UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

BENEFIT RECOVERY

VERSUS

J. ROBERT WOOLEY, IN HIS CAPACITY AS COMMISSIONER OF INSURANCE OF THE STATE OF LOUISIANA

CIVIL ACTION NO.

03-652-JJB-DLD

RULING ON CROSS MOTIONS FOR SUMMARY JUDGMENT

This matter is before this court on a Motion to Dismiss, or in the Alternative, Motion for Summary Judgment filed by the defendant (doc. 46). The plaintiff, Benefit Recovery, Inc., filed a memorandum in opposition (doc. 58). The defendant has filed a reply memorandum in support of its position (doc. 60).

The plaintiff has also filed a Motion for Summary Judgment (doc. 49). The defendant has filed a memorandum in opposition (doc. 55). The plaintiff has filed a reply memorandum in support of the motion (doc. 59). This court has jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

BACKGROUND FACTS

The plaintiff, Benefit Recovery, Inc., provides subrogation services to Louisiana self-funded and fully insured employer health benefit plans, many of which are governed by the Employee Retirement Income Security Act (ERISA).

On January 8, 2003, the Commissioner of Insurance issued Directive 175,

which states in pertinent part that, "any right of recovery on the part of the insurer, whether by subrogation or reimbursement, is subordinate to the insured's right to be fully compensated for his damages, and that the insurer is obligated to share in the legal expenses incurred."

Directive 175 encapsulates the "make whole" doctrine and the *Moody* doctrine. The "Make Whole" doctrine is "an insurance principle which mandates that, in the absence of a contrary agreement, an insurance company may not enforce its subrogation rights until the insured has been fully compensated for her injuries - 'made whole.'"[1] Under the *Moody* doctrine, a benefits provider may be "charged with a proportionate share of the reasonable and necessary costs of recovery, including attorneys' fees, incurred by the injured worker in the suit against the third person."[2]

The plaintiff alleges that prior to January 8, 2003, the Department of Insurance routinely allowed health plans paying for the treatment of accidental injuries to contract around the Make Whole and *Moody* doctrines. However, after the issuance of Directive 175, contracting around the doctrines is no longer permitted.

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[1]*Roberts v. Richard*, 743 So. 2d 731, 733 (La. App. 3 Cir. 1999).

[2]*See Moody v. Arabie*, 498 So. 2d 1081, 1083 (La. 1986) (amended by La. R.S. 23:1103).

Benefit Recovery sued J. Robert Wooley[3] alleging that Directive 175 was outside the scope of the Commissioner of Insurance's authority and that Directive 175 was preempted by the Employers Retirement Income Security Act (ERISA). The plaintiff seeks a declaration that Directive 175 is preempted by ERISA and an injunction.

STANDARD OF LAW

Summary judgment is appropriate when the pleadings, answers to interrogatories, admissions, and affidavits on file indicate that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986).

When the burden at trial rests on the non-movant, the movant need only demonstrate that the record lacks sufficient evidentiary support for the non-movant's case. *Id.* The movant may do this by showing that the evidence is insufficient to prove the existence of one or more elements essential to the non-movant's case. *Id.*

Although this court considers the evidence in the light most favorable to the non-movant, the non-movant may not merely rest on allegations set forth in the

[3]*But see* Doc. 45 (Unopposed Motion to Substitute Party Defendant). The defendant moved to have James J. Donelon substituted as defendant after he succeeded J. Robert Wooley as Commissioner of Insurance. The motion was granted on July 5, 2006 (doc. 50).

pleadings. Instead, the non-movant must show that there is a genuine issue for trial. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986). Conclusory allegations and unsubstantiated assertions will not satisfy the non-movant's burden. *Grimes v. Dep't of Mental Health*, 102 F.3d 137, 139-40 (5th Cir. 1996). If once the non-movant has been given the opportunity to raise a genuine factual issue, no reasonable juror could find for the non-movant, summary judgment will be granted. *See Celotex*, 477 U.S. at 322; *see also* Fed. Rule Civ. P. 56(c).

ANALYSIS

I. Standing

In a previous ruling in this case, this court decided that Benefit Recovery had standing to pursue this action under Article III. (doc. 17). Specifically, this court ruled that Benefit Recovery had alleged a concrete and immediate injury that was redressable by a favorable court decision.

