “[a] prepaid organized delivery system where the organization *and* the primary care physicians assume some financial risk for the care provided to its enrolled members. . . . In a *pure HMO*, members must obtain care from within the system if it is to be reimbursed.” *Rush Prudential*, 536 U.S. at 361 n.1 (alteration in original) (quoting Jonathan P. Weiner & Gregory de Lissvooy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL’Y & L. 75, 96 (1993)).

ments to insureds.⁵⁸ States began promulgating insurance laws that regulated the relationships between the provider networks and the insurance companies.⁵⁹ But because these laws regulated providers as well as insurance companies, it remained uncertain whether they were saved from ERISA preemption under the commonsense test and McCarran-Ferguson factors.⁶⁰ The fact that these laws regulated providers as well as insurers led some courts to find that they were neither aimed solely at insurance companies nor limited to entities within the insurance industry, and therefore not saved from preemption.⁶¹

IV. *KENTUCKY ASSOCIATION OF HEALTH PLANS, INC. v. MILLER*: A NEW TEST FOR ERISA SAVINGS

In 2003, the Supreme Court addressed the question of whether state laws that regulated the relationship between insurance companies and providers who participated in the insurers' managed care networks could be preempted by ERISA. In *Kentucky Association of Health Plans, Inc. v. Miller*, health maintenance organizations ("HMOs") and their trade association challenged Kentucky statutes that prohibited health insurers from discriminating against providers who were willing to meet the insurers' conditions for participation in their managed care provider networks,⁶² referred to

⁵⁸ See, e.g., *Grp. Life*, 440 U.S. at 213-14 (describing agreements between a Texas health insurance company and three pharmacies by which insureds were to pay a \$2 co-pay for each prescription drug purchased at the participating pharmacies and the remainder of the cost would be paid to the pharmacies by the insurer).

⁵⁹ E.g., N.Y. PUB. HEALTH LAW § 4406(1) (McKinney 2002) ("The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent [of insurance] as if it were a health insurance subscriber contract, and shall include . . . all mandated benefits required by . . . the insurance law.").

⁶⁰ E.g., *Tex. Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1038 (5th Cir. 1997) ("[T]he Texas statute in the present case does not fall within the savings clause because it is not limited to entities within the insurance industry. Instead, it also applies to . . . organizations that provide health care services."); *CIGNA Healthplan of La.*, 82 F.3d at 650 ("Even though the statute lists insurers as one group covered by its terms, it also specifies, in a non-exclusive list, that it applies to . . . 'health care financiers, third party administrators, providers, or other intermediaries.'" (quoting LA. REV. STAT. ANN. § 40:2202(3)(b) (1992))).

⁶¹ See, e.g., *Grp. Life*, 440 U.S. at 216-17 (finding that participating pharmacy agreements did not constitute the business of insurance for purposes of applying the McCarran-Ferguson exemption to the federal antitrust laws because they involved third-party pharmacy providers, who were outside the insurance industry).

⁶² See *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332 (2003). One of the challenged laws provided that "[a] health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships." KY. REV. STAT. ANN. § 304.17A-270 (West 2006). The other challenged statute provided that any "health benefit plan that includes chiropractic benefits shall . . . [p]ermit any

as “Any Willing Provider” (“AWP”) laws.⁶³ The petitioners argued that Kentucky’s AWP laws were not “specifically directed” at the insurance industry because they prohibited both insurance companies and providers from forming and participating in limited networks and thus could not be saved from ERISA preemption as the regulation of insurance.⁶⁴

In ruling that the AWP laws were indeed saved from preemption, the *Miller* Court announced an abandonment of the historical savings tests that had utilized the commonsense inquiry and considered the three McCarran-Ferguson factors.⁶⁵ The Court declared that 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.”⁶⁶ The Court further stated that the language of the McCarran-Ferguson statute and the language of ERISA’s preemption clause was inconsistent⁶⁷ and that cases interpreting the McCarran-Ferguson factors “raise[d] more questions than they answer[ed] and provide[d] wide opportunities for divergent outcomes.”⁶⁸

Accordingly, the Supreme Court replaced the old test with a new two-part inquiry. The first part of the new test preserved the commonsense inquiry, requiring that “the state law must be specifically directed toward entities engaged in insurance.”⁶⁹ As a substitute for the McCarran-Ferguson factor that required a state law to have the effect of spreading the policyholder’s risk, the second part of the new test requires that “the state law must substantially affect the risk pooling arrangement between the insurer and the insured.”⁷⁰

The *Miller* Court’s explanation of what it means to “substantially affect the risk pooling arrangement between the insurer and the insured” was scant.⁷¹ In fact, the Court provided only four explanatory points. First, the

licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.” *Id.* § 304.17A-171(2).

⁶³ *Miller*, 538 U.S. at 332.

⁶⁴ *Id.* at 334 (internal quotation marks omitted). “[T]he AWP laws equally prevent *providers* from entering into limited network contracts with *insurers*, just as they prevent insurers from creating exclusive networks in the first place. . . . [These laws] focus on the relationship between an insurer and *third-party providers*—which . . . does not constitute an ‘insurance practice.’” *Id.* at 334, 337.

⁶⁵ *Id.* at 333 (describing the old test that the lower courts applied).

⁶⁶ *Id.* at 339-40.

⁶⁷ *Id.* at 340 (comparing the McCarran-Ferguson Act’s concern with “whether certain practices constitute ‘[t]he business of insurance,’” as expressed in 15 U.S.C. § 1012(a), to ERISA’s focus on “whether a state law is a ‘law . . . which regulates insurance,’” as expressed in 29 U.S.C. § 1144(b)(2)(A) (alterations in original)).

⁶⁸ *Id.* at 340.

⁶⁹ *Miller*, 538 U.S. at 342.

⁷⁰ *Id.*

⁷¹ *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F. Supp. 2d 296, 305 (E.D. Pa. 2003) (“The Supreme Court’s decision in *Miller* does not provide much guidance in construing the meaning of the

Court stated that to be saved, a state law need not alter or control the actual terms of the insurance policy,⁷² thereby signaling an abandonment of this formerly utilized McCarran-Ferguson factor. Second, the Court stated that a saved state law need not actually spread risk, but must merely substantially affect the risk-pooling arrangement.⁷³ Third, the Court explained that some laws that were merely “aimed at insurance companies,” such as a law that regulated the wages that insurance companies pay to their janitors, would not be saved because they do not affect the risk-pooling arrangement.⁷⁴ And fourth, in contrast to the janitor-wages example, the Court explained that state laws such as mandated-benefits laws,⁷⁵ the notice-prejudice rule,⁷⁶ and independent review laws⁷⁷ all regulate insurance because they “alter the scope of permissible bargains between insurers and insureds.”⁷⁸ The Court further explained that the notice-prejudice rule, for example, is saved because it “dictates to the insurance company the conditions under which it must pay for the risk that it has assumed.”⁷⁹ These statements constitute the sum total of the Supreme Court’s guidance to aid lower courts in determining whether state laws “substantially affect the risk pooling arrangement between the insurer and the insured”⁸⁰ and are saved from ERISA preemption.

Concluding that the AWP laws at issue in *Miller* satisfied the new test, the Court observed that they prohibit insureds from obtaining—and insurers from offering—coverage in a closed network of providers in exchange for a

test it announces.”); *see also* *Weeks v. Unum Grp.*, 585 F. Supp. 2d 1305, 1310 (D. Utah 2008) (commenting that “the *Miller* Court is not entirely clear in its definition” of risk pooling).

⁷² *See Miller*, 538 U.S. at 338 (explaining that the Court 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 § 1144(b)(2)(A)” of ERISA (alterations in original)).

⁷³ *See id.* at 339 n.3 (“[O]ur test requires only that the state law substantially *affect* the risk pooling arrangement between the insurer and insured; it does not require that the state law actually spread risk.”).

⁷⁴ *Id.* at 338.

⁷⁵ *Id.* at 339 (citing *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985)). The mandated-benefits law at issue in *Metropolitan Life Insurance Co. v. Massachusetts* required “that specified minimum mental-health-care benefits be provided a Massachusetts resident who is insured under a general insurance policy, an accident or sickness insurance policy, or an employee health-care plan that covers hospital and surgical expenses.” 471 U.S. at 727.

⁷⁶ *Miller*, 538 U.S. at 339 (citing *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999)). The notice-prejudice rule at issue in *UNUM Life Insurance Co. of America v. Ward* provided that “an insurer cannot avoid liability although the proof of claim is untimely, unless the insurer shows it was prejudiced by the delay.” 526 U.S. at 364.

⁷⁷ *Miller*, 538 U.S. at 339 (citing *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)). The independent review law at issue in *Rush Prudential HMO, Inc. v. Moran* “provides recipients of health coverage by [HMOs] with a right to independent medical review of certain denials of benefits.” 536 U.S. at 359.

⁷⁸ *Miller*, 538 U.S. at 338-39.

⁷⁹ *Id.* at 339 n.3.

⁸⁰ *Id.* at 342.

lower premium.⁸¹ Therefore, the Court explained, the “AWP laws alter the scope of permissible bargains between insurers and insureds,” and thus, “substantially affect[] the type of risk pooling arrangements that insurers may offer.”⁸² Even though the laws undeniably affect providers as well as insurance companies,⁸³ the Court declared that the AWP laws do not impose any prohibitions or requirements on health care providers.⁸⁴ Instead, the AWP laws are violated only when an insurer excludes from its network a provider who is willing to meet the insurer’s terms of participation.⁸⁵ In sum, the *Miller* Court enunciated a new test for ERISA preemption, which retained the “commonsense inquiry” that a state law be specifically directed toward entities engaged in insurance, but further required a showing that the state law substantially affect the risk-pooling arrangement between the insurer and the insured.

V. DIFFICULTIES APPLYING THE *MILLER* SAVINGS TEST

Not surprisingly, many courts have experienced difficulty applying the *Miller* test to determine whether a state law “substantially affects the risk pooling arrangement between the insurer and the insured.” Even when examining similar types of state insurance laws, various courts have disagreed on whether the laws fulfill this element of the test.⁸⁶ As a result, the *Miller* test has not cured the problem of “divergent outcomes”⁸⁷ that precipitated its creation.

For example, courts have disagreed on whether or not state laws that prohibit discretionary clauses⁸⁸ are preempted by ERISA.⁸⁹ Some courts

⁸¹ *Id.* at 338-39 (“By expanding the number of providers from whom an insured may receive health services . . . [n]o longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium.”).

⁸² *Id.* at 338-39.

⁸³ *Id.* at 335-36 (“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 ERISA’s saving clause.”).

⁸⁴ *Miller*, 538 U.S. at 335.

⁸⁵ *Id.* (“Kentucky’s statutes are transgressed only when a ‘health insurer,’ or a ‘health benefit plan that includes chiropractic benefits,’ excludes from its network a provider who is willing and able to meet its terms.”).

⁸⁶ See discussion *infra* Part V.

⁸⁷ *Miller*, 538 U.S. at 340.

