

**Kentucky's “Any Willing Provider”  
Law and ERISA:**  
*Implications of the Supreme Court's Decision  
for State Health Insurance Regulation*

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**June 2003**

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©June 2003

by

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## **ACKNOWLEDGMENTS**

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The author is grateful for the help of several reviewers of an earlier draft of this paper: Jane Beyer (Senior Counsel, Democratic Caucus, Washington State House of Representatives); Kristin Jones (Committee Counsel, Maryland Department of Legislative Services); Kentucky State Senator Ernesto Scorsone; Mary Beth Senkewicz and Jennifer Cook (National Association of Insurance Commissioners); and Mimi Marchev and Neva Kaye (National Academy for State Health Policy).

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## INTRODUCTION

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In a case that helps to define state authority to regulate health insurance, the U.S. Supreme Court held that ERISA (the federal Employee Retirement Income Security Act of 1974) does not preempt Kentucky's Any Willing Provider (AWP) law.<sup>1</sup> The decision is important not only for the 21 states with similar laws<sup>2</sup> but also because it attempts to clarify which state laws regulating health insurance practices can be saved from ERISA preemption. This Issue Brief outlines ERISA preemption principles, explains the Supreme Court's opinion, and discusses its implications for state laws regulating Health Maintenance Organizations (HMOs) and other health insurers.<sup>3</sup>

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<sup>1</sup> *Kentucky Association of Health Plans, Inc. v. Miller*, 71 U.S.L.W. 4259, 538 U.S. \_\_\_\_ (April 8, 2003).

<sup>2</sup> Three other state AWP laws were held by courts to be preempted by ERISA and two others were repealed in 1997 and 2000, personal communication with Richard Cauchi, National Conference of State Legislatures, Denver, CO.

<sup>3</sup> For a more detailed analysis of the federal courts' preemption decisions, see Butler, Patricia A., 2000. *ERISA Preemption Manual for State Health Policy Makers*. Portland, ME: National Academy for State Health Policy and Washington, D.C., AcademyHealth, available on the web at [www.statecoverage.net](http://www.statecoverage.net) (available via a link from [www.nashp.org](http://www.nashp.org)). A January 1, 2001, update to the manual, an analysis of ERISA implications for state “pay or play” proposals, and a discussion of the Supreme Court's decision that ERISA does not preempt Illinois' “external review law” are available on the web at [www.nashp.org](http://www.nashp.org).

## ANY WILLING PROVIDER LAWS

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Any Willing Provider (AWP) laws are the earliest form of state managed care regulation (first enacted in the mid-1980s). Often promoted by providers, they require managed care plans using provider networks to permit all providers to participate in the network if they agree to accept the plan's contract terms, such as payment rates, quality monitoring, and other conditions. Two-thirds of AWP laws apply only to pharmacies and others, like that in Kentucky, cover physicians, hospitals, and other providers such as chiropractors or podiatrists. The laws generally apply to HMOs but also sometimes to other health insurers that use provider networks.

Supporters argue that the laws increase patient choice of providers, reduce patient travel times, and allow local businesses like pharmacies to compete with big national chains. These laws have been strongly opposed by insurers on the ground that they: 1) raise costs by both limiting insurers' ability to negotiate lower prices in exchange for patient volume and increasing insurers' administrative costs and 2) lower quality by reducing opportunities to restrict networks to the highest quality providers. Most researchers generally conclude that these laws raise HMOs' costs to some extent but do not find associations between the existence of these laws and employers' decisions to self-insure their health plans.<sup>4</sup>

Despite the prevalence of these laws, they also have been opposed by organizations like the National Governors' Association and the U.S. Federal Trade Commission. Federal courts have split on the issue of whether ERISA preempts AWP laws, upholding laws in Virginia, Kentucky and Massachusetts, while invalidating those in Louisiana, Texas, and Arkansas.<sup>5</sup>