In its latest motion, the defendant re-urges the issue of standing. This time, however, the defendant argues that even if the plaintiff has Article III standing, the plaintiff lacks prudential standing and so the matter should be dismissed.

The defendant correctly points out that the federal standing doctrine has two components. The first, Article III standing, which the court has already ruled upon, addresses the Constitution's case and controversy requirement. The second

component is prudential standing which "embodies judicially self-imposed limits on the exercise of federal jurisdiction." *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 11-12 (2004) (quoting *Allen v. Wright*, 468 U.S. 737, 751 (1984)). This court has not yet expressly ruled upon the prudential standing component in this case.

The Supreme Court has explained that "prudential standing encompasses 'the general prohibition on a litigant's raising another person's legal rights, the rule barring adjudication of generalized grievances more appropriately addressed in the representative branches, and the requirement that a plaintiff's complaint fall within the zone of interests protected by the law invoked.'" *Id.* at 12.

Under the prudential standing doctrine, the Supreme Court has held that generally, a party "must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." *Kowalski v. Tesmer*, 543 U.S. 125, 129 (2004) (quoting *Warth v. Seldin*, 422 U.S. 490, 499 (1975)). Nevertheless, the Supreme Court has stated that this rule is not absolute and the court has recognized "that there may be circumstances where it is necessary to grant a third party standing to assert the rights of another." *Id.* at 129-30. However, to fall within this exception, a party seeking third party standing must make two additional showings. *Id.* at 30. First, the party asserting the right must have a "close" relationship with the person who possesses the right. Second, there must be a "hindrance" to the possessor's ability to protect his own interests.

In its motion to dismiss, the defendant argues that because Benefit Recovery

is not an insurer, it has no legal rights at stake and must rely upon third party standing. The defendant further asserts that even if Benefit Recovery has a "close" relationship with persons who possess the right at issue, Benefit Recovery cannot establish that a "substantial hindrance" prevents insurers from asserting their own rights. In response, the plaintiff incorporates all of the arguments made in its memorandum in opposition to defendant's original motion to dismiss.

In *Burgio & Campofelice, Inc. v. NYS Dep't of Labor*, 107 F.3d 1000 (2d Cir. 1997), the plaintiff argued that the state was enforcing a law that was preempted by ERISA and the Supremacy Clause. In response, the defendants asserted that the plaintiff lacked standing to protest the law because he was not an ERISA plan participant, beneficiary, or fiduciary.

In deciding the matter, the *Burgio* court agreed "with those commentators who have concluded that 'the best explanation of *Ex parte Young* and its progeny is that the Supremacy Clause creates an implied right of action for injunctive relief against state officers who are threatening to violate the federal Constitution or laws.'" *Id*. at 1006. The court further explained that "remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." *Id*.

In this case, the plaintiff is not seeking enforcement of a state law, rather it is challenging the enforcement of the law and its constitutionality. Thus, the plaintiff need not assert third party standing. Accordingly, this court reaffirms that the

plaintiff has constitutional standing and also clarifies that the plaintiff has prudential standing.

II. The Preemptive Effect of ERISA upon Directive 175

The scope of ERISA is set out in 29 U.S.C. § 1144. It states in pertinent part that ERISA "shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." However, even if a state statute falls within the preemptive scope of ERISA, it will not be preempted if it is a "saved statute." ERISA's saving clause provides that "except as provided in [the deemer clause][4] nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

The Supreme Court has held that for a state law to be classified as a law which "regulates insurance," it must meet a two-pronged test. *Kentucky Assoc. of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003). First, the state law "must

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[4] The deemer clause states that:

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

29 U.S.C. § 1144(b)(2)(B).

be specifically directed toward entities engaged in insurance." Second, the state law must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.*

As a preliminary matter, it is necessary to address whether Directive 175 is preempted as a law that relates to ERISA. ERISA preempts "any and all State laws[5] insofar as they may now or hereafter relate to any employee benefit plan" that is covered by ERISA. 29 U.S.C. § 1144(a).