⁸⁸ Discretionary clauses allow insurers to allocate to themselves discretion to interpret the terms of their insurance policies and thereby obtain deferential judicial review of claims denials. *E.g.*, *Standard Ins. Co. v. Morrison (Morrison I)*, 537 F. Supp. 2d 1142, 1143 (D. Mont. 2008) (“A discretionary clause invokes a plan provision that grants the plan administrator . . . authority to interpret the plan and to resolve all questions arising under it. . . . A discretionary clause means a more deferential standard of judicial review when an administrator’s decision to deny benefits is challenged on appeal in district court.”), *aff’d*, 584 F.3d 837 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010).

have held that these laws substantially affect risk pooling because they control the terms of the insurance contracts⁹⁰ and dictate to the insurer the conditions under which it must pay for the risk it has assumed.⁹¹ Other courts have disagreed, with one court finding that a state law prohibiting discretionary clauses was preempted because it did not alter the risk the insurer assumed in the contract.⁹² Other courts have found that state laws that in-

⁸⁹ Compare, e.g., *Standard Ins. Co. v. Morrison (Morrison II)*, 584 F.3d 837, 845 (9th Cir. 2009) (“[Discretionary clauses] indeed affect[] the risk pooling arrangement.”), *cert. denied*, 130 S. Ct. 3275 (2010), *Am. Council of Life Ins. v. Ross*, 558 F.3d 600, 607 (6th Cir. 2009) (“We therefore conclude that the [laws that prohibit discretionary clauses] regulate insurance because they substantially affect the risk-pooling arrangement . . .”), *McClenahan v. Metro. Life Ins. Co.*, 621 F. Supp. 2d 1135, 1141 (D. Colo. 2009) (“[T]he statute substantially affects the risk pooling arrangement . . .”), *Am. Council of Life Insurers v. Watters*, 536 F. Supp. 2d 811, 823 (W.D. Mich. 2008) (“The Rules ‘substantially affect the risk pooling arrangement between the insurer and insured’ . . .”), *aff’d sub nom. Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009), *Kohut v. Hartford Life & Accident Ins. Co.*, No. 08-cv-00669-CMA-MJW, 2008 WL 5246163, at *8 (D. Colo. Dec. 16, 2008) (“[T]he statute affects the policy relationship between the insurer and the insured by affecting the interpretation of the insurance contract . . .”), and *Fenberg v. Cowden Auto. Long Term Disability Plan*, No. C 03-03898 SI, 2004 WL 2496174, at *3 (N.D. Cal. Nov. 2, 2004) (“The law also substantially affects the risk pooling arrangement between the insurer and the insured . . .”), *rev’d on other grounds*, 259 F. App’x 958 (9th Cir. 2007), with *Lucero v. Hartford Life & Accident Ins. Co.*, No. 2:08-CV-302 TS, 2009 WL 2170048, slip op. at *5-6 (D. Utah July 17, 2009) (finding that a state law providing limitations on discretionary authority clauses in ERISA plans does not affect the risk-pooling arrangement and is therefore preempted by ERISA under the *Miller* test); see also *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1151-52 (10th Cir. 2009) (finding that a state law that bans discretionary clauses unless the clause uses particular language is preempted by ERISA because it does not affect the risk-pooling arrangement); *Weeks v. Unum Grp.*, 585 F. Supp. 2d 1305, 1311 (D. Utah 2008) (finding that a state law that mandates the form of discretionary clauses and invalidates non-complying clauses is preempted by ERISA because it does not affect the risk-pooling arrangement).

⁹⁰ E.g., *Ross*, 558 F.3d at 606-07 (finding that a state law prohibiting discretionary clauses “chang[es] the terms of enforceable insurance contracts” and limits the authority that insurers can invest in the plan administrator); *McClenahan*, 621 F. Supp. 2d at 1141 (“The statute ‘alter[s] the scope of permissible bargains between insurers and insureds.’” (alteration in original) (quoting *Miller*, 538 U.S. at 338-39)); *Morrison I*, 537 F. Supp. 2d at 1151-52 (“[The state law] eliminat[ing] Standard’s option to minimize scrutiny of benefit denials . . . ‘is the stuff of garden variety insurance regulation through the imposition of standard policy terms.’” (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002))).

⁹¹ See, e.g., *McClenahan*, 621 F. Supp. 2d at 1141 (“[The statute] dictate[s] ‘to the insurance company the conditions under which it must pay for the risk that it has assumed.’” (quoting *Miller*, 538 U.S. at 339 n.3)); *Kohut*, 2008 WL 5246163, at *8 (“[T]he statute affects the policy relationship between the insurer and the insured by affecting the interpretation of the insurance contract . . .”); *Watters*, 536 F. Supp. 2d at 823 (finding that the discretionary clause rules place “‘conditions on the right to engage in the business of insurance’” (quoting *Miller*, 538 U.S. at 338)); *Fenberg*, 2004 WL 2496174, at *3 (finding that a California prohibition against discretionary clauses prevents the insurer from “re-view[ing] its own decisions on the payment of benefits”).

⁹² See *Lucero*, 2009 WL 2170048, slip op. at *6 (“[T]he Utah Rule applies only to the administrative function of interpreting the insurance plan’s terms and judicial review of the use of that administrative function[, which] is unrelated to either the risk of adverse events occurring or their potential magnitude.”).

validated discretionary clauses unless they complied with form requirements had no effect on risk pooling.⁹³ They ruled that the laws did not alter contractual risk because the discretionary provisions in the contract were left intact as long as they were stated “expressly and conspicuously.”⁹⁴

Another disagreement on savings exists with regard to state laws that regulate the ability of insurers to deny claims and/or rescind coverage due to an insured’s allegedly fraudulent statements in the insurance application.⁹⁵ One court found that such a state law was saved because it “alters the scope of permissible bargains by dictating the conditions under which the insurer may deny recovery for misrepresentations in the application.”⁹⁶ In contrast, another court found that because the state’s anti-rescission law “does not spread the risk of insurance (health) coverage for which the parties contracted,” it did not affect the risk-pooling arrangement and was preempted.⁹⁷

Probably the most protracted dispute over savings under the *Miller* test is whether insurance bad faith statutes, imposing liability on insurers for claims denials made in bad faith, substantially affect the risk-pooling arrangement. The majority of courts have found that such state laws do not affect the risk-pooling arrangement and are preempted.⁹⁸ The reasoning

⁹³ *Hancock*, 590 F.3d at 1149; *Weeks*, 585 F. Supp. 2d at 1311.

⁹⁴ *Weeks*, 585 F. Supp. 2d at 1311; *see also Hancock*, 590 F.3d at 1149 (finding that a state law imposing form requirements on insurers’ use of discretionary clauses “does not remove the option of insurer discretion from the scope of permissible insurance bargains in ERISA plans”).

⁹⁵ *Compare Johnson v. Conn. Gen. Life Ins. Co.*, 324 F. App’x. 459, 465 (6th Cir. 2009) (finding that a state law providing that the falsity of a statement in the application for sickness and accident insurance may not bar recovery unless willfully false affects risk pooling), *with Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 640-41 (5th Cir. 2004) (finding that a state law barring insurers from cancelling coverage due to innocent misrepresentations does not spread risk).

⁹⁶ *Johnson*, 324 F. App’x. at 465.

⁹⁷ *Provident Life*, 364 F.3d at 640-41 (quoting *Tingle v. Pac. Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993)) (internal quotation marks omitted).

⁹⁸ *See, e.g.*, *Barber v. UNUM Life Ins. Co. of Am.*, 383 F.3d 134 (3d Cir. 2004); *Ellis v. Liberty Life Assurance Co. of Bos.*, 394 F.3d 262 (5th Cir. 2004); *Allison v. UNUM Life Ins. Co. of Am.*, 381 F.3d 1015 (10th Cir. 2004); *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138 (9th Cir. 2003); *Kidneigh v. UNUM Life Ins. Co. of Am.*, 345 F.3d 1182 (10th Cir. 2003); *Van Natta v. Sara Lee Corp.*, 439 F. Supp. 2d 911 (N.D. Iowa 2006); *Knochel v. HealthAssurance Pa., Inc.*, No. Civ.A. 06-426, 2006 WL 3040847 (W.D. Pa. Oct. 22, 2006); *Jacobson v. Humana Ins. Co.*, No. 05 C 1011, 2005 WL 1563154 (N.D. Ill. June 6, 2005); *Desrosiers v. Hartford Life & Accident Ins. Co.*, 354 F. Supp. 2d 119 (D.R.I. 2005), *aff’d*, 515 F.3d 87 (1st Cir. 2008); *Waters v. Kemper Ins. Cos.*, No. Civ.A. 03-1803, 2004 WL 2700914 (W.D. Pa. Apr. 19, 2004); *Dreznin v. Reliance Standard Life Ins. Co.*, 350 F. Supp. 2d 308 (D. Mass. 2004); *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F. Supp. 2d 296 (E.D. Pa. 2003); *Dolce v. Hercules Inc. Ins. Plan*, No. COV/A/ 03-CV-1747, 2003 WL 22992148 (E.D. Pa. Dec. 15, 2003); *Dwyer v. UNUM Life Ins. Co. of Am.*, No. 03 C 1118, 2003 WL 22844234 (N.D. Ill. Dec. 1, 2003); *Leuthner v. Blue Cross & Blue Shield of Ne. Pa.*, 270 F. Supp. 2d 584 (M.D. Pa. 2003), *aff’d*, 454 F.3d 120 (3d Cir. 2006); *McGuigan v. Reliance Standard Life Ins. Co.*, 256 F. Supp. 2d 345 (E.D. Pa. 2003); *Duchesne-Baker v. Extencicare Health Servs., Inc.*, No. Civ.A. 02-0590, 2003 WL 22327192 (E.D. La.

underlying these rulings is varied. The most prevalent reason articulated to support preemption is that insurance bad faith statutes do not alter the contract terms⁹⁹ but are remedial only, allowing the policyholder to obtain consequential and punitive damages.¹⁰⁰ Also, a few courts have found that bad faith insurance laws do not affect risk because bad faith is not a risk assumed by the insurer in the contract.¹⁰¹ However, several courts have disagreed, ruling that insurance bad faith laws are saved because they substantially affect risk pooling.¹⁰² These courts found that insurance bad faith laws

Oct. 9, 2003); *Morales-Ceballos v. First UNUM Life Ins. Co. of Am.*, No. Civ.A. 03-CV-925, 2003 WL 22097493 (E.D. Pa. May 27, 2003).

⁹⁹ See, e.g., *Allison*, 381 F.3d at 1027 (“Such a law . . . does not affect the substantive terms of the insurance contract.” (emphasis omitted) (quoting *Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.3d 460, 466 (10th Cir. 1997))); *Van Natta*, 439 F. Supp. 2d at 931 (“[The bad faith law] does not bring about a ‘change in the risk borne by insurers and the insured, because it does not affect the substantive terms of the insurance contract.’” (quoting *Gaylor*, 112 F.3d at 466)); *Dreznin*, 350 F. Supp. 2d at 313 (“[The statute] merely compels insurers to act quickly to do that which they were already obligated to do: pay meritorious claims.”); *Dwyer*, 2003 WL 22844234, at *5 (“[If a law] does not regulate content, it does not affect the transfer or spread of a policyholder’s risk and is not an integral part of the policy relationship between the insurer and the insured, thereby failing the former ‘business of insurance’ consideration.”).

¹⁰⁰ See, e.g., *Barber*, 383 F.3d at 143 (“[T]he bad faith statute here is . . . a remedy to which the insured may turn when injured by the bad faith of an insurer.”); *Ellis*, 394 F.3d at 277 (“[These state insurance laws] provide only that ‘whatever the bargain struck,’ the insured may recover additional damages if thereafter the insurer acts in bad faith or unfairly.” (quoting *Barber*, 383 F.3d at 143)); *Waters*, 2004 WL 2700914, at *3 (“[T]he law of bad faith is remedial, ‘a resort to which the insured may turn when injured by its relationship with its insurer.’” (quoting *Tutolo v. Independence Blue Cross*, No. CIV. A. 98-CV-5928, 1999 WL 274975, at *3 (E.D. Pa. May 5, 1999))); *Dolce*, 2003 WL 2292148, at *3 (“[The statute] provides the policy holder with . . . additional remedies against the insurer for a breach of an existing obligation under the policy.”); *Duchesne-Baker*, 2003 WL 22327192, at *8 (“[The law] simply provides for penalties not available under ERISA”); *Leuthner*, 270 F. Supp. 2d at 593 (“[The bad faith law] serves a remedial function and designates specific awards that a court may grant in the event that a breach of an insurance contract has occurred.”); *Morales-Ceballos*, 2003 WL 22097493, at *2 (“[The statute] ‘provides the policy holder with a remedy against the insurer’” (quoting *Tutolo*, 1999 WL 274975, at *3)).

¹⁰¹ See, e.g., *Barber*, 383 F.3d at 143 (“The tort of bad faith breach of an insurance contract is not ordinarily a risk identified in the insurance policy as a risk of loss the insurer agrees to bear for its insured.”); *Ellis*, 394 F.3d at 277 (“[These bad faith laws] do not affect the risk—here, the covered employee’s disability—for which the insured contracted with the insurer.”); *Knochel*, 2006 WL 3040847, at *6 (“[P]laintiffs’ claim for bad faith is not a risk identified in the insurance contract and is not a risk of loss that defendants agreed to bear on plaintiffs’ behalf.”); *Van Natta*, 439 F. Supp. 2d at 931 (“There is simply no indication that an insurance unfair trade practices statute intends for any risk of medical care to be shared.”); *Waters*, 2004 WL 2700914, at *3 (“[C]laims for bad faith are neither a risk identified within insurance policies nor a risk of loss the insurer agrees to bear on behalf of the insured.”); *Nguyen*, 282 F. Supp. 2d at 306 (“The remedy of punitive damages for bad faith bears no relation to the risk insured against”).

