ERISA PREEMPTION AND MANAGED CARE:
STATE ANY WILLING PROVIDER AND EXTERNAL REVIEW LAWS

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Introduction

This paper will focus on two interesting areas of litigation involving ERISA preemption and managed care: state any willing provider laws and state laws requiring independent external review of adverse benefit decisions by managed care plans. Pending before the Supreme Court are several cases in these areas, although the Court has only agreed to hear one of them: Moran v. Rush Prudential. That case was argued on January 16, 2002 and a decision is expected shortly.

State Any Willing Provider Laws

In recent years, many states have enacted laws to respond to concerns expressed by consumers and physicians that managed care organizations’ (MCOs’) efforts to reduce costs and create limited networks have resulted in unduly restricting patient access to certain types of providers. A number of states have passed so-called “any willing provider” (AWP) laws that generally require MCOs to include in their network certain types of providers that are willing to meet all the MCO’s threshold price, quality, and credentialing requirements. A variant on those laws are the so-called “freedom of choice” laws that often require the plan to permit participants to seek treatment from and reimburse non-network providers under certain circumstances. Not surprisingly, the MCOs have resisted compliance, arguing that these laws undercut many of the cost containment tools that managed care provides, such as restricted networks and gatekeepers. MCOs have challenged these state laws as preempted by ERISA.

Like most other preemption issues, the judicial landscape has shifted somewhat for the AWP cases since the Supreme Court’s decision in Travelers. Travelers established a general presumption of validity for state laws of general applicability in areas of traditional state regulation, even those with an indirect economic effect on ERISA plans, unless the state law mandates benefit structures, plan administration or new remedies.

The Travelers opinion focused on the first part of the disjunctive test for determining whether a state law “relates to” an ERISA plan. This test was set forth in Shaw v. Delta Air Lines, 463 U.S. 85, 97 (1983) (a state law relates to a plan “if it has a connection with or reference to a plan”). Justice Souter’s discussion in Travelers centered around the “connection with” prong of the test and the second prong (i.e., the “reference to” prong) was not actually at issue in the case.

In several of the AWP cases, however, the question of whether the language of the state law explicitly referred to or implicitly swept in ERISA plans proved pivotal to the court’s ultimate
decision. The lesson one learns from those cases, as well as *Travelers* itself, is that the words states use in their laws and how they use those words are significant. As a result, post-*Travelers*, courts have to engage in a more detailed factual examination of the extent to which a state law actually affects a plan as well as how the state has described the entities to which its laws apply.

It is difficult to categorize the AWP decisions because each is so language-specific. At least in the cases decided after *Travelers*, the courts generally rigorously dissected the state law at issue. In several of the circuit court cases, however, the state statute at issue referenced ERISA plans directly and so was held to “relate to” ERISA-covered plans. See, e.g., *Blue Cross and Blue Shield of Alabama v. Neilson*, 917 F.Supp. 1532 (N.D. Ala. 1996) (Alabama anti-assignment, dental and pharmacy acts were preempted because they explicitly referenced employee benefit plans).

Occasionally, a court considered the distinction between the state’s regulation of an ERISA plan and the state’s regulation of a service provider to an ERISA plan. Alternatively, the court might have been persuaded by the fact that the state law applied broadly to those involved in both ERISA and non-ERISA plans. In those cases, the courts were more likely to conclude that the state law did not relate to ERISA plans. However, most frequently the ultimate fate of the state law rested on whether or not the statute was saved by the insurance savings clause.

The Supreme Court has denied *certiorari* in several of the conflicting cases, so it seems unlikely that definitive guidance regarding the proper analysis to be used in the AWP cases will be forthcoming any time soon. However, in light of the Supreme Court’s recent holding in the *UNUM* case that a state insurance law can be saved even if does not satisfy all three McCarran-Ferguson factors, the viability of the precedents established in the Fifth and Eighth Circuits (both of which required all three factors to be present in order for the challenged law to be saved as a law regulating insurance) is in question. The leading cases are discussed below.

The Ninth Circuit concluded that the State of Washington’s Alternative Provider Statute, which requires health maintenance organizations and health care services contractors to cover a variety of alternative medical treatments, does not “relate to” employee benefit plans covered by ERISA, and that even if it did, it was saved by the insurance savings clause. *Washington Physicians Serv. Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir.1998), *cert. denied*, 525 U.S. 1141 (1999).

Using a *Travelers*’ analysis, the court determined that the Washington law does not operate directly on ERISA plans, but only indirectly by regulating “health plans” that provide services to ERISA plans. If the ERISA plan does not choose to purchase benefits from one of the regulated entities, the challenged state law would not apply at all. In addition, the court held that even if the law did relate to ERISA plans, it would be saved under the insurance savings clause. In that regard, the Ninth Circuit held that the three McCarran Ferguson factors are merely “guideposts” for determining whether a state law regulates insurance and that not all three factors must be present to conclude that the state law is saved. See also *American Drug Stores v. Harvard Pilgrim Health Care, Inc.*, 473 F. Supp. 60 (D.MA 1997) (Massachusetts any willing pharmacy law only regulates the operation of service provider to ERISA plan and therefore it does not “relate to” an employee benefit plan; even if it did, it is saved as a law regulating insurance).
In Stuart Circle Hosp. Corp. v. Aetna Health Mgmt., 995 F.2d 500 (4th Cir.), cert. denied, 510 U.S. 1003 (1993), a Virginia law prohibiting insurance companies from excluding health care providers willing to meet all the terms and conditions of participation from their preferred provider organizations (PPOs) was saved from preemption as a law regulating insurance. When Aetna established its PPO in Richmond in early 1987, it included in its network only hospitals that were already participating in its HMO. Although Stuart Circle Hospital was willing to meet all of Aetna’s terms, it was not included in Aetna’s PPO. The Hospital sued, alleging that Aetna failed to comply with the Virginia “any willing provider” law. Aetna asserted that the Virginia law was preempted by ERISA.

