“Any Willing Provider” Law Not Preempted by ERISA

Introduction
A recurring issue for states that seek to regulate the health care insurance and managed care industry is whether a state law, as it would apply to services that the industry provides to employee benefit plans, is preempted by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The issue has not been simple to resolve, as illustrated by the considerable amount of litigation, including at the U.S. Supreme Court level, on the parameters of ERISA preemption.

In its most recent pronouncement on ERISA preemption, the Supreme Court has ruled that ERISA did not preempt Kentucky “any willing provider” laws that bar health insurers from excluding providers who are willing to meet the terms for participation in a managed care network. The decision, Kentucky Association of Health Plans, Inc. v. Miller, handed down on April 2 of this year, represents a further refinement and narrowing by the Court as to when state laws regulating the managed care industry are subject to ERISA preemption.

Supreme Court Decision
Background
An “any willing provider” law is a law that requires a managed care organization to contract with or accept services from any health care provider who is willing to meet the organization’s terms and conditions, such as payment levels. The effect is to prevent the organization from selectively contracting with a limited number of providers, so that subscribers have a broader choice of, for example, doctors and hospitals from which to seek care. While medical provider organizations and consumer groups generally support such laws as increasing access to medical care, managed care organizations generally oppose them as limiting their ability to control costs and improve quality.

Approximately 21 states currently have enforceable “any willing provider” laws, down from 28 in 1996. They vary principally as to the types of providers covered.

The Kentucky “any willing provider” law at issue consists of two parts. The first part prohibits a health insurer from discriminating against any provider located in the coverage area of a health benefit plan who is willing to meet the terms and conditions for participation established by the insurer. The second part requires a health benefit plan that includes chiropractic benefits to permit participation by any licensed chiropractor who agrees to abide by the plan’s terms, conditions, reimbursement rates, and standards of quality. Several health maintenance organizations (“HMOs”) doing business in Kentucky...
sued the state in 1997, asserting that ERISA preempted these laws. The lower courts ruled that the laws were not preempted.

ERISA Preemption Analysis
The goal of ERISA preemption is to permit employers to be able to establish consistent rules for their employee benefit plans on a nationwide basis, without being subject to varying state law requirements. Nevertheless, the statute places limits on the scope of ERISA preemption.

The result is a three-step test for whether ERISA preemption applies. The first step is whether a state law “relates to any employee benefit plan,” in which case preemption is triggered. The second step is whether the law regulates insurance, banking or securities, in which case the law is “saved” from preemption. The third step is the “deemer” clause, which provides that an employee benefit plan shall not be “deemed” to be an insurer or bank, or to be engaged in the business of insurance or banking, for purposes of any state law. The effect of the third step is to prevent a state from regulating a self-insured plan.

The part of the test at issue in the Kentucky case was the “savings” clause. The HMOs claimed that the Kentucky laws were not “saved” from preemption as insurance regulation because they were not “specifically directed toward” insurers and did not regulate an “insurance practice.” These arguments were based on language from prior Supreme Court decisions, and had been accepted in three prior lower-court decisions that had found “any willing provider” laws to be preempted.

The Supreme Court rejected these arguments here. Examining the terms of the Kentucky laws, the Court found that the effects of the laws on entities outside the insurance industry, such as health care providers, did not mean that they failed to be “directed toward” the insurance industry. The Court also found that the focus of the law on insurer-provider relationships, as opposed to the actual terms of insurance policies, did not mean that it failed to “regulate insurance,” because it had the effect of imposing conditions on the right to engage in the business of insurance. The important consideration, said the Court, is that the law should “substantially affect the risk pooling arrangement between the insurer and the insured to be covered by ERISA’s savings clause.” This was the case here, as the law expanded the number of providers from whom insureds may receive health services.

The Court concluded its opinion by clarifying the test for whether the insurance savings clause from ERISA preemption applies. In previous decisions, the Court had focused on a series of factors developed by the courts based on the McCarran-Ferguson Act as to whether a practice constitutes the “business of insurance.” Acknowledging that this approach raised more questions than it answered and permitted divergent outcomes, the Court explicitly rejected it. Instead, said the Court, for a state law to be deemed a law that “regulates insurance” for purposes of ERISA preemption, it must satisfy two requirements: (1) the state law must be specifically directed toward entities engaged in insurance; and (2) the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

Discussion
The principal effect of the recent Supreme Court decision is to clarify the analysis as to whether a state law is “saved” from preemption as a law that regulates insurance, establishing a two-part test in place of the confusion created by continually evolving approaches as to how to apply the McCarran-Ferguson factors. (Controversy continues over whether there is a third part to this test, which would preempt an otherwise saved law if it permits remedies not otherwise allowed by the ERISA statutory scheme.) But there are several additional implications as well.

The Court’s opinion makes clear that laws resembling the Kentucky “any willing provider” act will likely be saved from preemption, because it did not leave much room to argue otherwise. In the event that a state’s law is substantively different from the Kentucky law, it will be up to the lower courts to apply the new test articulated by the Supreme Court in determining whether the differences from the Kentucky law are significant.
enough to warrant a different result. This is the same process currently taking place with regard to state laws that provide a right to binding external review of a managed care organization’s adverse benefit determinations, the subject of last year’s consideration by the Supreme Court of the scope of the insurance savings clause. Following the Court’s decision in Rush Prudential HMO, Inc. v. Moran that the Illinois external review law was “saved” from ERISA preemption as a law regulating insurance, there were lower court cases finding that the Texas and Maryland external review laws also were saved from preemption (although the Maryland decision is currently being appealed to the Supreme Court).

In its decision, the Court acknowledged that that Kentucky law would not apply to self-insured ERISA plans. In fact, the Kentucky law specifically reached only those employee benefit plans “not exempt from state regulation by ERISA,” so as to avoid an issue under the “deemer” clause of the ERISA preemption provision. The law still reached HMOs that provided “administrative services only” to self-insured plans, though, which the HMOs argued was outside the regulation of “insurance,” thereby bringing the laws outside the insurance savings clause. The Court, in a footnote, rejected that argument, stating that the administration by the HMOs of self-insured plans was sufficient to bring them within the activity of “insurance” for purposes of ERISA preemption. Because self-insured plans generally contract out for administrative services to such entities as HMOs and insurance companies, this position may further narrow the scope of ERISA preemption, by providing a means for states to regulate certain aspects of self-insured plans through laws directed at their administrative service providers.

The more general implication of the case is its place in the overall trend of ERISA preemption cases. Early Supreme Court decisions on ERISA preemption generally established that preemption was quite broad, whereas more recent cases have tended to find situations in which ERISA preemption did not apply, thereby narrowing its scope. The Kentucky case, along with the Court’s decision last year that an external review law was saved from preemption, has staked out areas in which managed care organizations may now be subject to varying state regulation without being able to claim the protection of ERISA preemption. Moreover, unlike last year’s 5-4 decision, the decision in the Kentucky Association case was unanimous, suggested that the Justices are resolving their internal disagreements as to how to approach these cases. The presumed objective of the Court in clarifying the test for application of the insurance savings clause is to provide clearer and more consistent standards for the lower courts, with the possibly desired effect that the Court should not need to continue revisiting these preemption issues on an annual basis.

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