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Puncturing the Funnel—Saving the "Any Willing Provider" Statutes from ERISA Preemption

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I. INTRODUCTION

The proliferation of Managed Care Organizations (MCOs), like Health Maintenance Organizations (HMOs), was a result of the high cost and low oversight of the traditional fee for service model in medical care. Although cast in the light of “freedom to contract,” managed care arguably restricted competition by funneling a ready supply of patients to a few selected providers. In response, the market outcasts lobbied for laws to permit them access into the provider networks—these statutes, called “Any Willing Provider” (AWP) laws, enabled any provider willing to satisfy the MCO’s criteria the ability to participate in servicing a ready supply of the organization’s patients.

In response to these laws, managed care asked, What about our freedom to contract? What about our right to control quality? What about our right to control costs? What about our monopoly?

MCOs struck back with litigation. They invited the courts to find that the federal pension law, the Employee Retirement Income Security Act (ERISA)\(^1\) preempted any statutory action that related to managed care due to its employee benefit nature. The only way for the AWP laws to escape this preemption would be for the courts to find that the statutes did not relate to employee benefit plans within the meaning of the preemption provisions, or to deem those laws as laws regulating insurance and therefore saved from preemption under the Insurance Savings Clause. In April 2004 the United States Supreme Court deemed just that and found that ERISA does not preempt Kentucky’s AWP law because of the Savings Clause. The Court provided a new test which AWP laws will be required to satisfy in order to escape preemption under the Savings Clause.

This article explains the history and development of the issue, explores the economic ramifications before and after the Court’s ruling, and examines the statutes about to confront the Court’s new test to determine if they have a saving relationship with ERISA. This article discusses the following issues: the rise of managed care and the reason for adoption of the AWP

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laws, the collision of these laws with the preemption provisions of ERISA, and the Supreme Court’s response to the Kentucky AWP law. The article also examines whether other states can benefit from the saving of one state’s law and explores the impact of the Supreme Court’s decision on the provider and the recipient of care.

II. HISTORY OF MANAGED CARE

Unlike previous generations who paid for medical services on a fee-for-service basis, health care for most Americans today involves membership in a MCO. Traditionally, in the United States health care milieu, hospitals and physicians were reimbursed on a fee-for-service basis for medical services and procedures. The fee-for-service model led to rising health care costs because insurers paid for what the doctor ordered without any oversight. Under the “fee-for-service” model, patients paid fees for price-tagged services. The more services a doctor ordered, the more the patient would pay. The lack of administrative oversight allowed the ordering of extensive, and arguably unnecessary, services. Individual physicians and hospitals made more money whenever more procedures were ordered and the most expensive technologies were used.

To shift the risk away from the patient, indemnity insurance was often provided. To some extent, shifting and spreading risk is always economically wise. Most individuals have minimal medical costs, but a few others, like those with debilitating and chronic illness, may have crippling costs. Employers could pool these individuals and diversify or spread that risk. For a monthly or yearly fee, an individual could receive coverage for certain services. Indemnity insurance allowed patients to receive care from any licensed provider, and the costs for services would be partially or fully covered. Medical insurance was not much of an improvement over the fee-for-service model because it was fee-for-service based and suffered the same costly ills. Costs were not controlled—only spread among the participants.

The costs were not only affecting the patients but also their employers. United States employers were at a competitive disadvantage because other industrialized nations spent much less on healthcare as a cost of doing busi-

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2. See Nat’l Conference of State Legislatures, Managed Care Insurer Liability (Oct. 2002) available at www.ncsl.org/programs/health/liable.htm [hereinafter NCSL] (indicating that recent studies demonstrate at least 170 million participate in MCO managed health care),
6. Id.
ness. Some United States companies spent up to nineteen percent of their labor costs on health insurance. In fact, the current projection is that by 2005, the United States will be spending 14.9% of its gross domestic product on healthcare. Despite the United States’s expenditure on healthcare, the country ranks thirty-seventh in health care quality worldwide. The fact that Americans neither enjoy greater health nor have better prognoses because of these expenditures is counterintuitive. Some argue that empirically,

> [d]espite years of insistence by politicians and physicians that the United States had the best medical care in the world, there is scant evidence that the additional expenditures led to improvements in longevity, infant mortality, morbidity, or days lost from work, relative to other countries spending less than half as much per person.

To stem the tide of spiraling healthcare costs, management of the healthcare industry was explored. In fact, the MCO domination of the healthcare industry is a direct result of the rising costs under the fee-for-service model—where physicians were compensated for the services delivered, even if unnecessary.

Managed care plans operate by selling health care services, typically to an employer, on behalf of consumer-employees, and the employees access their medical care by enrolling in a network of preselected providers.