The defendant appears to argue that Directive 175 is not preempted by ERISA because Directive 175 does not apply to self-funded plans and only applies to fully insured plans.[6] The plaintiff directs the court to *Swerhun v. Guardian Life Ins. Co. of America*, 979 F.2d 195 (11th Cir. 1992). In that case, the appellant argued that the distinction between fully insured and self-funded plans "fundamentally altered the ERISA preemption analysis." However, the *Swerhun* court disagreed, it explained that:

> The Supreme Court addressed this distinction strictly in the context of the interplay between the saving clause and the deemer clause. Because Swehun's claims are not 'saved' by the saving clause, the deemer clause is immaterial, and her reliance upon the fully insured / self-insured distinction in the Court's deemer clause jurisprudence is misplaced.

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[5]Whether Directive 175 is a "state law" under ERISA is explored in depth in Section II(A) of this opinion.

[6]*See, e.g.*, Doc. 60 (Reply Memorandum in Support of Defendant's Motion to Dismiss, or in the Alternative, For Summary Judgment, p.2-5).

Id. at 199, n.6.

The court agrees with the plaintiff and finds that at this stage the fully insured and self-funded distinction is immaterial. Accordingly, in this case, the central issue is whether Directive 175 is saved from preemption by ERISA's saving clause.

A) Saving Clause Analysis, Part 1:

Whether Directive 175 is a state law that is directed toward entities engaged in Insurance

Relying upon one of the joint stipulations made by the parties, Benefit Recovery argues that Directive 175 cannot satisfy the first prong of the *Miller* test because the directive is not a "law." In Joint stipulation of Fact Number 2, the parties have stipulated that "directives do not themselves have the force of law, but directives inform insurers as to the position of the Commissioner regarding the law and public policy of Louisiana and instructs insurers of the need to draft their forms in compliance."[7]

In response, the defendant argues that ERISA's saving clause is not limited to statutes. The defendant points to the definition section of ERISA, which states that the term "state law" includes "all laws, decisions, rules, regulations, or other

[7]Doc. 44-1 (Joint Stipulation and Designation of Exhibits).

State action having the effect of law, of any State."

In support of its position that Directive 175 is a "state law" as envisioned by ERISA, the defendant cites *Gauthreaux v. USAA Casualty Ins. Co.*, No. 00-2045, 2001 WL 65573 (E.D. La. Jan. 25, 2001). In *Gauthreaux*, a district court held that although a directive issued by the Commissioner of Insurance was "not technically a regulation" the directives were "directed to all insurance companies operating in Louisiana, and compliance with its provisions is mandatory." *Id.* at *2. The court then took judicial notice of the directive as "a matter of public record and as a governing quasi-regulation." *Id.*

In this case, the categorization of the directive issued by the Commissioner of Insurance is not an easy task. A directive is defined by Louisiana Revised Statute 22:5 as a "written communication or order issued by or on behalf of the commissioner of insurance to a person whose activities are regulated by this Title, which instructs the person to act in conformance with this Title, or any rule or regulation adopted in accordance with the Administrative Procedure Act." This does not provide much aid in the classification of a directive.

Additionally, the stipulations in the parties' Joint Stipulation do not resolve the matter. It is true that stipulation of fact 2 states that "directives do not themselves have the force of law." Yet, this must also be paired with stipulation 1 which says

that directives "provide a mechanism for [the] enforcement" of the Insurance Code.[8] Moreover, it is not clear that the stipulation that 'directives do not have the force of law' is an accurate reflection of the true nature of a directive. Directive 175 is in effect a mandatory provision because it expressly states that insurers who do not follow the directive "will be subject to sanctions including but not limited to the imposition of such fines as are authorized by law."

Thus, the directives do not appear to fit neatly into any mold. Judge Vance's characterization of a directive as a "quasi-regulation" seems most fitting.[9] Directives instruct insurers; however, they are mandatory and enforced, and those who chose not to follow them can be sanctioned.[10]

This court agrees with the arguments asserted by the defendant. As the defendant aptly pointed out, whether this court treats the Directive as a "quasi-regulation," "a written communication or order," or "some other type of official instrument, it is clear that, at a minimum, Directive 175 is State action that instructs insurers on permitted practices and cautions them about the consequences of non-

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[8]Doc. 44-1 (Joint Stipulations and Designations of Exhibits; Stipulation of Fact, Number 1).