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<sup>4</sup> Insurance industry analyses have estimated various impacts from reduced bargaining leverage and higher administrative costs (The Wyatt Company. 1991. *Cost Analysis of State Legislative Mandates on Six Managed Care Practices*. Washington, D.C.: Wyatt Company (prepared for the Health Insurance Association of America); Health Economics Practice. 1997. *The Effects of legislation Affecting Managed Care on Health Plan Costs*. Washington, D.C.: Barents Group, LLC (prepared for the American Association of Health Plans)). But independent research evidence of the effects of these laws (controlling for a variety of confounding factors) is mixed. For example, researchers have found that state AWP laws limit the ability of HMOs to reduce health care expenditures (Vita, M.G. 2001. "Regulatory Restrictions on Selective Contracting: An Empirical Analysis of "Any Willing Provider" Regulations. *Journal of Health Economics* 20: 955-966) and that HMOs in states with AWP laws applicable to hospitals (but not pharmacies or physicians) experience higher costs (primarily for administration) than HMOs in other states (Morrisey, M.A., R.L. Ohsfeldt, and V. Johnson. 1998. "The Impact of State Any Willing Provider Laws on Expenditures in Health Maintenance Organizations," working paper, Lister Hill Center for Health Policy. Birmingham, AL: University of Alabama). But other research reveals no association between AWP laws and higher premiums for managed care products (Jensen, Gail A., M.A. Morrisey, and M. Bulycheva. 1998. "Employers' Managed Care Plans Under Selective Contracting Laws," working paper, Lister Hill Center for Health Policy. Birmingham, AL: University of Alabama.).

<sup>5</sup> The Fourth Circuit Court of Appeals upheld Virginia's law (*Stuart Circle Hosp. v. Aetna Health Management*, 995 F.2d 500 (4<sup>th</sup> Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993)) and a federal district court upheld the Massachusetts statute (*American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997)), while the Fifth and Eighth Circuits held that ERISA preempts laws in Texas, Louisiana, and Arkansas (*Cigna Healthplan v. State of Louisiana*, 82 F.3d 642 (5<sup>th</sup> Cir. 1996), *cert. denied*, 117 S. Ct. 387 (1996); *Texas Pharmacy Association v. Prudential Ins. Co.*, 105 F.3d 1035 (5<sup>th</sup> Cir. 1997), *cert. denied*, 118 S. Ct. 75 (1997);

## ERISA PREEMPTION PRINCIPLES

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ERISA is the federal law governing pension and other employee benefit plans sponsored by private sector unions or employers (other than churches). Such employee benefit plans are “ERISA plans” whether they are offered through insurance or self-insured by the sponsor. While regulating pension plans, ERISA provides limited federal regulation of health plans.

Nevertheless, it contains a broad preemption provision stating that federal law supercedes any state law that “relates to” ERISA plans, except state laws that regulate insurance, banking, and securities. States cannot “deem” employee plans themselves to be insurers; consequently, states cannot regulate employee health plans directly but can regulate insurers with which the employee plans contract, creating the distinction between insured plans (states can regulate) and self-insured plans (they cannot). Both insured and self-insured plans, however, are ERISA plans.

In preemption cases, the Court asks several questions:

- First, does the state law relate to employee benefit plans (like health plans) by attempting to regulate their benefits, structure, or administration?
- If so, is the law exempt from preemption under ERISA's “savings” clause because it regulates insurance?
- And, even if it qualifies as insurance regulation, does the state law directly conflict with any ERISA provisions so as to be preempted under the U.S. Constitution’s supremacy clause?

Until it decided the Kentucky AWP case, the Supreme Court had analyzed state laws purporting to regulate insurance by reference to earlier cases interpreting the term “business of insurance” in the McCarran-Ferguson Act of 1945. In this law Congress:

- Delegated to states the authority to regulate insurance operating in interstate commerce (which otherwise would fall under federal jurisdiction), and
- Exempted certain insurance practices from federal anti-trust law.

In deciding whether state insurance regulation fell within the authority delegated under the McCarran-Ferguson Act,<sup>6</sup> the Court looked at several factors, whether the law:

1. Is an integral part of the insured-insurer policy relationship,
2. Spreads or transfers risk across policy holders, and
3. Is limited to entities in the insurance industry.

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*Prudential Insurance Co. v. National Park Medical Center*, 154 F.3d 812 (8<sup>th</sup> Cir. 1998)).