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7. See Dranove, supra note 5, at 65 (observing that costs for providing healthcare in “Canada, Europe and Japan were 25-50% less than in the United States and were paid for by the government”).

8. Lamm, supra note 3, at xii.

9. Id.

10. Id. at xi.


13. Justin Goodyear, What is an Employee Benefit Plan?: ERISA Preemption of “Any Willing Provider” Laws After Pegram, 101 COLUMBIA. L. REV 1107. A classic example of how prepayment for medical services became a precursor to managed care plans can be seen in the development of the Kaiser-Permanente program. Dranove, supra note 5, at 38–39. The Kaiser Industrial Organization, with its principal, Henry Kaiser, owned several companies. Id. A California physician named Sidney Garfield approached Mr. Kaiser with the proposal that for a certain daily rate per employee the doctor would provide unlimited medical services to the Kaiser employees. Id. Dr. Garfield repeated this plan in the state of Washington, providing prepaid family medicine for Kaiser employees working on construction of the Grand Coulee Dam. Id.

As Kaiser expanded, it built medical and hospital facilities for 200,000 employees
Managed care plans form a network of providers with whom they negotiate a prepaid fee to provide services to the employee enrollees. If enrollees receive treatment from providers outside the network, they are required to pay all or some of their treatment costs.\textsuperscript{14}

Fundamentally, MCOs differ from traditional fee-for-service models because MCOs manage care by “interven[ing] to monitor and control the transaction between the doctor and the patient.”\textsuperscript{15} MCOs limit costs by contracting with a limited network of providers to whom its members can visit. The MCOs, in turn, pay those providers a predetermined fee, or “capitation rate.”\textsuperscript{16} MCOs literally captured the industry, which forced providers to join up or lose business.\textsuperscript{17} Of individuals with employer-sponsored health insurance, managed care covered ninety-five percent by 2002, up from ninety-two percent in 2000 and seventy-three percent in 1996.\textsuperscript{18}

MCOs include both HMOs\textsuperscript{19} and Preferred Provider Organizations (PPOs).\textsuperscript{20} PPOs operate on a predetermined contracted rate with certain and hired physicians to provide medical care in group practice settings. \textit{Id.} Later, Kaiser opened its plan to the public, and the Kaiser Foundation Health Plan was born. \textit{Id.} It was not called an HMO until 1970, when Paul Elwood coined the term. \textit{Id.}

The Kaiser Foundation Health Plan provided health insurance to a variety of enrollee’s, typically employees, on site in exchange for an annual premium paid by the employer. \textit{Id.} The plan also compensated providers who cared for the enrollees. \textit{Id.} Later, it secured all physician services under an exclusive prepayment arrangement with a provider group, called the Regional Permanente Group. \textit{Id.} The doctors in the Permanente group provided care exclusively for Kaiser enrollees. \textit{Id.}


\textbf{15. GETZEN, supra note 4, at 211.} It is tempting to consider the managed care model as a new phenomenon. In reality, its precursor, prepaid services in healthcare can be traced to the 1890’s. DRANOVE, supra note 5, at 36. In the late nineteenth century a few physicians would accept prepayment for providing medical services to certain groups like fraternal orders, unions, and other worker’s associations. This fixed prepayment provided enrollees with unlimited free access to medical care in exchange for an annual fee per member. Whether the patient needed more or less care the amount remained the same. This was not widespread, and often care was limited to work-related injuries. \textit{See id.}


\textbf{16. GETZEN, supra note 4, at 211.}

\textbf{17. Recent studies demonstrate at least 170 million people participate in MCO managed health care. See NCSL, supra note 2.}

\textbf{18. HAAS-WILSON, supra note 14, at 23 (citing Jon Gabel et al., \textit{HEALTH AFFAIRS} 21 (222): 148, \textit{Academy for Health Services Research and Health Policy, The Challenge of Managed Care Regulation: Making Markets Work?} (Wash. D.C. August 2001)).}

\textbf{19. The term “Health Maintenance Organization,” or “HMO,” was coined by Paul El-}
providers who hope the influx of guaranteed patients will offset the reduced fees.\textsuperscript{21} HMOs are more restricted in that when a patient or employee chooses a provider, he or she is limited. This allows the provider to maintain a precise list of potential patients.\textsuperscript{22}

Paul Elwood grouped HMOs into categories—called "models"—classifying each based on how the type organized the providers.\textsuperscript{23} In "staff model HMOs" the insurance companies employ the physicians directly. The physicians are salaried.\textsuperscript{24} "Group model HMOs' are insurance companies that contract with large physician groups to provide professional services."\textsuperscript{25} The physicians in the staff and group models often work exclusively for the HMO.\textsuperscript{26} Independent Practice Associations (IPAs) are groups of physicians who want to retain their current practice style and independence. IPAs act as insurance companies, collecting fixed fees per enrollee and then remitting payment to IPA members.\textsuperscript{27}