[9]*Gauthreaux*, 2001 WL 65573, at *2.

[10]*See, e.g.*, La. R.S. 22:1316(A). It states that "[a]ny person subject to the regulatory authority of this department who fails to comply with any directive issued by the commissioner in connection with a consumer complaint shall be fined an amount not to exceed two hundred fifty dollars for each occurrence." *Id.*

compliance."[11] This is sufficient to satisfy the "state law" requirement of the saving clause analysis.

Additionally, as a practical matter, the plaintiff's argument that Directive 175 is not a "state law" for the purpose of ERISA's savings clause must fail.[12] If this court accepts the premise that Directive 175 is not a "state law" and not subject to ERISA's savings clause, the plaintiff may have won that battle, but it will have lost the war. Arguing that Directive 175 is not a "state law" is a dubious argument that places the plaintiff on unsteady footing and causes a more problematic issue to come to light. The United States Code provides that ERISA's preemptive power applies to "state laws." The term "state law" is defined only once in the ERISA context. Accordingly, if Directive 175 is not a "state law" for the purpose of ERISA's saving clause; it is also not a "state law" that is subject to ERISA preemption. This would make Directive 175 immune from ERISA's reach and there would be no need to even conduct a saving clause analysis.

In essence, for this court to adopt the plaintiff's argument it would have to find

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[11]Doc. 60 (Defendant's Reply Memorandum in Support of Defendant's Motion to Dismiss, or in the Alternative, For Summary Judgment, p. 6-7).

[12]This court has taken notice of the fact that the plaintiff has made seemingly contradictory arguments about the Directive's status as a "state law." In arguing that the Directive can be preempted by ERISA, the plaintiff urges that "semantics aside, it is clear that the Commissioner enforces Directive 175 and treats it as *having* the force of law." (Doc. 58, p.4) (emphasis added). However, in arguing that ERISA's saving clause analysis does not apply, the plaintiff urges that the directives "do *not* have the force of law." (Doc. 59, p.2) (emphasis added). Thus, the plaintiff's arguments pertaining to whether the directive is a "state law" have varied, depending upon what provides the most advantageous result to the plaintiff.

that Directive 175 *is* a "state law" such that it can be preempted by ERISA, but it is *not* a "state law" in that it cannot be saved by ERISA's saving clause. As "state law'" has only one definition under ERISA, this court is not prepared to reach such a contradictory result.

Having decided that Directive 175 is a law for the purpose of ERISA's Saving Clause, it is clearly apparent that such a law is directed toward the insurance industry. The plaintiff cites *Levine v. United Healthcare Corp.*, 402 F.3d 156 (3d Cir. 2005) which concluded that a New Jersey statute was not preempted by ERISA because the statute was one of general applicability and was not directed to the insurance industry. However, this court does not find *Levine* to be persuasive under the present facts. In this case, Directive 175 is directed specifically to insurers and was written by the Commissioner of Insurance. It specifically states that the purpose of the directive was to streamline the insurance policy review process and to supplement Regulation 78, an insurance provision.

Accordingly, this court concludes that Directive 175 is a law that is specifically directed toward the insurance industry.

B). *Saving Clause Analysis, Part 2*:

Whether Directive 175 substantially affects the risk pooling arrangement between the insurer and the insured.

The second prong of the Saving Clause analysis requires that the state law "substantially affect the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 342. The plaintiff cites *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989), in support of its position that Directive 175 does not substantially affect the risk pooling arrangement between an insurer and the insured.[13] The plaintiff relies upon language in *Baxter* in which the court stated that "the practice of subrogation does not transfer the risk from a policyholder to his or her insurer. Rather it limits the recovery available to the policyholder by preventing a double recovery."

In response, the defendant argues that *Baxter* should not be relied upon because *Baxter* was decided before *FMC Corp*[14] and *Miller* and is not in accord with current jurisprudence.

Prior to *Miller*, the Saving Clause analysis was governed by the McCarran-Ferguson factors. These factors were: 1) whether the practice has the effect of transferring or spreading a policyholder's risk; 2) whether the practice is an integral

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[13]Doc. 52 (Plaintiff's Memorandum in Support of Motion for Summary Judgment).