¹⁰² See *Rosenbaum v. UNUM Life Ins. Co. of Am.*, No. 01-6758, 2003 WL 22078557, at *6 (E.D. Pa. Sept. 8, 2003) (“A quick look at the risk equation between an insurer and an insured prior to, and just after, [the bad faith law’s] enactment shows a significant shift of risk from the insured to the insurer”); *Stone v. Disability Mgmt. Servs., Inc.*, 288 F. Supp. 2d 684, 695 (M.D. Pa. 2003) (“[The bad

nullify risk deflection practices used by insurers, which effectively alter policy provisions.¹⁰³

In fact, the sheer variety of the reasons stated by various courts to explain why particular state laws do not affect risk pooling pointedly shows that there is no consensus on what this component of the *Miller* test means or how it is to be applied. While a number of courts have concluded that state laws that merely provide additional remedies for insureds do not affect risk,¹⁰⁴ others have held that these laws do affect risk but are not saved because the remedies are “too attenuated” from the risks the insurers assumed in the insurance policy.¹⁰⁵ A number of courts have refused to save state laws due to timing—finding that the risk between the insurer and insured was not affected by the law because the risk had already been set by the insurance contract when the law was applied.¹⁰⁶ Still other courts have re-

faith law] satisfies both prongs of the *Miller* test and thus qualifies for exemption via ERISA’s savings clause.”); see also *Kidneigh*, 345 F.3d at 1199 (Henry, J., concurring in part and dissenting in part) (opining that Colorado’s insurance bad faith law substantially affects the risk-pooling arrangement).

¹⁰³ See *Rosenbaum*, 2003 WL 22078557, at *6 (“[R]isk deflection provisions used by an insurer to create limitations on claims and damages are effectively nullified by [the bad faith law.]”); *Stone*, 288 F. Supp. 2d at 694 (“[The bad faith law] . . . limits the ability of insurers to deflect risk in insurance policies.”); see also *Kidneigh*, 345 F.3d at 1198-99 (concurring in part and dissenting in part) (opining that Colorado’s bad faith insurance law gives insureds protection they did not previously possess by diminishing the insurer’s incentives to play the “delay game” and drive down settlement amounts).

¹⁰⁴ See, e.g., *Ercole v. Conectiv & Coventry Health Care of Del., Inc.*, No. Civ.A. 03-186 GMS, 2003 WL 21104926, at *2 (D. Del. May 15, 2003) (ruling that a bad faith breach of contract claim does not affect risk pooling because it “simply provides extra-contractual damages not permitted by ERISA”); *Bank of La. v. Aetna U.S. Healthcare, Inc.*, No. Civ.A. 02-236, 2003 WL 21634306, at *2 & n.5 (E.D. La. July 9, 2003) (“[The statute,] provid[ing] for a penalty double the amount of benefits due plus attorney’s fees for an insurer’s unreasonable failure to pay a claim within 30 days from receipt of written notice and proof of claim . . . [does not] ‘substantially affect[] the risk pooling arrangement between insurer and insured’ . . . [because] [t]he statute merely provides additional penalties for late payment.”); *Young v. Prudential Ins. Co. of Am.*, No. H-07-612, 2007 WL 1234929, at *4 n.2 (S.D. Tex. Apr. 24, 2007) (holding that provisions of the Texas Insurance Code and the Texas Deceptive Trade Practices Act “are remedial in nature and do not address the pooling of risk for individual policies”); *Burgos v. Grp. & Pension Adm’rs, Inc.*, 286 F. Supp. 2d 812, 819 (S.D. Tex. 2003) (concluding that bad faith claims made under the Texas Insurance Code and the Texas Deceptive Trade Practices Act do not affect the risk pooling because they “merely provide extracontractual damages not permitted by ERISA”).

¹⁰⁵ *Barber*, 383 F.3d at 144 (“[T]he threat that punitive awards may result in increased costs that could be passed on to the insured is too attenuated to be deemed to ‘substantially affect’ the risk pooling arrangement.”); see also *Waters*, 2004 WL 2700914, at *3 (“[T]he threat of [bad faith] claims may result in increased costs which may be passed on to the insured . . . is too attenuated to be deemed to ‘substantially affect’ the risk pooling arrangement.”).

¹⁰⁶ See, e.g., *Barber*, 383 F.3d at 144 (“[T]he transfer of risk occurred when Barber entered into the insurance contract, not when his claim was settled.”); *Ellis*, 394 F.3d at 277 (finding that insurance bad faith laws “cannot possibly affect the *bargain* that an insurer makes with its insured *ab initio*”); *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 569-70 (11th Cir. 1994) (“[The state law] does not have the effect of transferring or spreading a policyholder’s risk. . . . [Risk] transfer is complete at the time the contract is entered . . . [and the state law here] does not affect the apportionment of risks . . . that the

fused to save state laws because the prohibited insurance practices were not the same risks assumed by the insurer in the insurance policy.¹⁰⁷ Despite the *Miller* Court's express statements that a state law need not alter the terms of the insurance contract¹⁰⁸ or spread risk¹⁰⁹ to be saved, a number of courts have doggedly refused to save state laws on these very grounds.¹¹⁰ Finally, some courts have signaled their doubt and confusion about the test by failing to provide any explanation for their conclusion that a particular state law did not affect risk pooling.¹¹¹

parties made upon entering the contract.”); *Dreznin v. Reliance Standard Life Ins. Co.*, 350 F. Supp. 2d 308, 313 (D. Mass. 2004) (ruling that an insurance bad faith statute “merely compels insurers to act quickly to do that which they were already obligated to do: pay meritorious claims”); *Beard v. Benicorp Ins. Co.*, No. 04-2417 B, 2005 WL 3576842, at *4 (W.D. Tenn. Dec. 28, 2005) (“Because the transfer of risk is effected by means of the insurance policy, ‘that transfer is complete at the time that the contract is entered.’” (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 130 (1982))); *Young*, 2007 WL 1234929, at *4 n.2 (stating that the insured’s claims alleging violations of the Texas Insurance Code and the Texas Deceptive Trade Practices Act “cannot possibly affect the *bargain* that an insurer makes with its insured *ab initio*” (quoting *Ellis*, 394 F.3d at 277)). *But see* *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 606 (6th Cir. 2009) (“[T]he Miller test for whether laws ‘substantially affect the risk-pooling arrangement between insurers and insureds’ does not contain any timing element.” (quoting *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 338-39 (2003))).

¹⁰⁷ *See, e.g.*, *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 640-41 (5th Cir. 2004) (stating that the statute barring insurance companies from cancelling insurance contracts due to innocent or nonmaterial misrepresentations by the insured “does not even address the risk for which the insurance company contracted”); *Rogers v. Rogers & Partners, Architects, Inc.*, No. 08-11730-NG, 2009 WL 5124652, at *10 (D. Mass. July 27, 2009) (finding that a Massachusetts law regulating the notice of rights granted by a group life insurance policy “does not alter the risks for which the insurer and the insured contracted”); *Beard*, 2005 WL 3576842, at *4 (finding that a state law requiring notice to insureds prior to cancellation “does not alter the risks for which the insurer and insured originally contracted”); *Lucero v. Hartford Life & Accident Ins. Co.*, No. 2:08-CV-302 TS, 2009 WL 2170048, slip op. at *6 (D. Utah July 17, 2009) (refusing to save a law regulating discretionary clauses because it was “unrelated to either the risk of adverse events occurring or their potential magnitude”).

¹⁰⁸ *Miller*, 538 U.S. at 338 (2003) (“We 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) . . .” (alteration in original)).

¹⁰⁹ *Id.* at 339 n.3 (“[O]ur test requires only that the state law substantially *affect* the risk pooling arrangement between the insurer and insured; it does not require that the state law actually spread risk.”).

¹¹⁰ Many courts have cited a state law’s failure to alter the terms of the contract as a reason that the law was preempted by ERISA. *E.g.*, *Kidneigh v. UNUM Life Ins. Co. of Am.*, 345 F.3d 1182, 1187 (10th Cir. 2003); *Price v. Minn. Life Ins. Co.*, No. 06-cv-1040-DRH, 2008 WL 687131, at *4 (S.D. Ill. Mar. 10, 2008); *Dwyer v. UNUM Life Ins. Co. of Am.*, No. 03 C 1118, 2003 WL 22844234, at *5 (N.D. Ill. Dec. 1, 2003); *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F. Supp. 2d 296, 305 & n.6, 306 (E.D. Pa. 2003). Similarly, numerous courts have ruled that a state law was not saved under the *Miller* test because it did not spread risk. *See Provident Life & Accident*, 364 F.3d at 640-41; *Desrosiers*, 354 F. Supp. 2d at 128-29; *Duchesne-Baker v. Extencicare Health Servs., Inc.*, No. Civ.A. 02-0590, 2003 WL 22327192, at *8 (E.D. La. Oct. 9, 2003); *Dolce v. Hercules Inc. Ins. Plan*, No. COV/A/ 03-CV-1747, 2003 WL 22992148, at *3-4 (E.D. Pa. Dec. 15, 2003).

¹¹¹ *See, e.g.*, *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1144 (9th Cir. 2003); *Sun Life Assurance Co. v. Tinsley*, No. 06-06-CV-00010, 2007 WL 1052485, at *6 (W.D. Va. Apr. 4, 2007); *Van*

VI. CLARIFYING THE NEW SAVINGS TEST

It is unsurprising that courts are confused in applying the requirement that a state law must “substantially affect the risk pooling arrangement between the insurer and the insured,” as the language itself is flawed. Experts have explained the concept of insurance as being comprised of two components: risk transfer and risk pooling.¹¹² First, a risk is transferred from the insured to the insurer.¹¹³ In the health insurance context, when the insured pays the insurance premium, he transfers the risk of paying for his medical treatments to the insurer, in accordance with the specific terms of coverage set forth in the insurance policy.¹¹⁴ Second, insurance entails a pooling of the risk assumed by the insurer among a large group of insureds.¹¹⁵ Through pooling, “[m]any people pay relatively small amounts of money [premium payments] so that there is a large pot of money to cover the costs of the unfortunate few who suffer a loss.”¹¹⁶ Risk pooling thereby enables a health insurer to meet its financial obligations to specific insureds when the risk of a serious and costly illness materializes.¹¹⁷

One court has explained the concept of risk pooling as follows:

[R]isk pooling refers to the principle that risk averse individuals will often prefer to take a small but certain loss [payment of premiums] in preference to a large uncertain one [cata-

Natta v. Sara Lee Corp., 439 F. Supp. 2d 911, 930 (N.D. Iowa 2006); Adams v. UNUM Life Ins. Co. of Am., No. Civ.A. H-04-2179, 2005 WL 2030840, at *28 (S.D. Tex. Aug. 23, 2005).

¹¹² See, e.g., 1 ERIC MILLS HOLMES & MARK S. RHODES, HOLMES’S APPLEMAN ON INSURANCE § 1.3, at 10 (2d ed. 1996) (“Risk sharing is the linchpin of insurance. . . . Risk sharing connotes not only a transfer of risk (risk-shifting) to others but a distribution (sharing) of the risk among the others.”).

¹¹³ See, e.g., Lucero v. Hartford Life & Accident Ins. Co., No. 2:08-CV-302 TS, 2009 WL 2170048, slip op. at *5 (D. Utah July 17, 2009) (“By purchasing insurance, then, the insured has transferred the risk of adverse events from herself to the insurer, and the insurer contracts to accept that risk in return for insurance premiums.”); TOM BAKER, INSURANCE LAW AND POLICY: CASES, MATERIALS, AND PROBLEMS 2 (2d ed. 2008) (“A risk transfer is just what it sounds like: a transaction or institutional arrangement that transfers, or shifts, risk from one person or entity [the policyholder] to another [the insurer].”).

¹¹⁴ See, e.g., Barber v. UNUM Life Ins. Co. of Am., 383 F.3d 134, 143 (3d Cir. 2004) (“Within the insurance industry, ‘risk’ means the risk of . . . loss for which the insurer contractually agrees to compensate the insured.”).