Studies proved that MCOs lowered and controlled costs, owing explicitly to the shifting of the cost risk to the providers who, receiving a capped fee, had interest in controlling procedures to only those deemed necessary.\textsuperscript{28} MCOs also control costs through financial incentives awarded to providers who contain costs.\textsuperscript{29} MCOs use utilization review procedures to evaluate treatment plans for necessity\textsuperscript{30} and may even result in the denial of certain treatment after precertification review. MCOs are able to selectively contract for lower rates with a certain limited number of providers who are willing to accept those rates in return for those providers receiving a higher volume of patients.\textsuperscript{31} In view of this basic economic principle, the MCO func-

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\textsuperscript{21} Reece, supra note 12, at 26.
\textsuperscript{22} Id.
\textsuperscript{23} DRANOVE, supra note 5, at 68.
\textsuperscript{24} Id. The early Kaiser model was strictly the staff model. When Kaiser contracted with the Permanente group it also displayed the group model HMO. Id.
\textsuperscript{25} Id.
\textsuperscript{26} See DRANOVE, supra note 5, at 68.
\textsuperscript{27} Id., at 69.
\textsuperscript{28} Id.
\textsuperscript{29} Id.; see also Wendy Silver, The Inadequacy of State Legislative Responses to ERISA Preemption of Managed Care Liability, 78 N.Y.U. L. REV. 845 (2003).
\textsuperscript{30} Reece, supra note 12, at 31–32; see also Silver, supra note 29, at 852.
\textsuperscript{31} See Silver, supra note 29, at 851.
tions as a funnel for a huge supply of patients into a limited demand market, theoretically driving the price down. Of course, this seemingly anticompetitive or concerted monopoly is economically injurious to providers who refuse to contract for such rates because a large amount of patients participate in some type of MCO.32

III. PROTEST AND RESPONSE

Providers outside of the networks began to protest the restrictive contracting. Arguments against the restrictions included limitation on the choice of providers, burdensome travel times to distant in-network providers, and the obvious restraint of competition.33

Those providers dissatisfied with this monopolistic control appealed to the state legislatures, leading to the passage of AWP laws. AWP laws are statutes requiring a managed care network to accept any physician or non-physician provider who meets the network’s usual selection criteria, who is willing to be reimbursed at the managed care organization’s rates, and who agrees to the managed care organization’s utilization guidelines.34 This clever line of attack, presented initially through powerful pharmacist lobbies, defeated the restrictive MCO construct and became a thorn to MCO controlled networks.

MCOs, the National Governors’ Association, and the United States Federal Trade Commission35 fought against AWP legislation, concerned that they were anticompetitive and would limit their ability to manage quality and control costs through a limited network. Increased costs would mean

32. Id.
34. These laws come in four categories: (1) Freedom of Choice Laws—requiring insurers to reimburse a non-network provider as long as the provider agrees to accept the insurer’s level of reimbursement for service; (2) Mandatory Admittance Laws—requiring insurers to include in a network any provider willing to abide by the terms and conditions of the network, including price; (3) Due Process Laws—requiring insurers to follow certain procedures in creating and maintaining a network, such as publishing the criterion for participation in the network and providing for an appeal process in the event of termination of a provider from participation in the network; and (4) Essential Community Provider—requiring insurers to contract with essential community providers serving medically needy populations. See Gary A. Gransesconi, ERISA Preemption of “Any Willing Provider” Laws—An Essential Step Toward National Healthcare Reform, 73 WASH. U. L. Q. 227, 230 n.11 (1995) (citing Andrew L. Jiranek & Susan D. Baker, Any Willing Provider Laws: Regulating the Health Care Provider’s Contractual Relationship with the Insurance Company, A.B.A. F. HEALTH L., Winter 1994–95, at 3).
35. BUTLER, supra note 33, at 2.
increased premiums—and a return to the results of the fee-for-service model. Surprisingly, the most obvious means to defeat these AWP statutes was to attack them via ERISA. The very law designed to protect employees' rights was now used to defeat those rights provided by statutes. To understand how ERISA was the chosen weapon of attack, one must understand how ERISA operates in the managed care arena.