<sup>6</sup> The Court also drew from its analysis in cases raising the issue of whether certain insurance practices fell within the anti-trust exemption.

Because ERISA's savings clause exempts laws regulating insurance (language similar, but not identical, to that in the McCarran-Ferguson Act), the Court drew on its McCarran-Ferguson Act cases to determine which state laws would be exempt from ERISA preemption. In its first ERISA savings clause case, the Court examined Massachusetts' requirement that health insurers cover mental health benefits by applying these three factors and also considered whether the state law regulated insurance from a "common sense" perspective.<sup>7</sup> While the Court's McCarran-Ferguson Act and ERISA opinions made clear that these factors were only "considerations" or "guideposts" to determine whether a law regulated insurance, many federal district courts and Courts of Appeal considered them explicit "tests" to be met and often held that ERISA preempted state laws failing to satisfy every factor.<sup>8</sup>

As recently as its 2002 term, the Court applied the three-factor analysis to decide whether ERISA preempted Illinois' "external review" law, which provides an independent appeal mechanism for HMO enrollees to dispute benefit denials. The Court held that ERISA did not preempt the external review law because, among other criteria, the law applies only to insurers and, by adding an extra layer of review for enrollee benefits disputes, regulates an integral part of the policy relationship between HMOs and their enrollees.<sup>9</sup> In its 2003 decision upholding Kentucky's AWP law, however, the Court explicitly abandoned the three-factor analysis in favor of a more streamlined approach to deciding whether a state law regulates insurance so as to be saved from ERISA preemption.

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<sup>7</sup> *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

<sup>8</sup> Several courts disregarded the Supreme Court's admonition in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), that all three Royal Drug factors need not all apply for a state law to regulate the business of insurance. Some courts have invalidated a state law only because the regulated activity did not spread risk, *Tingle v. Pacific Mutual Ins. Co.*, 996 F. 2d 105 (5th Cir. 1993), *Kelly v. Sears, Roebuck & Co.*, 882 F. 2d 453 (10th Cir. 1989). Others have held a law was not saved only because the activity did not involve the relationship between the insurer and insured, *Guaranty Life v. Gaylord Entertainment Co.*, 105 F. 3d 210 (5th Cir. 1997), *Anschultz v. Connecticut General Life Ins. Co.*, 850 F. 2d 1467 (11th Cir. 1988). Several courts have determined that the third factor (that the law be limited to entities in the insurance industry) was absent when state laws applied to HMOs as well as other insurers because HMOs are not insurers, *Texas Pharmacy Assoc. Prudential Ins. Co., Cigna Health Plan v. State of Louisiana*.

<sup>9</sup> *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).



## **THE KENTUCKY ASSOCIATION OF HEALTH PLANS CASE**

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The Kentucky AWP law prohibits health insurers from discriminating against any provider within the plan's service area 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.”<sup>10</sup> Another section of the insurance code requires health plans that include chiropractic benefits to permit any licensed chiropractor to participate in the plan who agrees to meet the health plan's terms, payment rates, and quality standards.<sup>11</sup> These laws were challenged by the state's HMO association and several individual HMOs as being preempted by ERISA insofar as they might be applied to insurers contracting with ERISA plans. The federal district court and Sixth Circuit Court of Appeals had held that, although the state laws “relate to” ERISA plans (by affecting plan structures), ERISA did not preempt the state laws because they regulated insurance within the meaning of ERISA's savings clause (using the three-factor McCarran-Ferguson analysis).

### **Supreme Court Decision**

The Supreme Court affirmed the Court of Appeals' decision, but used this case to clarify the standards by which to decide whether a state law regulates insurance. First, the Court noted that state laws can be saved from ERISA preemption only if they regulate *insurance practices*, not merely any activities in which insurers engage. The Court then addressed the HMO association's main assertions: 1) that the state's AWP law regulates conduct of not only health insurers but also providers (who cannot participate in limited networks, if they want to do so), and 2) that the state law does not dictate insurance policy terms but rather relationships between health plans and providers.