¹¹⁵ See Lucero, 2009 WL 2170048, slip op. at *5 (“Risk pooling is the term used to describe the means by which insurers cover individuals of all risk levels across a variety of adverse event probabilities.”); 1 HOLMES & RHODES, *supra* note 112, at 11 (“In the insurance contract, the risk of an actual loss is distributed (socialized) among a large group of persons exposed to a comparable risk of loss.”).

¹¹⁶ BAKER, *supra* note 113.

¹¹⁷ See Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 127 n.7 (1982) (“[A] number of risks are accepted, some of which involve losses, and that such 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.” (quoting 1 G. COUCH, CYCLOPEDIA OF INSURANCE LAW § 1:3 (2d ed. 1959))).

strophic illness]. Thus, insurance systems pool economic risk, resulting in a small loss to many [in the form of insurance premiums] rather than a large loss to the unfortunate few.¹¹⁸

In view of the above explanation of risk pooling, it appears that the *Miller* Court's savings requirement that a state law must "substantially affect the risk pooling arrangement between the insurer and the insured" suffers from some innate confusions.¹¹⁹ First, risk pooling is *not* an arrangement "between the insurer and the insured." Rather, it is the insurer's means of spreading the risks it has assumed from the insureds.¹²⁰ Risk pooling does not refer, per se, to the particular risk agreement between the insurer and insured (i.e., which risks the insurer has agreed to accept and what the insurer will require in terms of payment and performance from the insured). Instead, risk pooling refers to the insurer's practice of selling the same insurance arrangement to a large number of policyholders, only a few of whom will ultimately require the benefits provided by the policy.¹²¹ Therefore, the language of the *Miller* test referring to "the risk pooling arrangement *between the insurer and the insured*" raises questions as to its meaning.¹²²

Second, the *Miller* Court expressly declared that to be saved, a state law need not spread risk.¹²³ However, risk pooling is precisely the means by which insurers spread risk.¹²⁴ Insurers attempt to get the greatest number of people into the risk pool to amass the greatest amount of funds possible to pay potential claims, and to increase the likelihood that sufficient premiums will be collected from healthy policyholders to offset the insurers' risk of being required to pay for benefits incurred by sickly policyholders.¹²⁵

¹¹⁸ *Standard Ins. Co. v. Morrison (Morrison I)*, 537 F. Supp. 2d 1142, 1150 (D. Mont. 2008) (fourth alteration in original) (internal quotation marks omitted), *aff'd*, 584 F.3d 837 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010).

¹¹⁹ *See* *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F. Supp. 2d 296, 306 (E.D. Pa. 2003) (referring to the *Miller* test's "inherent opacity").

¹²⁰ *See Morrison I*, 537 F. Supp. 2d at 1150 ("[I]nsurance systems pool economic risk, resulting in a small loss to many [in the form of insurance premiums] rather than a large loss to the unfortunate few." (second alteration in original) (internal quotation marks omitted)).

¹²¹ *See Standard Ins. Co. v. Morrison (Morrison II)*, 584 F.3d 387, 844 (2009) ("By receiving a large number of relatively small premiums, the insurer can afford to compensate the few insureds who suffer losses."), *cert denied*, 130 S. Ct. 3275 (2010).

¹²² *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003) (emphasis added).

¹²³ *Id.* at 339 n.3 ("[O]ur test . . . does not require that the state law actually spread risk.").

¹²⁴ *See Morrison II*, 584 F.3d at 844 ("Risk pooling involves spreading losses 'over all the risks so as to enable the insurer to accept each risk.'" (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 127-28 & n.7 (1982))); *Lucero v. Hartford Life & Accident Ins. Co.*, No. 2:08-CV-302 TS, 2009 WL 2170048, slip op. at *5 (D. Utah July 17, 2009) ("By risk pooling, an insurer is able to spread the risk that it will have to expend its resources to compensate a particular victim of an adverse event over all those paying premiums.").

¹²⁵ *See Morrison II*, 584 F.3d at 844 (explaining that the insurer receives a large number of premiums so that it can afford to compensate the relatively few policyholders who require benefits).

Therefore, to declare that the state law must affect risk pooling, but need not spread risk, is plainly inconsistent.¹²⁶

Further, from the examples it provided, the *Miller* Court apparently did not intend to save only those state laws that affect the risk-pooling arrangement. In fact, none of the examples of justifiably saved state laws provided by the Court are laws that affect risk pooling. The mandated-benefits law¹²⁷ increases the insurer's risk by requiring it to cover particular treatments it might otherwise exclude¹²⁸ and certainly increases the cost of the coverage.¹²⁹ But it does not affect risk pooling. The notice-prejudice rule,¹³⁰ by requiring the insurer to pay certain late claims that it would otherwise deny under the terms of the policy,¹³¹ increases the insurer's risk and may result in higher premiums for the insureds. But it does not affect risk pooling. The independent review law¹³² imposes additional contract obligations on insurers by requiring them to furnish independent reviews of denied claims.¹³³ This law may ultimately require insurers to pay claims that they initially denied, thereby increasing their costs.¹³⁴ But it does not affect risk pooling. Even the AWP laws at issue in *Miller* require an insurer to contract with more providers and arguably undercut the insurer's ability to drive down provider reimbursement rates by impairing its ability to direct a large

¹²⁶ As proof of this confusion between risk pooling and risk spreading in the *Miller* test, post-*Miller* courts continue to require a state law to spread risk as proof that it affects risk pooling. Numerous courts have then ruled that a state law was not saved under the *Miller* test because the state law did not spread risk. *E.g.*, *Desrosiers v. Hartford Life and Accident Ins. Co.*, 354 F. Supp. 2d 119, 128-29 (D.R.I. 2005); *Burgos v. Grp. & Pension Adm'rs, Inc.*, 286 F. Supp. 2d 812, 818 (S.D. Tex. 2003); *Duchesne-Baker v. Extencicare Health Servs., Inc.*, No. Civ.A. 02-0590, 2003 WL 22327192, at *8 (E.D. La. Oct. 9, 2003); *Dolce v. Hercules Inc. Ins. Plan*, No. COV/A/ 03-CV-1747, 2003 WL 22992148, at *3-4 (E.D. Pa. Dec. 15, 2003).

¹²⁷ See generally *Miller*, 538 U.S. at 338-39 (discussing the mandated-benefits rule).

¹²⁸ See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727 (1985) ("A Massachusetts [mandated-benefit] statute require[d] that specified minimum mental-health-care benefits be provided [to] a Massachusetts resident who is insured under a general insurance policy . . .").

¹²⁹ See *id.* at 731 (noting that the mandated-benefits law results in a shifting of the financial burden of mental-health treatment from individuals and the Commonwealth to the insurers).

¹³⁰ See generally *Miller*, 538 U.S. at 339 n.3 (discussing the notice-prejudice rule).

¹³¹ See *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 364 (1999) ("[Under California's 'notice-prejudice' rule,] an insurer cannot avoid liability although the proof of claim is untimely, unless the insurer shows it was prejudiced by the delay.>").

¹³² See generally *Miller*, 538 U.S. at 339 (discussing the independent review law).

¹³³ See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359 (2002) ("[Illinois's independent review law] provides recipients of health coverage by [HMOs] with a right to independent medical review of certain denials of benefits.>").

¹³⁴ See *id.* at 361 ("In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service." (quoting 215 ILL. COMP. STAT. 125 / 4-10 (2000)) (internal quotation marks omitted)).

number of plan members to each participating provider.¹³⁵ Therefore, the law increases the insurer's provider reimbursement costs and possibly the insured's premium. But it does not affect risk pooling. Thus, all these laws affect the *risk arrangement* between the insurers and their insureds (i.e., their relative rights and obligations under the terms of the policy). But the laws do not affect the *risk-pooling* arrangement. None of these laws has any discernible impact on an insurer's pooling of risk over a large number of insureds.¹³⁶

Instead, what these laws all have in common is that they regulate the respective rights and obligations of the insurer and insureds under the insurance policy (i.e., *the risk arrangement between the insurer and insureds*). In practical terms, the risk an insurer assumes when it accepts an insured's premium for the sale of an insurance contract is that the insurer may be required to perform its contractual obligations for the benefit of the insured.¹³⁷ These obligations come from two sources: (1) obligations that are set forth expressly in the insurance contract; and (2) obligations that are set forth in state insurance laws that ERISA's savings clause saves from preemption. Therefore, viewed in a commonsense way, state insurance laws substantially affect the risk arrangement between the insurer and insureds whenever the laws substantially affect the contract performance of the insurer or insured.¹³⁸

The AWP laws at issue in *Miller* do this. The AWP laws were entitled to be saved under the *Miller* test because they changed the parties' performance under the contract. The insured was entitled to utilize—and the insurer was required to furnish—an expanded network of providers.¹³⁹ By requiring the insurer to contract with any provider willing to meet its terms of partici-

¹³⁵ See *Miller*, 538 U.S. at 332 (“Kentucky’s AWP statutes impair petitioners’ ability to limit the number of providers with access to their networks, and thus their ability to use the assurance of high patient volume as the *quid pro quo* for the discounted rates that network membership entails.”).

¹³⁶ It is conceivable that by giving additional state law protections to the insureds, these laws might impact risk pooling because they may entice more ERISA plans to purchase the policy, thereby increasing the size of the pool. See 1 HOLMES & RHODES, *supra* note 112, at 11 (describing risk pooling as the distribution of loss among a large group of insureds). Such a speculative impact, however, is probably too attenuated to constitute a substantial impact on the risk-pooling arrangement.

¹³⁷ See, e.g., *Standard Ins. Co. v. Morrison (Morrison II)*, 584 F.3d 837, 844 (9th Cir. 2009) (“By receiving a large number of relatively small premiums, the insurer can afford to compensate the few insureds who suffer losses.”), *cert. denied*, 130 S. Ct. 3275 (2010); *Hollaway v. UNUM Life Ins. Co. of Am.*, 89 P.3d 1022, 1029 (Okla. 2003) (“Risk’ within the meaning of the insurance industry and as it relates to the insurer-insured relationship involves the event or happening for which the insurance company has specifically contracted to reimburse its insured—the actual risk transferred from the insured to the insurer.”).

¹³⁸ *Accord Stone v. Disability Mgmt. Servs., Inc.*, 288 F. Supp. 2d 684, 694-95 (M.D. Pa. 2003) (ruling that Pennsylvania’s insurance bad faith law is saved because it “clearly affects the allocation of risk between an insurer and an insured”).

¹³⁹ See *Miller*, 538 U.S. at 331-32 (stating that the AWP laws required health insurers to accept participation by any provider willing to meet the insurers’ terms).

pation, the laws may impair the insurer's ability to discount its reimbursement rates to providers.¹⁴⁰ Consequently, the AWP laws may also raise premium rates to the insureds.¹⁴¹ By impacting performance of the insurance contract and the costs of performance, the AWP laws substantially affect the risk arrangement between the insurer and the insured.¹⁴² However, they have no impact whatsoever on the risk-pooling arrangement (i.e., how many and which particular insureds the insurer will cover under the same contract).

The other saved state laws used as illustrations in *Miller* similarly affect the performance of the insurance contract. The mandated-benefits law reviewed in *Metropolitan Life Insurance Co. v. Massachusetts*¹⁴³ requires insurers to cover additional benefits, thereby raising insurers' costs and possibly premiums.¹⁴⁴ The notice-prejudice rule at issue in *UNUM Life Insurance Co. of America v. Ward*¹⁴⁵ requires insurers to pay certain claims even if filed late and thereby nullifies the contractual deadlines for filing claims in certain cases.¹⁴⁶ The independent review law at issue in *Rush Prudential HMO, Inc. v. Moran*¹⁴⁷ imposes additional obligations on insurers and gives insureds added protections against wrongful claim denials.¹⁴⁸ Thus, each of these laws substantially affects the risk arrangement between the insurer and insureds by affecting their performance of the contract in a substantial way.

Accordingly, the savings test articulated in *Miller* is viewed more correctly as requiring the state law to substantially affect the *risk arrangement* between the insurer and the insured, not the *risk-pooling* arrangement.