[14]*FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

part of the policy relationship between the insurer and the insured; and 3) whether the practice is limited to entities within the insurance industry. *Miller*, 538 U.S. at 333.

The Supreme Court, however, came to the conclusion that the McCarran-Ferguson analysis had "misdirected attention, failed to provide clear guidance to lower federal courts" and had "added little to the relevant analysis." *Id.* at 339-40. The court then declared that it was making "a clean break" from the McCarran-Ferguson factors and adopted the two part Miller analysis discussed above. *Id.*

Courts have found that *Miller* has "dramatically changed the analysis for determining whether state legislation qualifies for exemption from express preemption under ERISA via ERISA's saving clause." *Stone v. Disability Mgmt. Servs., Inc.*, 288 F. Supp. 2d 684, 693 (M.D. Pa. 2003) (quoting *Rosenbaum v. Unum Life Ins. Co.*, No. 01-6758, 2003 WL 22078557 (E.D. Pa. Sept. 8, 2003)).

Specifically, in *Stone*, the court explained that "it is critically important to note the difference between the second prong of the *Miller* test and the first of the now defunct McCarran-Ferguson factors which asks 'whether the [law] has the effect of transferring or spreading a policyholder's risk." *Id.* at 693-94. Thus, the focus of the old test (McCarran-Ferguson) was on the transfer and spreading of the risk. The new test (Miller), however, speaks in terms of substantially affecting the risk pooling arrangement.

In this case, the plaintiff urges this court to rely on the Eighth Circuit's holding

in *Baxter* that "the practice of subrogation does not transfer the risk from a policyholder to his or her insurer." 886 F.2d at 186. However, the plaintiff's argument suffers from several deficiencies. First, the plaintiff failed to point out that at least one other circuit court had reached a different conclusion from *Baxter* and held that the practice of disallowing subrogation clauses *does* transfer the policyholder's risk. *See United Food v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986). The plaintiff does not attempt to distinguish *United Food* nor does the plaintiff offer any explanation as to why this court should follow *Baxter* instead.

Second, even assuming that *Baxter* correctly decided the matter, *Baxter* was decided using the McCarran-Ferguson factors, not the current Miller factors. The two tests are not the same. Therefore, a state law that does not spread the policyholder's risk can *still* substantially affect the risk pooling arrangement. *See Miller*, 538 U.S. at 339, n.3 (distinguishing McCarran-Ferguson from Miller and concluding that although the state law at issue did not spread the policyholder's risk, it did substantially affect the risk pooling arrangement). *See also Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1145 (9th Cir. 2003) (concluding that current risk-pooling jurisprudence offers a potentially broader concept of risk allocation than earlier precedent suggested).

One recent case, decided by a federal district court offers a persuasive analysis of whether subrogation substantially affects the risk pooling arrangement under the current rubric established by *Miller*. In *Smith v. Life Ins. Co. of N.*

America, No. 05-2215, 2006 WL 2842529 (N.D. Ga. Sept. 28, 2006), the plaintiff suffered a debilitating injury due to a car accident. The plaintiff reached a monetary settlement with the driver and the driver's employer for $5 million. The defendant, an insurance provider of Long Term Disability plans, was required to provide benefits to the plaintiff during the disability. The defendant argued that it should have a set-off of the settlement amount and it reduced the amount of the plaintiff's benefits. The plaintiff countered that because his future medical expenses would be in the $1 million to over $5 million range and because his loss in earnings would exceed $14 million, he had not been made whole by the third party settlement. Therefore, the plaintiff argued that the make whole doctrine precluded any offset of the settlement. *Id*. at *1-3.

In deciding the matter, the district court examined Georgia's anti-subrogation provision.[15] The statute provided that "the benefit provider may require reimbursement only if the amount of recovery exceeds the sum of all economic and non-economic losses incurred as a result of the injury" (Make Whole doctrine) and it provided that "the amount of the reimbursement claim must be reduced by the pro rata amount of attorney's fees and the expenses of litigation incurred by the injured party" (*Moody* doctrine). *Id*. at *10.