The Court observed first that the Kentucky AWP law specifically regulates the conduct of only insurers (against whom it can be enforced), not health care providers (despite some practical effect on them). The Court then noted that the state law is directed at insurers even though it includes non-ERISA self-insured<sup>12</sup> or multiple employer welfare arrangements that bear risk or

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<sup>10</sup> Ky. Rev. Stat. Ann. Section 304.17A-270. Providers are defined to include physicians, osteopaths, podiatrists, chiropractors, dentists, physician assistants, nurse practitioners, and other practitioners to be defined in regulations of the Insurance Commissioner. Insurers include insurance companies, HMOs, self-insured employers or MEWAs not exempt from state regulation under ERISA, provider-sponsored integrated delivery networks, self-insured employer associations or Blue Cross and Blue Shield plans.

<sup>11</sup> Ky. Rev. Stat. Ann. Section 304.17A-171(2).

<sup>12</sup> The state law specifically exempts application to self-insured or other arrangements exempt from state regulation by ERISA, but would apply to non-ERISA self-insured plans (for example, those offered by state or local government).

insurers providing only administrative services that do not bear insurance risk.<sup>13</sup> Drawing on its 2002 external review law decision, the Court noted both that non-ERISA plan self-insured arrangements operate like insurers that could be regulated by state law<sup>14</sup> and that overbroad language does not automatically doom state laws.

Finally, the Court addressed the question of whether the state law regulates insurance if it involves the relationship between providers and insurers (rather than explicitly regulating the terms of the insurer-insured policy). The Court distinguished McCarran-Ferguson Act cases involving anti-trust allegations that made this distinction, holding that the state law “regulates” insurance by imposing conditions on the right to engage in the business of insurance.” But the Court held that such conditions “must also substantially affect the risk pooling arrangement between the insurer and the insured to be covered by ERISA’s savings clause.” In other words, not every law directed at insurers will be held to regulate insurance—only those laws involving risk-spreading. Nor do state laws have to explicitly mandate insurance policy terms as long as they substantially affect insurer-insured risk pooling arrangements. “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 the insureds in a manner similar to mandated-benefit laws....No longer may Kentucky insureds seek insurance from a closed network of health care providers in exchange for a lower premium.”<sup>15</sup>

The Court explicitly abandoned its previous reliance on the three factors used in McCarran-Ferguson Act cases. The Court noted that this earlier analysis has “failed to provide clear guidance to lower federal courts” and “added little to the relevant analysis.” The Court acknowledged that relying on McCarran-Ferguson Act cases was inappropriate because the Act’s language (regarding the *business of insurance*) differs from that of ERISA’s savings clause (regarding regulating *insurance*) and the former is concerned with conduct by private actors

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<sup>13</sup> The discussion (in the opinion’s footnote number 1) of the application of the state law to insurers performing administrative, not insurance, functions is the opinion’s major peculiarity. The Court could have held that application to non-risk-bearing insurers did not doom the statute by merely being overbroad (relying on language in *Rush Prudential*). The Court went on to say, however, that such insurers administer self-insured plans, which bear risk, and this “suffices to bring them within the activity of insurance” for purposes of ERISA’s savings clause. It might be argued from this language that states can impose AWP laws on insurers that bear no risk but administer ERISA self-insured plans. But such an interpretation is inconsistent with ERISA’s deemer clause (that states cannot deem self-insuring employers to be insurers). Since the Kentucky law applies explicitly to non-ERISA self-insured plans, it is baffling why the Court felt it necessary to include this language. In any event, it seems unlikely that states can rely on this language to impose benefits or other traditional insurance standards on insurers performing “administrative-services only” (ASO) functions, activities which lower courts have held are not “insurance” under the savings clause, e.g., *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F. 2d 408 (3<sup>rd</sup> Cir. 1987); *Powell v. Chesapeake & Potomac Telephone Co. Of Va.*, 780 F. 2d 419 (4<sup>th</sup> Cir. 1985).

<sup>14</sup> ERISA explicitly prohibits states from “deeming” self-insured private-sector employer-sponsored plans to be insurers in order to regulate them. States can, however, regulate non-ERISA plans, such as those operated by churches or state or local government.