¹⁴⁰ *Id.* at 332 (explaining that the AWP laws impair insurers' ability to limit the number of providers in their networks and their ability to negotiate reduced reimbursement rates in return for increased patient volume).

¹⁴¹ *Id.* ("Petitioners believe that AWP laws will frustrate their efforts at cost and quality control, and will ultimately deny consumers the benefit of their cost-reducing arrangements with providers.")

¹⁴² *Id.* at 339 ("The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer.")

¹⁴³ 471 U.S. 724 (1985).

¹⁴⁴ *See id.* at 743 ("[The mandated-benefits law] effectuate[s] the legislative judgment that the risk of mental-health care should be shared [by the insurers and policy holders].")

¹⁴⁵ 526 U.S. 358 (1999).

¹⁴⁶ *Id.* at 366-67 (explaining that the notice-prejudice rule requires the insurer to prove that it suffered substantial prejudice before it may deny a claim based on an insured's failure to give timely notice).

¹⁴⁷ 536 U.S. 355 (2002).

¹⁴⁸ *Id.* at 361 (explaining that the independent review law requires HMOs to provide for a timely review of denied claims by a physician who is unaffiliated with the HMO and that if the reviewing physician determines that the covered service is medically necessary, the HMO is required to provide the covered service).

VII. WRONGFUL PREEMPTION OF STATE INSURANCE LAWS RESULTING FROM A TOO NARROW READING OF THE *MILLER* TEST

If the *Miller* savings test were applied to require a state law to substantially affect the risk arrangement—not the risk-pooling arrangement—between the insurer and the insured, it would be apparent that in many instances, state insurance laws that should have been saved have been wrongfully preempted. Courts have applied the test too narrowly, having been led astray by the *Miller* Court’s reference to the “risk pooling arrangement”¹⁴⁹ rather than the “risk arrangement.”¹⁵⁰

Numerous courts have wrongfully preempted state insurance laws that qualified for savings by falling victim to the fallacious view that to be saved, the state law must alter the specific risks of payment for medical treatment that the insurer assumed in the insurance policy.¹⁵¹ But under this

¹⁴⁹ See *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003) (“[To be saved, a] state law must substantially affect the risk pooling arrangement between the insurer and the insured.”).

¹⁵⁰ This reference to “risk pooling” has confused many courts. See, e.g., *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1149 (10th Cir. 2009) (ruling that a state law mandating the form of discretionary clauses in insurance contracts does not affect risk pooling because, inter alia, it does not “affect[] who gets in the risk pool”); *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 640 (5th Cir. 2004) (“[A]lthough [a state law prohibiting insurers from cancelling policies due to innocent or nonmaterial misrepresentations by the insureds] does shift the burden of innocent misrepresentations (the legal risks) onto the insurer, it does not spread the risk of insurance (health) coverage for which the parties contracted.” (quoting *Tingle v. Pac. Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993)) (internal quotation marks omitted)); *Young v. Prudential Ins. Co. of Am.*, No. H-07-612, 2007 WL 1234929, at *4 n.2 (S.D. Tex. Apr. 24, 2007) (ruling that the state law claims “do not address the pooling of risk for individual policies”); *Van Natta v. Sara Lee Corp.*, 439 F. Supp. 2d 911, 931 (N.D. Iowa 2006) (“[A]n unfair trade practices statute does not spread any risk among policyholders.”); *Desrosiers v. Hartford Life & Accident Ins. Co.*, 354 F. Supp. 2d 119, 129 (D.R.I. 2005) (“There is simply no indication that an insurance bad faith statute intends for any risk of medical care to be shared.” (quoting *Morris v. Highmark Life Ins. Co.*, 255 F. Supp. 2d 16, 25 (D.R.I. 2003)) (internal quotation marks omitted)); *Dolce v. Hercules Inc. Ins. Plan.*, No. COV/A/ 03-CV-1747, 2003 WL 22992148, at *3 (E.D. Pa. Dec. 15, 2003) (“Because [Pennsylvania’s insurance bad faith law] serves solely as a special damages section, it is doubtful that the provisions [of the law] spread a policy holder’s risk.” (quoting *Rosenbaum v. UNUM Life Ins. Co. of Am.*, No. Civ.A. 01-6758, 2002 WL 1769899, at *2 (E.D. Pa. July 29, 2002)) (internal quotation marks omitted)); *Duchesne-Baker v. Extencicare Health Servs., Inc.*, No. Civ.A. 02-0590, 2003 WL 22327192, at *8 (E.D. La. Oct. 9, 2003) (ruling that an insurance bad faith law “does not spread the risk that the insurer will be required to pay benefits to any one person among the pool of all insureds”).

¹⁵¹ See, e.g., *Provident Life & Accident*, 364 F.3d at 640-41 (“[I]n the context of an insurance policy, the risk focused upon is that risk for which the insurance company has specifically contracted to reimburse the insured.’ [The law at issue] does not even address the risk for which the insurance company contracted.” (citation omitted) (quoting *Tingle*, 996 F.2d at 108 n.13)); *Rogers v. Rogers & Partners, Architects, Inc.*, No. 08-11730-NG, 2009 WL 5124652, at *10 (D. Mass. July 27, 2009) (holding that a Massachusetts statute regulating the notice of rights granted by a group life insurance policy does not affect risk pooling because it “does not alter the risks for which the insurer and the insured contracted”); *Lucero v. Hartford Life & Accident Ins. Co.*, No. 2:08-CV-302 TS, 2009 WL 2170048, slip

very restricted view, the only saved state laws would be those that mandate or prohibit a particular contract benefit.¹⁵² It is obvious that this approach is too narrow a reading of the *Miller* test because the *Miller* Court itself declared that “[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.’”¹⁵³ Rather, if a state law substantially alters the manner in which the insurer or insured performs its contractual obligations, then that is an impact upon the risk arrangement sufficient to constitute a regulation of insurance for savings purposes.¹⁵⁴

Another example of wrongful preemption is the declaration by numerous courts in various jurisdictions that insurance bad faith statutes do not affect risk pooling because bad faith is not a risk identified in the insurance policies themselves.¹⁵⁵ In contrast, several courts have rightfully observed

op. at *6 (D. Utah July 17, 2009) (finding that a Utah rule limiting discretionary authority clauses in ERISA insurance plans fails the risk-pooling requirement because it is “unrelated to either the risk of adverse events occurring or their potential magnitude”); *Forbes v. Cemex*, No. Civ.A. 1:03CV67-R, 2005 WL 1801923, at *2 (W.D. Ky. July 18, 2005) (“For a law to affect risk-pooling it must affect the substantive terms of the insurance contract by changing the risk borne by insurers and the insured . . .”); *Kindel v. Cont’l Cas. Co.*, No. 1:02CV879, 2005 WL 1241975, at *2 (S.D. Ohio May 25, 2005) (holding that an Ohio statute requiring exceptions and deductions from indemnity to be adequately captioned and clearly set forth in the policy does not affect risk pooling because it “does not regulate ‘the scope of permissible bargains between insurers and insureds’ by mandating the type of benefits which must be provided” (quoting *Miller*, 538 U.S. at 338)). *But see* *Standard Ins. Co. v. Morrison (Morrison I)*, 537 F. Supp. 2d 1142, 1151 (D. Mont. 2008) (rejecting the insurer’s argument that “‘risk’ only means, literally, the type of risk insured against, e.g., the risk of physical injury or property loss”), *aff’d*, 584 F.3d 837 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010).

¹⁵² See, e.g., *Kindel*, 2005 WL 1241975, at *2 (“[A law which] forbid[s] insurance providers from reducing or excepting coverage in certain circumstances . . . would clearly be a law which regulates insurance because it would alter the permissible scope of bargains between the insurer and insured.”).

¹⁵³ *Miller*, 538 U.S. at 338 (alteration in original).

¹⁵⁴ See *id.* at 339 n.3 (stating that the notice-prejudice rule at issue in *Cisneros v. UNUM Life Ins. Co. of Am.*, 134 F.3d 939, 945-46 (1998), *aff’d in part, rev’d and remanded in part sub nom.* *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), was saved because it “dictates to the insurance company the conditions under which it must pay for the risk that it has assumed[, which] certainly qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured”).

¹⁵⁵ See, e.g., *Ellis v. Liberty Life Assurance Co. of Bos.*, 394 F.3d 262, 277 (5th Cir. 2004) (“[U]nfair practices and bad faith are not risks identified in the Policy as a risk of loss that Liberty agrees to bear . . .”); *Barber v. UNUM Life Ins. Co. of Am.*, 383 F.3d 134, 143 (3d Cir. 2004) (“The tort of bad faith breach of an insurance contract is not ordinarily a risk identified in the insurance policy as a risk of loss the insurer agrees to bear for its insured.”); *Allison v. UNUM Life Ins. Co. of Am.*, 381 F.3d 1015, 1027 (10th Cir. 2004) (“[Oklahoma’s insurance bad faith law] does not effect a change in the risk borne by insurers and the insured, because it does not affect the substantive terms of the insurance contract.” (quoting *Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.3d 460, 466 (10th Cir. 1997)) (internal quotation marks omitted)); *Kidneigh v. UNUM Life Ins. Co. of Am.*, 345 F.3d 1182, 1187 (10th Cir. 2003) (“[A Colorado insurance bad faith law] does not define the terms of the relationship between the insurer and the insured . . .” (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987))); *Price v. Minn. Life Ins. Co.*, No. 06-cv-1040-DRH, 2008 WL 687131, at *4 (S.D. Ill. Mar. 10, 2008) (“[The insurance bad faith law] ‘does not govern the substantive content of the insurance contract

that an insurance bad faith statute shifts risk from the insured to the insurer by “dissuading insurers from denying claims in bad faith” and by nullifying “risk deflection provisions used by an insurer to create limitations on claims and damages.”¹⁵⁶ By affecting contract performance, insurance bad faith statutes alter the risk arrangement between insurers and their insureds and thereby qualify for savings under the *Miller* test.¹⁵⁷

Many courts have erroneously preempted state insurance laws on the basis of “timing.” These courts have declared that because the risks were already set by the insurance contract at the time the state law was applied, it is clear that the law did not affect these risks.¹⁵⁸ However, since a state law

. . . .” (quoting *Buehler Ltd. v. Home Life Ins. Co.*, 722 F. Supp. 1554, 1561 (N.D. Ill. 1989)); *Knochel v. HealthAssurance Pa., Inc.*, No. Civ.A. 06-426, 2006 WL 3040847, at *6 (W.D. Pa. Oct. 22, 2006) (“[P]laintiffs’ claim for bad faith is not a risk identified in the insurance contract and is not a risk of loss that defendants agreed to bear on plaintiffs’ behalf.”); *Van Natta*, 439 F. Supp. 2d at 931 (“[Iowa’s unfair trade practices statute] does not bring about a ‘change in the risk borne by insurers and the insured, because it does not affect the substantive terms of the insurance contract.” (quoting *Gaylor*, 112 F.3d at 466)); *Jacobson v. Humana Ins. Co.*, No. 05 C 1011, 2005 WL 1563154, at *4 (N.D. Ill. June 6, 2005) (“[Illinois’ insurance bad faith law] does not regulate the substantive content of insurance policies” (quoting *Dwyer v. UNUM Life Ins. Co. of Am.*, No. 03 C 1118, 2003 WL 22844234, at *5 (N.D. Ill. Dec. 1, 2003)) (internal quotation marks omitted)); *Desrosiers*, 354 F. Supp. 2d at 128-29 (“A bad faith law does not bring about a change in the risk borne by insurers and the insured, because it does not affect the substantive terms of the insurance contract.” (quoting *Morris v. Highmark Life Ins. Co.*, 255 F. Supp. 2d 16, 25 (D.R.I. 2003)) (internal quotation marks omitted)); *Dreznin v. Reliance Standard Life Ins. Co.*, 350 F. Supp. 2d 308, 313 (D. Mass. 2004) (“[An insurance bad faith law] merely compels insurers to act quickly to do that which they were already obligated to do: pay meritorious claims.”); *Waters v. Kemper Ins. Cos.*, No. Civ.A. 03-1803, 2004 WL 2700914, at *3 (W.D. Pa. Apr. 19, 2004) (“[C]laims for bad faith are neither a risk identified within insurance policies nor a risk of loss the insurer agrees to bear on behalf of the insured.”).