In examining whether the statute was preempted by ERISA, the *Smith* court

[15]The district court concluded that under federal common law the make whole doctrine applied. However, it included the discussion of Georgia's anti-subrogation statute as an alternative grounds for reaching its conclusion. *Smith*, 2006 WL 2842529, at *14, n.9.

was directed by the Supreme Court's two-pronged *Miller* test. After finding that the law was directed toward the insurance industry, the court turned to the issue of whether Georgia's anti-subrogation statute substantially affected the risk pooling arrangement between the insurer and the insured. *Id.* at *14-15. The court concluded that:

> Georgia's anti-subrogation statute also satisfies the second prong of the Supreme Court's test, as it affects the risk pooling arrangement between the insurer and the insured. The statute specifically controls the terms of insurance policies by rendering unenforceable policies and contracts, which contain or incorporate provisions in conflict with the Code. Because the state law controls the actual terms of the insurance policies, it is a prime example of a law that substantially affects the risk-pooling arrangement between the insured and the insurer.

Id. at *14.

In this case, like the Geogia anti-subrogation statute, Directive 175 incorporates the *Moody* and Make Whole doctrines. Therefore, this court finds that *Smith* sheds persuasive light on the matter currently before this court.

The holding in *Smith* is further bolstered by language by the Supreme Court in *Miller*. 528 U.S. 329. In *Miller* the court was called upon to examine an Any Willing Provider statute ("AWP"), which mandated that an insurer could not discriminate against a provider located within the geographic area of the plan and willing to meet the conditions for participation. *Id.* at 332-33. The petitioner argued that the AWP statutes did not substantially affect the risk pooling arrangement because they did not alter or affect the terms of insurance policies and only

pertained to the relationship between insureds and third-party providers. *Id.* at 338. The Supreme Court concluded that:

> 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 [the saving clause]; it suffices that they substantially affect the risk pooling arrangement between insurer and insured. By expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds...

Id.

In the instant case, Directive 175 not only affects the risk pooling arrangement, but it also controls the actual terms of insurance policies. Insurers are no longer able to contract out of the Make Whole doctrine or the *Moody* doctrine and attempts around it are treated as if they were not written. Thus, Directive 175 alters the scope of permissible bargains between insurers and insureds. This court agrees with *Smith* that anti-subrogation laws, such as the one at issue in this case, substantially affect the risk-pooling arrangement between the insured and the insurer.

Although it may be true that anti-subrogation laws do not transfer or spread the risk,[16] as previously discussed, that is no longer the inquiry and the plaintiff's reliance upon cases that explore whether such statutes spread or transfer the risk is misguided.

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[16] *But cf. United Foods*, 801 F.2d at 1161 (finding that an anti-subrogation statute did transfer the risk).

III. The Contract Clause and Directive 175

The plaintiff has alleged that Directive 175 "violates the Contracts Clause of the Louisiana and United States Constitutions, in that it attempts to invalidate provisions that health benefits plans have the contractual freedom to enact."[17]

In its motion for summary judgment, the defendant argues that Directive 175 does not violate the Contracts Clause because: 1) Directive 175 did not change the law; 2) even if Directive 175 changed the law, the directive only applies prospectively and would not affect existing contracts; and 3) even if Directive 175 did change the law and substantially impaired existing contractual rights, the Commissioner issued Directive 175 for a legitimate public purpose.[18] The plaintiff did not respond to the Contracts Clause issue in its Memorandum in Opposition to the defendant's motion, nor did the plaintiff address the Contracts Clause issue in its own Motion for Summary Judgment. Accordingly, the plaintiff has not offered any explanation or citation to any authority to support its position that Directive 175 is in violation of the Contract Clause.

The United States Constitution states that "no state shall. . . pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant

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[17]Doc. 1 (Plaintiff's Original Complaint for Declaratory and Injunctive relief, par. 16).

[18]Doc. 48 (Memorandum in Support of Defendant's Motion to Dismiss, or in the Alternative, For Summary Judgment, p. 12).

any Title of Nobility." U.S. Const. art. 1, § 10. Similarly, the Contracts Clause of the Louisiana Constitution states that "no bill of attainder, ex post facto law, or law impairing the obligation of contracts shall be enacted." La. Const. art. 1, § 23. Courts have concluded that the Contracts Clauses of the Louisiana and Federal Constitutions are "virtually identical" and "substantially similar" and the Louisiana Supreme Court has adopted the analysis enunciated by the United States Supreme Court.[19] *See, e.g., Smith v. Bd. of Trustees of Louisiana State Employee's Retirement Sys.*, 851 So. 2d 1100, 1108-09 (La. 2003). Therefore, although two Contract Clauses are at issue, this court need only engage in one Contract Clause analysis.