<sup>15</sup> Mandated benefits laws were upheld in the Court’s first ERISA savings clause case, *Metropolitan Life Ins. Co. v. Massachusetts*.

(involving potential anti-trust violations as opposed to state regulatory authority). Noting that its recent ERISA savings clause cases “raise more questions than they answer,” the Court made “a clean break from the McCarran-Ferguson factors.”

## Criteria for State Insurance Regulation

State laws that relate to ERISA plans can be saved from ERISA preemption if they:

- are directed toward the practices of entities engaged in insurance, which includes HMOs,<sup>16</sup> and
- substantially affect the risk pooling arrangement between the insurer and the insured.

Because laws must “substantially affect” risk pooling arrangements in order to be saved from ERISA preemption, it is important to understand what the Court means by the term “risk pooling,” which appears broader than the traditional insurance notion of spreading the risk of experiencing a rare event, such as a medical condition, across a large population. The Court explains that risk-pooling occurs when a law expands the number of providers from whom an insured may receive services by altering “the scope of permissible bargains between insurers and insureds in a manner similar to” mandated benefit laws upheld in *Metropolitan Life*, the notice-prejudice rule upheld in *UNUM Life Ins. Co. of America v. Ward*,<sup>17</sup> and the external review law upheld in *Rush Prudential*.

While mandated benefits laws fit a traditional notion of spreading the risk of needing care for an unexpected event, the other insurance laws the Court cites to explain risk pooling appear to spread risk because they regulate policy terms (permissible bargains), thereby imposing higher costs on the insured group. In *UNUM*, for example, the Court did not decide whether the notice-prejudice law spread risk, holding it explicitly changed the policy terms, but the Court acknowledged the argument of the U.S. Solicitor General, that the law shifted the risk of a late notice to the insurer, whose costs (payment of late claims) would be born by all insured people. Likewise, in *Rush Prudential*, the Court did not decide whether the external review law spreads risk but held it adds an insurance policy term requiring a procedure to appeal coverage disputes. While the Court didn't say so, external review presumably also spreads among insured people the additional costs of services approved through the appeal process. The Court appears to define laws affecting risk pooling arrangements to be those regulating the terms of the insurance policy (the bargain between insurers and insured people) that will raise costs that must be spread across the insurance pool.<sup>18</sup> The precise scope of this definition may be subject to further litigation.

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<sup>16</sup> Disagreeing with several lower courts, the Supreme Court held in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) that HMOs are insurers.

<sup>17</sup> 526 U.S. 358 (1999). The notice-prejudice rule prevented insurers from refusing to pay claims not filed within the policy deadlines if the insurer suffered no actual prejudice from the filing delay.

<sup>18</sup> The Court's new two-step test is a reconfiguration of its previous approach: State laws must: 1) be directed at insurers' insurance activities (like the “common sense” test and the third McCarran-Ferguson Act factor) and 2) substantially affect risk pooling arrangements by directly regulating insurance policy terms (incorporating the first two McCarran-Ferguson Act factors).

## IMPLICATIONS FOR STATE HEALTH INSURANCE REGULATION

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Traditional state insurance law that regulates insurer solvency, marketing, disclosure, underwriting, premiums, and other typical insurance activities should face no ERISA preemption problems under the standards set out in the *Kentucky Association of Health Plans* case.<sup>19</sup> Standards for insurer information disclosure and marketing arguably do not “relate to” private sector employer plans so as to implicate ERISA preemption. Standards for solvency, underwriting, or premiums clearly affect insurer risk arrangements and so should easily be saved from preemption.

Several types of state managed care laws that are similar in impact to AWP laws should be easily defended against ERISA preemption challenges under the Court's reasoning. A few other types of laws that explicitly regulate relationships between providers and plans do not fit as neatly into the Supreme Court's new tests, but may be defended against preemption on other grounds.