¹⁵⁶ *Rosenbaum v. UNUM Life Ins. Co. of Am.*, No. 01-6758, 2003 WL 22078557, at *6 (E.D. Pa. Sept. 8, 2003); see also *Stone v. Disability Mgmt. Servs., Inc.*, 288 F. Supp. 2d 684, 694 (M.D. Pa. 2003) (“[Pennsylvania’s insurance bad faith statute] necessarily increases the risk faced by an insurer[, which] significantly affects the risk pooling arrangement between an insurer and an insured.”).

¹⁵⁷ See, e.g., *Stone*, 288 F. Supp. 2d at 694 (concluding that Pennsylvania’s bad faith insurance statute qualifies for savings because it “limits the ability of insurers to deflect risk in insurance policies” and “has the affect of altering provisions in insurance policies”).

¹⁵⁸ See, e.g., *Barber*, 383 F.3d at 144 (“Here, the transfer of risk occurred when Barber entered into the insurance contract, not when his claim was settled. The scope of the risk pooled is defined by the policy, not by a claims settlement statute allowing for bad faith remedies.”); *Young v. Prudential Ins. Co. of Am.*, No. H-07-612, 2007 WL 1234929, at *4 (S.D. Tex. Apr. 24, 2007) (holding that plaintiff’s claims “cannot possibly affect the *bargain* that an insurer makes with its insured *ab initio*” (quoting *Ellis*, 394 F.3d at 277)); *Beard v. Benicorp Ins. Co.*, No. 04-2417 B, 2005 WL 3576842, at *4 (W.D. Tenn. Dec. 28, 2005) (holding that a requirement under Tennessee common law imposing a contractual duty on insurers providing group coverage under a policy purchased by an employer to notify the employee insureds of cancellation does not alter the parties’ risks “[b]ecause the transfer of risk is effected by means of the insurance policy [and] ‘that transfer is complete at the time that the contract is entered’” (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 130 (1982))). But see *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 606 (6th Cir. 2009) (“[T]he *Miller* test . . . does not contain any timing element[; n]or has the Supreme Court inquired into the timing of the ‘substantial [e]ffect’ on the ‘risk-

need not alter the actual terms of the policy,¹⁵⁹ it is sufficient if the law substantially affects the manner in which the parties perform their contractual obligations. Accordingly, state laws that impose procedural requirements on contract performance may also substantially affect the risk arrangement.¹⁶⁰ If these laws substantially alter the parties' burdens and costs of performance under the insurance contract, they are entitled to be saved.¹⁶¹

Finally, many courts have erroneously preempted state insurance laws whenever they provide remedies to insureds to redress unfair contract prac-

pooling arrangement' in its analysis." (third alteration in original) (citation omitted) (quoting *Miller* at 338-39)).

¹⁵⁹ *Miller*, 538 U.S. at 338 ("We have never held that state laws must alter or control the actual terms of insurance policies to be deemed 'laws . . . which regulat[e] insurance' . . ." (alterations in original)).

¹⁶⁰ See, e.g., *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 364 (1999) (saving a state law that imposed a procedural requirement upon insurers of providing an independent review of certain claims denials); see also *Miller*, 538 U.S. at 339 (discussing *Ward*).

¹⁶¹ See *Celentano v. Comm'r of Mass. Div. of Ins.*, No. 09-11112-DPW, 2010 WL 559121, slip op. at *4 (D. Mass. Feb. 2, 2010) ("The requirement that insurance regulations substantially affect risk pooling ensures that the regulations are targeted at *insurance practices* . . ." (quoting *Standard Ins. Co. v. Morrison (Morrison II)*, 584 F.3d 837, 844 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010))); see also, e.g., *Werdehausen v. Benicorp Ins. Co.*, 487 F.3d 660, 669 (8th Cir. 2007) (holding that a Missouri law that "bars enforcement of a provision excluding coverage if the insurer preauthorized the medical procedure" is saved because, inter alia, it "increases the insurer's liability for health care services already provided"); *La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529, 545-46 (5th Cir. 2006) (holding that a Louisiana law requiring insurers to honor assignments of benefits to hospitals "substantially affects the risk pooling arrangement between the insurer and the insured" because it requires insurers to honor policyholders' assignments of benefits to hospitals, expands insureds' access to hospitals, and may result in unrecoverable costs to the insurers when they pay beneficiaries in error); *Kidneigh v. UNUM Life Ins. Co. of Am.*, 345 F.3d 1182, 1198 (10th Cir. 2003) (Henry, J., concurring in part and dissenting in part) (opining that Colorado's insurance bad faith law, by increasing the likelihood of an insurer's liability for bad faith behavior, makes bad behavior more costly, and thus "changes the conditions under which an insurer will 'pay for the risk that it has assumed'" (quoting *Miller*, 538 U.S. at 339 n.3)); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 286 (4th Cir. 2003) ("[Maryland's antisubrogation law] addresses who pays in a given set of circumstances and is therefore directed at spreading policyholder risk."); *Benefit Concepts v. Macera*, 413 F. Supp. 2d 404, 407-08 (E.D. Pa. 2005) ("By limiting the rates that medical providers can charge insurers, [a state law cap on medical charges paid by insurers] reduces insurers' actuarial risk thereby permitting them to pass [sic] the cost savings onto insureds."); *Stone*, 288 F. Supp. 2d at 694 ("[An insurance bad faith law gives the insured] a greater possible reward if he or she prevails in a bad faith claim . . . which necessarily increases the risk faced by an insurer. This increased risk faced by an insurer significantly affects the risk pooling arrangement between an insurer and an insured.").

The only basis under the *Miller* test to find that a law that increases a party's costs of performance does not affect risk is that the impact on risk is insubstantial. See, e.g., *Sgro v. Danone Waters of N. Am., Inc.*, 532 F.3d 940, 944 (9th Cir. 2008) (holding that a California insurance regulation requiring insurers to reimburse policyholders for the cost of copying medical records requested by the insurer could be deemed to affect insurers' risks by making it slightly easier for insureds to file claims and by causing insurers to pay more benefits than they otherwise would absent the regulation, but that this effect is "too remote and speculative to 'substantially' affect the risk pooling arrangement between insurers and their insureds" (quoting *Miller*, 538 U.S. at 342)).

tices.¹⁶² These courts have declared that the statutes do not affect risk because they are remedial only.¹⁶³ The wholesale preemption of insurance bad faith laws is one example of such findings.¹⁶⁴ Certainly, when such laws permit an ERISA plan member to assert state law claims and pursue remedies that are not provided by ERISA's exclusive remedial scheme, these claims are completely preempted.¹⁶⁵ Nevertheless, contrary to the holdings

¹⁶² See, e.g., *Forbes v. Cemex*, No. Civ.A. 1:03CV67-R, 2005 WL 1801923, at *3 (W.D. Ken. July 28, 2005) (preempting a plan member's claim to enforce a state law requiring insurers to notify policyholders of their right to convert group life insurance plans to individual life insurance plans on the basis that the claim was a "separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme" (quoting *Aetna Health Inc. v. Davila*, 542 U.S. 200, 217 (2004))); *Burgos v. Grp. & Pension Adm'rs, Inc.*, 286 F. Supp. 2d 812, 818-19 (S.D. Tex. 2003) (preempting a Texas insurance statute that provides extracontractual damages for insurers' misrepresentations and false advertising); *Bank of La. v. Aetna U.S. Healthcare, Inc.*, No. Civ.A. 02-236, 2003 WL 21634306, at *2 (E.D. La. July 9, 2003) (preempting a Louisiana law providing for a penalty double the amount of benefits due plus attorney's fees for an insurer's unreasonable failure to pay a claim within thirty days from receipt of written notice and proof of claim).

¹⁶³ See, e.g., *Burgos*, 286 F. Supp. 2d at 818 (stating that a Texas insurance statute prohibiting false advertising does not affect risk because it merely "provides a remedy for violations of that law by an insurance company" (quoting *Ramirez v. Inter-Cont'l Hotels*, 890 F.2d 760, 763 (5th Cir. 1989))); *Bank of La.*, 2003 WL 21634306, at *2 (stating that a Louisiana insurance law penalizing late claims payment does not affect the risk-pooling arrangement because "[t]he statute merely provides additional penalties for late payment").

¹⁶⁴ See, e.g., *Allison v. UNUM Life Ins. Co. of Am.*, 381 F.3d 1015, 1027 (10th Cir. 2004) ("[Oklahoma's insurance bad faith law provides that] 'a breach of [the insurance] contract may in certain circumstances allow the policyholder to obtain [consequential and] punitive damages.'" (third alteration in original) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987))); *Kidneigh*, 345 F.3d at 1187 (finding that bad faith claims are not integral to the risk-pooling arrangement because they merely "allow the policyholder to obtain punitive damages" (quoting *Pilot Life*, 481 U.S. at 51) (internal quotation marks omitted)); *Van Natta v. Sara Lee Corp.*, 439 F. Supp. 2d 911, 931 (N.D. Iowa 2006) (finding that the state law does not change risk because it is "remedial in nature"); *Waters v. Kemper Ins. Co.*, No. Civ.A. 03-1803, 2004 WL 2700914, at *3 (W.D. Pa. Apr. 19, 2004) ("[T]he law of bad faith is remedial, 'a resort to which the insured may turn when injured by its relationship with its insurer.'" (quoting *Tutolo v. Independence Blue Cross*, No. Civ.A. 98-CV-5928, 1999 WL 274975, at *3 (E.D. Pa. May 5, 1999))); *Dolce v. Hercules Inc. Ins. Plan*, No. COV/A/ 03-CV-1747, 2003 WL 22992148, at *3 (E.D. Pa. Dec. 15, 2003) ("[An insurance bad faith law merely] provides the policy holder with a new cause of action and additional remedies against the insurer for a breach of an existing obligation under the policy."); *Leuthner v. Blue Cross & Blue Shield of Ne. Pa.*, 270 F. Supp. 2d 584, 593 (M.D. Pa. 2003) ("[Pennsylvania's bad faith law] serves a remedial function and designates specific awards that a court may grant in the event that a breach of an insurance contract has occurred."), *aff'd*, 454 F.3d 120 (3d Cir. 2006); *Morales-Ceballos v. First UNUM Life Ins. Co. of Am.*, No. Civ.A. 03-CV-925, 2003 WL 22097493, at *2 (E.D. Pa. May 27, 2003) ("[A] bad faith law does not serve to transfer or spread the policy holder's risk; it provides the policy holder with a remedy against the insurer' and constitutes 'a resort to which the insured may turn when injured by its relationship with its insurer.'" (quoting *Tutolo*, 1999 WL 274975, at *3)).

¹⁶⁵ The Supreme Court has clarified that even when insurance laws fulfill the *Miller* savings test, under principles of complete preemption, ERISA plan members are precluded from receiving remedies under state law that are not provided by ERISA's comprehensive remedial scheme. See *Aetna Health Inc. v. Davila*, 542 U.S. 200, 217 (2004). In *Davila*, the Court said:

of the majority of courts that have considered this issue,¹⁶⁶ laws that impose additional penalties upon insurers clearly affect the risk arrangement between the insurer and insured.¹⁶⁷ They add administrative burdens and costs to the insurer's performance,¹⁶⁸ and may alter the insurer's conduct by making it more likely that the insurer will pay the insured's contracted-for benefits.¹⁶⁹ Moreover, it is completely feasible to preempt only that portion of the state law that provides the ERISA plan member an extracontractual remedy, while leaving intact the law's prohibition of unfair contract prac-

“[O]ur understanding of [the savings clause] must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA [T]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.”

. . . . [E]ven a state law that can arguably be characterized as “regulating insurance” will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.

Id. at 217-18 (quoting *Pilot Life*, 481 U.S. at 52, 54); *see also* *Duchesne-Baker v. Extencicare Health Servs., Inc.*, No. Civ.A. 02-0590, 2003 WL 22327192, at *8 (E.D. La. Oct. 9, 2003) (“[Louisiana’s insurance bad faith law] simply provides for penalties not available under ERISA”); *Morales-Ceballos*, 2003 WL 22097493, at *2 (“[E]ven if the Pennsylvania bad faith statute satisfies the *Miller* factors, the statute is nevertheless preempted by ERISA since it expands ERISA’s exclusive remedy provisions by providing for an award of punitive damages against the insurer.”); *Ercole v. Conective & Coventry Health Care of Del., Inc.*, No. Civ.A. 03-186 GMS, 2003 WL 21104926, at *2 (D. Del. May 15, 2003) (finding that the state bad faith law “provides extra-contractual damages not permitted by ERISA”).