As a preliminary matter, the defendant argues that Directive 175 does not change the law; however, even if Directive 175 did change the law, the defendant argues that any change does not affect existing contracts, only future contracts. In support of its position, the defendant cites *Guidroz v. Lewis*, 626 So. 2d 736 (La. App. 5 Cir. 1993).

In *Guidroz*, the court examined the retroactive or prospective application of administrative directives by the Commissioner of Insurance. The court noted it found no authority that would mandate that the Insurance Commissioner's

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[19]The analysis adopted by the United States Supreme Court is explained in *Energy Reserves Group, Inc. v. The Kansas Power & Light Co.*, 459 U.S. 400 (1983). The Court ruled that the "threshold inquiry is 'whether the state law has, in fact, operated as a substantial impairment of a contractual relationship.'"

determination be applied retroactively.

Although the court recognized that Louisiana's rule on the retroactivity of laws referred to "*laws* rather than administrative directives," the court still found the rules of construction to be instructive. *Id.* at 739 (emphasis in original). Louisiana Civil Code article 6 states that, "in the absence of contrary legislative expression, substantive laws apply prospectively only. Procedural and interpretative laws apply both prospectively and retroactively, unless there is a legislative expression to the contrary."[20]

The *Guidroz* court concluded that substantive laws apply prospectively and even interpretative legislation "cannot operate retroactively to disturb vested rights." *Id.* at 739. *See also Am. Fin. Corp. of Coushatta v. Small*, 250 So. 2d 768 (La. App. 2 Cir. 1971).[21] Thus, whether the plaintiff argues that Directive 175 was a substantive change in the law, or an interpretive change, the Directive need not be given a retroactive effect. If Directive 175 has no retroactive effect, the Contract Clause is not implicated. Again, the plaintiff has failed to cite any authority or explain how Directive 175 violates the Contracts Clause of the United States Constitution or the Louisiana Constitution.

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[20]In evaluating the retroactively of laws, the Louisiana Civil Code recognizes three types of laws: substantive, procedural, and interpretative.

[21]The court explained that even remedial statutes that have a retroactive effect "should not be construed to operate retroactively where vested rights are impaired" because such an interpretation would run afoul of the Federal and State Constitutions. *Small*, 250 So. 2d at 770.

IV. Legal Authority to Support the Enforcement of Directive 175

The plaintiff attempts to challenge the substance of Directive 175 and asserts that there is a lack of legal authority to support the make whole doctrine or attorney fee provisions contained in Directive 175.[22] However, in a prior ruling, this court decided that matters addressing whether Directive 175 contravened Louisiana law would not be decided by this court.[23]

Specifically, this court ruled that "insofar as Benefit Recovery seeks declaratory or injunctive relief that Directive 175 is contrary to Louisiana law, Benefit Recovery's claims are barred by the Eleventh Amendment."[24] Accordingly, this court expresses no opinion as to whether the substance of Directive 175's provisions has adequate support in Louisiana law.

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[22] *See* Doc. 58 (Plaintiff's Memorandum to Defendant's Motion to Dismiss or, Alternatively, Motion for Summary Judgment, p. 6). *See also* Doc. 52 (Plaintiff's Memorandum in Support of Motion for Summary Judgment, p.2) (stating that "rather than attempt to impose the provisions of Directive 175 through the legislative process, Defendant unilaterally and unconstitutionally imposed Directive 175 on insurers in excess of its statutory and constitutional authority.")

[23] Doc. 17 (Ruling on Motion to Dismiss).

[24] Doc. 17, p. 9.

CONCLUSION

For the reasons stated herein, the defendant's Motion to Dismiss based upon a lack of standing is DENIED. The defendant's Motion for Summary Judgment based upon ERISA preemption and the Contract Clause is GRANTED. Therefore, the plaintiff's Motion for Summary Judgment is DENIED.

Baton Rouge, Louisiana, December 5 7 4, 2006.

JAMES J. BRADY
UNITED STATES DISTRICT JUDGE