### Laws Expanding Access to Non-Network Providers

Not only other state AWP laws, but laws with similar impacts should escape preemption based on the Supreme Court's analysis in this case, when drafted to apply to HMOs and/or other types of health insurers, for example:

- “Freedom of choice” (FOC) laws (in 23 states)<sup>20</sup> permitting managed care plan enrollees to seek care from non-network providers, typically pharmacies, which do not explicitly expand networks but do have an impact similar to that of AWP laws because they expand enrollee access to a broader range of providers,<sup>21</sup>
- “Network adequacy” laws (in 18 states) requiring plans to have sufficient numbers and types of providers to meet enrollee needs or else permit enrollees to seek care outside the network expand provider networks on a case-by-case basis,
- “Continuity of care” laws (in 35 states) requiring plans to allow enrollees whose

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<sup>19</sup> In an early case interpreting the scope of state authority to regulate insurance under the McCarran-Ferguson Act (not the anti-trust exemption from which the three factors were derived), the Court held that states can regulate “the type of policy which could be issued, its reliability, interpretation, and enforcement,” and other activities that are “part of the relationship between the insurance company and the policyholder,” *SEC v. National Securities, Inc.*, 393 U.S. 453, 458-59 (1969). This language supports traditional state insurance regulation.

<sup>20</sup> Tallies of these state laws are derived from Health Policy Tracking Service. 2001. *Major Health Care Policies, 50 State Profiles*. Denver, CO: National Conference of State Legislatures.

<sup>21</sup> A Missouri district court had previously upheld Missouri's pharmacy FOC law against an ERISA challenge on various grounds, *Express Scripts v. Wenzel*, 102 F. Supp. 2d 1135 (W.D. Mo. 2000).

providers leave a network during the course of treatment (for conditions such as pregnancy or a terminal illness) to pay for care by these providers for a specified period of time after the provider leaves the network have the effect of expanding provider networks to some extent in limited circumstances, and

- “Point of service” mandates (in 20 states) requiring plans to allow prospective health plan enrollees to choose to purchase a “point of service” option (often for a higher premium), under which they can decide at the point of service to seek care outside the network but pay higher coinsurance for such a visit.

## **Laws Expanding Access to Services**

Laws that expand access to services (arguably more like the Massachusetts mental health benefit mandate previously approved by the Court<sup>22</sup>) spread the risk of needing more broadly defined benefits over all insurance subscribers so as to fall within ERISA's savings clause, for example:

- “Off-label pharmaceutical” laws requiring plans covering prescription drugs to include drugs for uses not approved by the FDA,
- “Prudent layperson emergency services” laws (in 41 states) requiring plans to cover care for services a “prudent layperson” would consider an emergency (even if the condition turned out not actually to be an emergency) expand access to services beyond those a health plan might have offered, and
- “Experimental services” laws requiring plans to cover treatment for experimental services or care being investigated in a clinical trial also expand access to services beyond those a health plan might have offered.

## **Other Provider Access Laws**

States have enacted other types of laws designed to assure that health plan enrollees can obtain access to appropriate providers without expanding the scope of provider networks, for example:

- “Direct access” laws that require plans to allow enrollees to see certain specialists (e.g., an ob-gyn for women or a physician specialist for a person with chronic illness) without first obtaining approval from a primary care “gatekeeper” and
- “Primary care provider definitions” that expand the types of providers plans must consider to be primary care “gatekeepers,” including ob-gyns for women or other specialists for people with certain types of chronic illness.

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<sup>22</sup> *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

These types of laws do not expand networks in the same way as AWP laws, although they do expand access to providers within the network, but may be saved under the Supreme Court's broader definition of risk pooling because they change policy terms by mandating expanded access to in-network providers and may therefore increase plan costs. These types of state managed care laws have not been challenged but would best be defended by two different arguments. First, state health policy makers could argue that these laws mandate a new “benefit,” much like mental health coverage, which the Court held regulates insurance so as to be saved from preemption. Second, like the provider protection laws discussed below, states can argue that these laws do not “relate to” health plans because they regulate health plans as *providers*. The Supreme Court has previously held that state regulation of health care and health care providers is a long-standing authority that ERISA does not preempt.<sup>23</sup>

## Provider Protection Laws

States have enacted several other types of managed care laws that do not as clearly affect “risk pooling arrangements between the insurer and the insured” as do AWP laws. Such laws include those that regulate provider-plan relationships in ways that do not directly affect health plan enrollees, for example:

- “Provider due process” laws such as those requiring plans to permit all providers to apply to participate in networks, publish the standards used to select or terminate providers, and provide an opportunity to appeal a denial, non-renewal, or termination of network participation,
- “Physician incentive payment limits” (in 31 states) that ban managed care plans from payment approaches that limit access to medically necessary care,
- “Gag clause” limitations (in 48 states) that prohibit plans from forbidding physicians to discuss with patients treatment options the plan may not favor,
- “Anti-retaliation” laws that prohibit plans from dropping or refusing to renew a provider who advocates medically necessary treatment,
- “Prompt payment” laws (in 46 states) that prescribe limits by which plans must pay provider claims, and

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<sup>23</sup> In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers' Insurance*, 514 U.S. 645 (1995), the Court held that New York's hospital rate-setting law was permissible state health care regulation. The Court held that regulating health care providers was a traditional exercise of state authority and did not “relate to” ERISA plans as long as it did not impose “exorbitant” costs on ERISA plans (a test that 24% higher hospital costs for ERISA plans buying coverage from insurers other than Blue Cross did not meet).

- “Anti-indemnification” laws (in 27 states) that prohibit plans from requiring providers to hold the plan harmless for its own errors.

Because these laws affect health care providers' ability and willingness to participate in health plan networks, they can have an impact on health plan enrollees' choices among providers, satisfaction with plans and providers, and even ability to make decisions about health care. But despite their potential to protect consumers, it is harder to argue that these types of laws affect risk arrangements between insurers and insured people. They do not easily meet either the Supreme Court's new test or the three factors previously used.

It is arguable, however, that ERISA does not preempt these types of laws because they do not meet the first test for ERISA preemption: they do not “relate to” ERISA plans, so a court need never reach the question of whether they might be saved as insurance regulation. Lower federal and state courts have upheld some of these laws on this ground. For example, the Fifth Circuit Court of Appeals held that ERISA does not preempt the Texas anti-retaliation and anti-indemnification laws.<sup>24</sup> The court held that the laws govern managed care entities in their role as health care providers<sup>25</sup> (involving allocation of tort responsibility and the independence of physician judgment) and therefore are in the nature of state health care regulation. A Connecticut state court upheld a state law prohibiting plans from rejecting providers applying to their networks if the PPO had not filed information on selection and termination criteria with the state because the state law did not regulate ERISA plans' benefits or enrollee eligibility.<sup>26</sup>

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<sup>24</sup> *Corporate Health Insurance, Inc. v. Texas Dept. of Insurance*, 215 F. 3d 526 (2000).

<sup>25</sup> In *Pegram v. Herdrich*, 539 U. S. 211 (2000), the Court noted that HMOs can be both providers and insurers (that administer ERISA health plans).

<sup>26</sup> *Napoletano v. Cigna Healthcare of Connecticut*, 680 A. 2d 127, (Conn. 1996), *cert. denied*, 520 U. S. 1103 (1997).

## CONCLUSION

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In the *Kentucky Association of Health Plans* case, the Supreme Court continues the line of decisions beginning with its 1995 *Travelers Insurance* case that gradually remove ERISA obstacles to state health policy initiatives. Abandoning its three-factor test from McCarran-Ferguson Act cases, the Court has enunciated a somewhat simpler approach to state insurance regulation: state laws directed at insurer practices that “substantially affect” insurance risk-pooling among insured people will be saved from ERISA preemption. Some types of state laws, especially those regulating how plans must treat providers, do not fit the test of insurance regulation, and the Court noted that not all laws regulating insurers do so. But many of these types of laws arguably avoid ERISA preemption because they do not affect the benefits, administration, or structure of the underlying employer-sponsored plan and therefore fail to meet the threshold criterion of “relating to” ERISA plans. It will be important for state health policy makers to consider ERISA in drafting further insurance and managed care standards, for instance, by explicitly considering how the law would regulate insurance policy terms or affect risk-pooling across insurance subscribers, but most carefully drawn consumer protection laws should not risk preemption challenges.