¹⁶⁶ *See, e.g.*, cases cited *supra* note 164.

¹⁶⁷ *See, e.g.*, *Benefit Recovery v. Wooley*, No. 03-652-JJB-DLD, 2006 U.S. Dist. LEXIS 97456, at *13, *24 (M.D. La. Dec. 5, 2006) (finding that a state insurance directive, prohibiting an insurance company from enforcing its subrogation rights until the insured had been fully compensated for his injuries, affects risk because insurers who do not follow the directive will be subject to sanctions, including the imposition of fines).

¹⁶⁸ *See Kidneigh*, 345 F.3d at 1198 (Henry, J., concurring in part and dissenting in part) (arguing that Colorado’s insurance bad faith law substantially affects the risk-pooling arrangement because it, *inter alia*, “makes bad behavior more costly”); *Johnson v. Conn. Gen. Life Ins. Co.*, No. 5:07-CV-167, 2007 WL 2509866, at *5 (N.D. Ohio Aug. 30, 2007) (stating that an Ohio law prohibiting insurers from denying claims based on insureds’ misrepresentations unless fraudulently made “addresses who pays in a given set of circumstances and is therefore directed at spreading policyholder risk” (quoting *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 286 (4th Cir. 2003))). *But see Waters*, 2004 WL 2700914, at *3 (“The fact that the threat of such claims may result in increased costs which may be passed on to the insured or that it may place an additional burden on insurers to act in good faith to avoid increased awards is too attenuated to be deemed to ‘substantially affect’ the risk pooling arrangement.”).

¹⁶⁹ *See Stone v. Disability Mgmt. Servs., Inc.*, 288 F. Supp. 2d 684, 694 (M.D. Pa. 2003) (finding that Pennsylvania’s insurance bad faith law shifts risk to the insurer by increasing the likelihood that meritorious claims will be paid and by limiting the insurer’s ability to deflect risk); *Rosenbaum v. UNUM Life Ins. Co. of Am.*, No. 01-6758, 2003 WL 22078557, at *6 (E.D. Pa. Sept. 8, 2003) (finding that Pennsylvania’s insurance bad faith law shifts risk to the insurer by “dissuading insurers” from denying claims in bad faith).

tices and any administrative penalties imposed upon the insurer for violations.¹⁷⁰

VIII. APPLICATION OF THE *MILLER* TEST TO STATE LAWS BANNING OR LIMITING DISCRETIONARY CLAUSES

Recent cases applying the *Miller* savings test to state laws that ban or limit discretionary clauses effectively illustrate how some federal courts are currently applying the test too narrowly.¹⁷¹

Courts have routinely found that state laws that ban discretionary clauses are saved from ERISA preemption under the *Miller* test.¹⁷² Under a state law ban, “insurers [in the state can] no longer invest the plan administrator with unfettered discretionary authority” to determine claims or interpret the plan.¹⁷³ Courts have concluded that the ban alters the “scope of permissible bargains between insurers and insureds” by prohibiting insureds from “agree[ing] to a discretionary clause in exchange for a more affordable premium.”¹⁷⁴ State laws prohibiting discretionary clauses “dictat[e] to

¹⁷⁰ See, e.g., *Spellman v. United Parcel Serv., Inc.*, 540 F. Supp. 2d 237, 240 (D. Me. 2008) (“ERISA preempts the employee’s request for a penalty, but not the substance of the rule and statute.”).

¹⁷¹ Some courts have found that state law prohibitions on discretionary clauses in insurance contracts are saved from ERISA preemption. E.g., *Standard Ins. Co. v. Morrison (Morrison II)*, 584 F.3d 837, 845 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010); *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 602 (6th Cir. 2009); *McClenahan v. Metro. Life Ins. Co.*, 621 F. Supp. 2d 1135, 1141 (D. Colo. 2009); *Kohut v. Hartford Life & Accident Ins. Co.*, No. 08-cv-00669-CMA-MJW, 2008 WL 5246163, at *8-9 (D. Colo. Dec. 16, 2008); *Am. Council of Life Insurers v. Watters*, 536 F. Supp. 2d 811, 823 (W.D. Mich. 2008), *aff’d sub nom.* *Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009); *Fenberg v. Cowden Auto. Long Term Disability Plan*, No. C 03-03898 SI, 2004 WL 2496174, at *3 (N.D. Cal. Nov. 2, 2004), *rev’d on other grounds*, 259 F. App’x 958 (9th Cir. 2007). Other courts, however, have found state laws mandating a particular type of discretionary clause in insurance contracts preempted by ERISA—though not banned altogether—because they do not substantially affect the risk-pooling arrangement between the insurer and the insured. *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1149 (10th Cir. 2009); *Weeks v. Unum Grp.*, 585 F. Supp. 2d 1305, 1311 (D. Utah 2008).

¹⁷² Many courts have found that state law prohibitions on discretionary clauses in insurance contracts are saved from ERISA preemption. E.g., *Morrison II*, 584 F.3d at 845; *Ross*, 558 F.3d at 600; *McClenahan*, 621 F. Supp. 2d at 1141; *Kohut*, 2008 WL 5246163, at *8-9; *Watters*, 536 F. Supp. 2d at 823; *Fenberg*, 2004 WL 2496174, at *3.

¹⁷³ *Ross*, 558 F.3d at 607; see also *Kohut*, 2008 WL 5246163, at *8 (“[The discretionary clause law] affects the policy relationship between the insurer and the insured by affecting the interpretation of the insurance contract.”); *Standard Ins. Co. v. Morrison (Morrison I)*, 537 F. Supp. 2d 1142, 1152 (D. Mont. 2008) (“[Montana’s law prohibiting discretionary clauses] eliminates [the insurer’s] autonomy to guarantee terms congenial to its own interests [and is] ‘the stuff of garden variety insurance regulation.’” (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002))), *aff’d*, 584 F.3d 837 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010).

¹⁷⁴ *Morrison II*, 584 F.3d at 844-45; see also *McClenahan*, 621 F. Supp. 2d at 1141 (concluding that bans on discretionary clauses alter the bargains between insurers and their insureds).

the insurance company the conditions under which it must pay for the risk it has assumed.¹⁷⁵ Courts have observed that by removing the benefit of deferential review, insurers are more likely to pay a greater number of claims, thereby covering more losses and increasing benefits for consumers.¹⁷⁶ Even further, bans on discretionary clauses “directly control the terms of insurance contracts” by prohibiting discretionary clauses as a term of an ERISA plan and by invalidating any such clauses.¹⁷⁷ Thus, federal courts have experienced little difficulty in applying the *Miller* test to state laws prohibiting discretionary clauses and have uniformly found the risk-pooling requirement of the test to be satisfied.

In sharp contrast, with regard to state laws that merely impose limitations on the use of discretionary clauses—as opposed to banning them altogether—courts have found that such laws are preempted because they do not affect the risk-pooling arrangement.¹⁷⁸ In *Hancock v. Metropolitan Life Insurance Co.*,¹⁷⁹ for example, the Tenth Circuit Court of Appeals found that a Utah law that permits insurers to use discretionary clauses if they adhere to a particular form of language and type size, termed a discretionary clause “safe harbor,”¹⁸⁰ does not affect risk because it “does not remove

¹⁷⁵ *Morrison II*, 584 F.3d at 845 (quoting *Morrison I*, 537 F. Supp. 2d at 1151) (internal quotation marks omitted); see also *McClenahan*, 621 F. Supp. 2d at 1141 (observing that laws banning discretionary clauses dictate conditions under which insurers must pay for the risk they assumed).

¹⁷⁶ *Morrison II*, 584 F.3d at 845 (“[C]onsumers can be reasonably sure of claim acceptance only when an improperly balking insurer can be called to answer for its decision in court.”); see also *Kohut*, 2008 WL 5246163, at *8 (“[E]limination of the insurer’s sole discretion in deciding whether to accept or deny a claim makes it more likely that the insurer will pay more money in claims, and thus that the insured will pay higher premiums.”); *Watters*, 536 F. Supp. 2d at 823 (“[State rules prohibiting discretionary clauses] will result in insurers paying over more money in claims and incurring more of the risk they have assumed.”); *Fenberg*, 2004 WL 2496174, at *3 (holding that California’s law preventing discretionary clauses “shifts the risk pooling arrangement in favor of the insured” because “increased oversight over the payment of benefits will lead to increased payments for the insured”).

¹⁷⁷ *Ross*, 558 F.3d at 606-07.

¹⁷⁸ *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1149 (10th Cir. 2009) (holding that a state law mandating the form of insurers’ discretionary clauses “has no impact on risk pooling” and is therefore preempted by ERISA); *Weeks v. Unum Grp.*, 585 F. Supp. 2d 1305, 1311 (D. Utah 2008) (finding that a state law mandating the form of insurer’s discretionary clauses is preempted by ERISA because it does not affect the risk-pooling arrangement); see also *Lucero v. Hartford Life & Accident Ins. Co.*, No. 2:08-CV-302 TS, 2009 WL 2170048, slip op. at *6 (D. Utah July 17, 2009) (holding that a state law permitting courts to select the standard of review despite an insurer’s use of a discretionary clause is preempted because it does not affect the risk-pooling arrangement).

¹⁷⁹ 590 F.3d 1141 (10th Cir. 2009).

¹⁸⁰ The “safe harbor” of Utah’s Rule 590-218-5(2) authorizes reservation-of-discretion clauses in ERISA plans if the clause is printed in bold and at least twelve point type, and if the language “is the same as, or substantially similar to” the following:

Benefits under this plan will be paid only if (the plan administrator) decides in its discretion that (the claimant) is entitled to them. (The plan administrator) also has discretion to determine eligibility for benefits and to interpret the terms and conditions of the benefit plan. Determinations made by (the plan administrator) pursuant to this reservation of discretion do

the option of insurer discretion from the scope of permissible insurance bargains in ERISA plans.”¹⁸¹ As a result, the Tenth Circuit ruled that the law had no impact on risk pooling because it “relates to the form, not the substance, of ERISA plans.”¹⁸² The *Hancock* court rejected the policyholder’s argument that the rule affected risk pooling because failure to conform to the rule’s mandated language requirements would invalidate the insurer’s discretionary clause, thereby depriving the insurer of discretion and altering the standard of review.¹⁸³ Instead, the court declared, “[w]e decline to interpret *Miller* so broadly. The change in risk pooling must result from *compliance* with the state law, not its violation.”¹⁸⁴

In declining to apply the *Miller* test more broadly, the *Hancock* court effectively preempted a classic form of insurance regulation. The law at issue in *Hancock* regulates insurance by dictating the form of a contractual discretionary clause,¹⁸⁵ ostensibly adopted by the state to ensure that policyholders receive clear notice of this key provision.¹⁸⁶ To the extent that such state laws prevent obfuscation and possible misrepresentation about the terms of coverage, these laws substantially affect the risk arrangement between the insurer and insureds. Moreover, because such laws have the potential to invalidate noncomplying provisions,¹⁸⁷ they may directly affect the risk arrangement by nullifying discretionary provisions that deviate from the safe harbor language.¹⁸⁸

not prohibit or prevent a claimant from seeking judicial review in federal court of (the plan administrator’s) determinations.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when (a claimant) seeks judicial review of (the plan administrator’s) determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the benefit plan.

(The plan administrator) is an insurance company that provides insurance to this benefit plan and the federal court will determine the level of discretion that it will accord (the plan administrator’s) determinations.

Id. at 1146-47 (quoting UTAH ADMIN. CODE r. 590-218-5(2) to -5(3) (2003)) (internal quotation marks omitted).

¹⁸¹ *Id.* at 1149.

¹⁸² *Id.*; see also *Weeks*, 585 F. Supp. 2d at 1311 (“[Utah’s rule requiring discretionary clauses to] be explicit, explained, and conspicuous, has no substantial effect on the risk pooling arrangement between insurers and insureds . . . because the rule leaves the underlying discretion itself unchanged.”).

¹⁸³ *Hancock*, 590 F.3d at 1149-50.