The district court granted summary judgment for Aetna, holding that the Virginia statute relates to plans because it regulates the structure of an insurer’s PPO. In addition, the court held that the statute was not a law regulating the business of insurance, but rather the business of insurance companies. Stuart Circle Hosp. Corp. v. Aetna Health Mgmt., 800 F.Supp. 328, 333-37 (E.D. Va. 1992). The hospital appealed.

The Fourth Circuit agreed with the district court that the Virginia law related to plans. However, it found the law to be a law regulating insurance and therefore saved from preemption. The district court had concluded that the Virginia law was not saved because it regulated the non-insurance business of insurance companies. The Fourth Circuit reexamined this conclusion closely, relying on the two-pronged approach used by the Supreme Court in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985). In Metropolitan Life, the Court first took a “common sense approach” and then looked to three factors used in the cases interpreting the McCarran-Ferguson Act. Applying the Metropolitan Life analysis, the Fourth Circuit concluded that the Virginia law was a law regulating insurance. Under the “common sense approach,” the law applied to insurance contracts, although indirectly through the PPO (the statute applied to “health benefit programs” operated by insurers). Noting that none of the three factors under McCarran-Ferguson is determinative in itself, the court decided that the Virginia statute met all three (i.e., the practice transfers or spreads the policyholder’s risk, it is an integral part of the relationship between the insurer and the insured, and the state law applies only to entities in the insurance industry).

Similarly, in Kentucky Ass’n of Health Plans, Inc. v. Nichols, 227 F.3d 352, reh’g en banc denied (6th Cir. 2000), pet. for cert. filed, 69 U.S.L.W. 3646 (2001)(No. 00-1471), the Sixth Circuit recently used the savings clause to uphold a Kentucky law that prohibited health insurers, including HMOs, from discriminating against providers within a geographic area who were willing to meet the insurers’ conditions of participation. It also limited the circumstances in which health plans providing chiropractic benefits could exclude certain chiropractors.

In 1994, Kentucky passed the Kentucky Health Care Reform Act containing a broad any willing provider (AWP) provision. The AWP provisions applied to health benefit plans, including “… a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA …”.

In 1996, the Kentucky legislature added a narrower AWP provision relating only to
chiropractors. A suit was filled challenging these provisions under ERISA in 1997 and the district court upheld the Kentucky law as saved under ERISA’s insurance savings clause, even though the law related to ERISA-covered employee benefit plans. After the plaintiffs (seven HMOs and their trade association) appealed this decision, the legislature repealed the broad AWP provision and reenacted it substituting “health insurer” for “health benefit plan.” The definition of “insurer” was codified in 1999, including within its ambit, any “… self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA …”.

Rather than consider the validity of the repealed statutes on appeal, the parties agreed that the court should address the new statutory language. After examining the language, the Sixth Circuit concluded that although the Kentucky AWP provisions met both prongs of the “relates to” test, it was nevertheless saved under the insurance savings clause. First, the court noted that the Supreme Court has clarified in the UNUM case (discussed supra) the framework for resolving the question of whether a state law “regulates insurance” within the meaning of ERISA’s savings clause:

Therefore, in determining whether Kentucky’s AWP laws are saved from preemption by ERISA § 514(b)(2)(A), one must first ask whether as a matter of common sense they regulate insurance, and then look to the McCarran-Ferguson factors as checking points or guideposts to aid the analysis. 227 F.3d at 364.

The court then methodically discussed each part of this test and concluded that not only did the Kentucky statutes meet the common sense test, but they also met each of the three McCarran-Ferguson factors.

One interesting point that the court makes in reaching its conclusion relates to HMOs. The Kentucky law applies in the same manner to HMOs as to traditional insurance companies. The HMOs had argued that because they deliver medical services directly, they are not in the business of insurance and therefore the challenged state law is not limited to entities within the insurance industry. The court rejected that argument, citing Washington Physicians Service Ass’n v. Gregoire, 147 F.3d 1039 (9th Cir. 1998) (discussed supra). The 8th Circuit also agrees that HMOs are in the business of insurance. See Express Scripts, Inc. v. Wenzel, 262 F.3d 829 (8th Cir. Aug. 21, 2001) (discussed below).

Another interesting argument made by the plaintiffs is that the Kentucky statute was not limited to entities in the insurance industry because it applied to self-insured health plans not covered under ERISA (i.e., government plans and church plans). However, the court noted that it is only because of the deemer clause in ERISA that the state cannot treat self-insured health plans as insurers, because they certainly bear risk just like insurers do. Therefore, the state was perfectly within its authority to regulate non-ERISA self-insured plans in the same way as traditional insurers. 227 F.3d. at 365.

Finally, the court made clear that although the Kentucky statutes were not preempted by ERISA, they could not be enforced against a self-insured ERISA plan or an otherwise covered entity who served as an administrator of an ERISA plan. Id. at 366.