¹⁸⁴ *Id.* at 1150.

¹⁸⁵ *Id.* at 1146-47 (citing UTAH ADMIN. CODE r. 590-218-5(2) (2003)).

¹⁸⁶ See *Weeks*, 585 F. Supp. 2d at 1311 (noting that the rule requires an insurer’s reservation of authority to be “explicit, explained, and conspicuous”).

¹⁸⁷ See *Hancock*, 590 F.3d at 1149-50 (stating but rejecting plaintiff’s argument that “Rule 590-218 affects risk pooling because if a discretion-granting clause does not substantially conform to the rule’s safe-harbor language, the clause is invalid”).

¹⁸⁸ But see *id.* at 1150 (rejecting the notion that the rule affects risk pooling because of its potential to invalidate noncomplying clauses, ruling instead that “[t]he change in risk pooling must result from *compliance* with the state law, not its *violation*”).

It is apparent that a broader application of the *Miller* test is warranted to avoid the completely illogical results that federal courts reached here—holding that state laws prohibiting discretionary clauses altogether are saved, but that state laws prohibiting discretionary clauses that do not adhere to safe harbor requirements are preempted.¹⁸⁹ Nowhere does ERISA indicate that a state law must flatly mandate or prohibit particular conduct by insurers in order to be saved, but that laws merely regulating insurers' conduct—by imposing contractual form or procedural requirements upon insurers—do not qualify for savings.¹⁹⁰ Here, both types of discretionary laws—either outright banning or merely limiting discretionary clauses—directly regulate the terms of ERISA plans and insurers' performance of their contractual obligations. In fact, the Utah statute at issue in *Hancock* does function as a mandate; it mandates the form of a valid discretionary clause in an insurance contract. Under the *Miller* test, the only legitimate basis to preempt the Utah statute would be if its effect on the parties' risk arrangement were too insubstantial to qualify for savings.¹⁹¹ But since a discretionary clause may well be central to an insurance company's interpretation of its contract and its determinations to deny claims,¹⁹² it is unlikely that the Utah statute could be preempted on the basis of insubstantiality. Thus, state laws banning and regulating discretionary clauses provide a

¹⁸⁹ See Jo-el J. Meyer, *Legal Challenges Expected to Continue as More States Ban 'Discretionary Clauses'*, 19 BNA HEALTH L. REP. 229, 232 (2010) (“Anything less than a complete ban on all discretionary clauses may be preempted by ERISA”); see also *Kindel v. Cont'l Cas. Co.*, No. 1:02CV879, 2005 WL 1241975, at *2 (S.D. Ohio May 25, 2005) (erroneously preempting an Ohio statute that requires exceptions and deductions from indemnity to be adequately captioned and clearly set forth in the policy because it “does not forbid insurance providers from reducing or excepting coverage in certain circumstances”).

¹⁹⁰ See ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (2006) (asking merely whether a state law is a “law . . . which regulates insurance”).

¹⁹¹ The *Miller* test requires the state law to “substantially affect the risk pooling arrangement between the insurer and the insured,” so that a law that affects risk may nevertheless be preempted if its impact on risk is trivial. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003) (emphasis added); see also, e.g., *Sgro v. Danone Waters of N. Am., Inc.*, 532 F.3d 940, 944 (9th Cir. 2008) (holding that a California law requiring insurers to reimburse policyholders for the costs of copying medical records requested by the insurers may affect insurers' risk by making it easier for insureds to file claims, thereby causing insurers to pay more benefits, but that “this possibility is too remote and speculative to ‘substantially’ affect the risk pooling arrangement between insurers and their insureds” (quoting *Miller*, 538 U.S. at 342)); *Barber v. UNUM Life Ins. Co. of Am.*, 383 F.3d 134, 144 (3d Cir. 2004) (“[T]he threat that punitive awards [for insurers' bad faith] may result in increased costs that could be passed on to the insured is too attenuated to be deemed to ‘substantially affect’ the risk pooling arrangement.”).

¹⁹² Courts have found that discretionary clauses substantially affect benefits decisions and policyholders' review rights. See, e.g., *Kohut v. Hartford Life & Accident Ins. Co.*, No. 08-cv-00669-CMA-MJW, 2008 WL 5246163, at *8 (D. Colo. Dec. 16, 2008); *Am. Council of Life Insurers v. Watters*, 536 F. Supp. 2d 811, 823 (W.D. Mich. 2008), *aff'd sub nom.* *Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009); *Fenberg v. Cowden Auto. Long Term Disability Plan*, No. C 03-03898 SI, 2004 WL 2496174, at *3 (N.D. Cal. Nov. 2, 2004), *rev'd on other grounds*, 259 F. App'x 958 (9th Cir. 2007).

clear example of the problems created by federal courts applying the *Miller* savings test too narrowly.

CONCLUSION

A broader reading of the *Miller* savings test is in keeping with the spirit and intent of *Miller*. It is clear that the *Miller* Court intended to liberalize the savings test to apply to a wider range of state insurance laws than those that qualified under the old commonsense and McCarran-Ferguson factor tests.¹⁹³ This liberalization is obvious, as several of the considerations under the old tests were discarded, thereby making it easier for state laws to avoid preemption based on ERISA's savings clause. Moreover, the *Miller* court saved the AWP laws under its new test, despite arguments that the laws were preempted under the former test, because they were directed at entities outside the insurance industry (i.e., providers).¹⁹⁴ Under the new test, however, the AWP laws clearly passed muster.¹⁹⁵

Even more importantly, a broader reading of the *Miller* savings test to require state laws to substantially affect the risk arrangement between insurers and insureds, not the risk-pooling arrangement, would implement the goals of ERISA.¹⁹⁶ It would allow states to regulate insurers' performance of their obligations under health insurance policies purchased by ERISA

¹⁹³ See *Kidneigh v. UNUM Life Ins. Co. of Am.*, 345 F.3d 1182, 1197 (10th Cir. 2003) (Henry, J., concurring in part and dissenting in part) ("*Miller* expanded the scope in ERISA direct preemption analysis as to what affects risks. The court's use of the word 'only' to describe the new test shows that '[s]ubstantially affect[ing] the risk pooling arrangement between the insurer and the insured' is likely an easier hoop to jump through." (alterations in original) (quoting *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1145 (2003))); *Watters*, 536 F. Supp. 2d at 822 ("As apparent from the new test articulated in *Kentucky Ass'n*, the standards have been unmistakably relaxed for deciding when a state law 'regulates insurance' [T]his new test gives more power to states to regulate insurance."); *Benefit Recovery v. Wooley*, No. 03-652-JJB-DLD, 2006 U.S. Dist. LEXIS 97456, at *20 (M.D. La. Dec. 5, 2006) (citing to *Elliot v. Fortis Benefits Insurance Co.* for its observation that "current risk-pooling jurisprudence offers a potentially broader concept of risk allocation than earlier precedent suggested"). For an explanation of the pre-*Miller* commonsense and McCarran-Ferguson factor tests for savings, see *supra* Part III.

¹⁹⁴ See *Miller*, 538 U.S. at 334-46 (rejecting petitioners' argument that the AWP laws were not saved because they "equally prevent *providers* from entering into limited network contracts with *insurers*, just as they prevent insurers from creating exclusive networks in the first place"); see also *Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 217 (1979) (holding that third-party provider arrangements between insurers and pharmacy providers were not "the 'business of insurance'" under Section 2(b) of the McCarran-Ferguson Act, as pharmacies were not insurance entities).

¹⁹⁵ See *Miller*, 538 U.S. at 335 ("Neither of Kentucky's AWP statutes, by its terms, imposes any prohibitions or requirements on health-care providers.").

¹⁹⁶ See ERISA § 2(b), 29 U.S.C. § 1001(b) (2006) ("[The goal of ERISA is 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.").

health benefit plans, hopefully protecting the reasonable expectations of insureds.¹⁹⁷ This could mean that a wide variety of protectionist state insurance laws—including laws requiring discretionary clauses to be stated clearly and conspicuously,¹⁹⁸ prohibiting insurers’ failure to pay claims in a timely fashion,¹⁹⁹ requiring insurers providing employee group coverage to notify individual employees when coverage is cancelled, prohibiting insurers’ misrepresentations and false advertising, requiring insurers to notify policyholders of their rights to convert to another type of coverage, requiring policy exceptions and deductions to be captioned and clear, and barring insurance companies from cancelling contracts because of innocent or nonmaterial misrepresentations by the policyholder—could all be saved as the regulation of insurance. Since ERISA has largely failed to provide similar substantive health plan protections, saving such state insurance laws is essential to the security of ERISA health plan members.²⁰⁰

Admittedly, saving a broader range of state insurance laws will provide benefits to ERISA health plan members only within limits. The Supreme Court has clarified that saved state laws cannot provide remedies to ERISA insureds beyond those already provided by ERISA.²⁰¹ Further, ERISA’s “deemer” clause prevents the application of state insurance laws to self-insured ERISA health benefit plans.²⁰²

¹⁹⁷ See, e.g., *Kidneigh*, 345 F.3d at 1199 (“Colorado’s insurance bad faith law thus substantially affects the risk-pooling arrangement by giving insureds clear protection they did not previously possess in their settlement negotiation practices with insurers.”).

¹⁹⁸ See *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1149 (10th Cir. 2009) (preempting a Utah law that requires discretionary clauses to utilize form language and to be printed in a particular font size because the law does not affect risk pooling); *Weeks v. Unum Grp.*, 585 F. Supp. 2d 1305, 1311 (D. Utah 2008).

¹⁹⁹ See *Bank of La. v. Aetna U.S. Healthcare, Inc.*, No. Civ.A. 02-236, 2003 WL 21634306, at *2-3 (E.D. La. July 9, 2003) (finding that a Louisiana law penalizing an insurer’s unreasonable failure to pay a claim within thirty days from receipt of written notice and proof of claim was preempted because it did not affect risk pooling).

²⁰⁰ See, e.g., *Standard Ins. Co. v. Morrison (Morrison II)*, 584 F.3d 837, 845 (9th Cir. 2009) (“[C]onsumers can be reasonably sure of claim acceptance only when an improperly balking insurer can be called to answer for its decision in court. By removing the benefit of a deferential standard of review from insurers, it is likely that the Commissioner’s practice will lead to a greater number of claims being paid.”), *cert. denied*, 130 S. Ct. 3275 (2010).

²⁰¹ The Supreme Court declared in *Aetna Health Inc. v. Davila* that the preemptive force of ERISA’s comprehensive remedial scheme trumps even a state law that qualifies for saving as the regulation of insurance. For a discussion of *Davila*, see *supra* Part II.

²⁰² Courts have applied the deemer clause to prevent the regulation of self-insured plans through laws intended to regulate insurance. See, e.g., *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (“We read the deemer clause to exempt self-funded ERISA plans from state laws that ‘regulat[e] insurance’ within the meaning of the saving clause. . . . State laws that directly regulate insurance are ‘saved’ but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.” (alteration in original)); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (“[O]ur decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation [via

But at least with regard to fully insured ERISA plans, a broader reading of the *Miller* test to protect state laws that substantially affect the risk arrangement—not the risk-pooling arrangement—between an insurer and insured will provide much needed procedural and substantive safeguards to ERISA health plan members. Even if affording ERISA members additional civil remedies is precluded,²⁰³ expanding the state’s ability to regulate insurers’ contract performance and to impose administrative penalties might prevent the offending conduct at the outset, thereby preventing a policyholder’s harm and obviating the member’s need for an additional remedy.²⁰⁴ In this way, a broader reading of the *Miller* savings test will narrow the gap between ERISA’s broad preemption of state laws and its lack of substantive protections to health plan members.

state laws regulating insurance] while the latter are not. By so doing we merely give life to a distinction created by Congress in the ‘deemer clause,’ a distinction Congress is aware of and one it has chosen not to alter.”).

²⁰³ *Aetna Health Inc. v. Davila*, 542 U.S. 200, 217-18 (“[A] state law . . . will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.”).

²⁰⁴ *See Prudential Ins. Co. of Am. v. Nat’l Park Med. Ctr.*, 413 F.3d 897, 912-13 (8th Cir. 2005) (saving the Act’s “any willing provider” provisions under the *Miller* test, but preempting the civil enforcement of the Arkansas Patient Protection Act of 1995 under principles of complete preemption).