IV. ERISA AND ITS IMPACT ON HEALTH CARE LAW

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 to protect employee benefits, however, the law regulates pension benefits more substantively. Prior to federal regulation, employers often frustrated the pensioners' right to collect at retirement—either through mismanagement, company bankruptcy or by characterizing retirement benefits as a conditional gift. ERISA was enacted to protect these benefits. It contained disclosure and fiduciary responsibilities which gave some transparency to the management of plans and has established other rules to ensure security for employees and “recourse if the employer or other fiduciary violated the rules.” The underlying policy is obvious: In these times of longer lifespans, the government does not want the ever-increasing elderly, retired population to become wards of the state. The Supreme Court has reiterated this protective purpose on many occasions. ERISA does regulate health care law, albeit to a much lesser extent, because its coverage extends to employee welfare benefit plans.

36. Id. In fact, industry analyses disagree on whether the AWP laws increase or decrease premiums. Id. at n.4.
38. Id. at 382.
39. Id. at 384. ERISA seeks to ensure that employees will not be left empty handed after employers have guaranteed them certain benefits. Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996). Accordingly, ERISA tries to make certain that pension-fund assets will be adequate to meet expected benefit payments. Id. ERISA’s purpose is to ensure that if a worker has been promised a defined pension benefit upon retirement, and he has fulfilled whatever conditions are required to obtain a vested benefit, he actually will receive it. Cent. States v. Cent. Transp., 472 U.S. 559, 569 (1985).
40. ERISA was adopted to provide a uniform set of rules to govern employee benefit plans including health plans. Yates v. Hendon, 541 U.S. 1, 4 (2004). “Congress enacted ERISA to ‘protect . . . the interests of participants in employee benefit plans and their beneficiaries’ by setting out substantive regulatory requirements for employee benefit plans and ‘to provid[e] for appropriate remedies, sanctions, and ready access to the [federal courts].” Aetna Health Inc. v. Davila, 542 U.S.W. 200, 200 (2004); see 29 U.S.C. § 1001(b) (2000). ERISA is designed to ensure the proper administration of pension and welfare plans both during the years of active service and in his or her retirement years. Boggs v. Boggs, 520 U.S. 833, 839 (1997).
41. Reece, supra note 12, at 20 (citing ERISA’s definition of a “welfare benefit plan” as
include plans that provide health benefits, [] and fall within the parameters of ERISA’s regulation because HMO’s contract with employers to provide health benefits. This interpretation of ERISA’s reach caused ERISA to effectively embrace health care in America. This probably would not be a problem if this purpose was originally intended, but the drafters were not thinking about the legislation’s effect on MCOs because the impact of managed care was not foreseeable at the time ERISA was enacted. In fact, ERISA’s embracing of employee health plans is problematic because ERISA focuses more on retirement security and preempts all laws attempting to trod on this turf. The by-product of this was the restriction of state police powers to control health insurance plans. ERISA preempts all state laws “insofar as they may now or hereafter relate to any employee benefit plan.” Since the Supreme Court has interpreted “related to” broadly, few follows:

any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title, other than pensions on retirement or death, and insurance to provide such pensions. ERISA § 3, 29 U.S.C. § 1002(1) (2000)).

42. Reece, supra note 12, at 42; see also Kearney v. United States Healthcare, Inc., 859 F. Supp. 182, 187 n.6 (E.D. Pa. 1994) (explaining that when Congress drafted the preemption provision, “it is doubtful that Congress envisioned HMOs operating hospitals, clinics, or treatment centers and directly providing professional health services by employees or agents free from tort liability even in the most blatant cases of malpractice where the unfortunate patients were enrolled by their employers”); Blum v. Harris Methodist Health Plan, Inc., No. CIV.A.3:97-CV-0374P, 1997 WL 452750, at *3-4 (N.D. Tex. July 31, 1997) (holding that the plaintiff’s claim for negligence and medical malpractice is not preempted by federal law because the claim “only affect[s] the relationship . . . as provider-patient, and not as fiduciary-participants”); Schwartz v. FHP Int’l Corp., 947 F. Supp. 1354, 1358 (D. Ariz. 1996) (noting that the HMO was established by the Plaintiff’s employer “for the purpose of providing employees and eligible dependents with medical benefits,” establishing, as a matter of fact, the HMO as an ERISA plan).

43. See ERISA § 514, 29 U.S.C. § 1144(a) (2000) (providing that the section relates to “any employee benefit plan described in section1003(a)’”); see also 139 CONG. REC. H8974 (daily ed. Nov. 9, 1993) (statement of Rep. Dent) (stating that the preemption doctrine is the “crowning achievement of this legislation,” because it would forestall “conflicting and inconsistent” state laws); John H. Langbein & Bruce A. Wolk, PENSION AND EMPLOYEE BENEFIT LAW 417 (2000) (stating that “Congress chose to handle explicit preemption under ERISA by means of an express provision, ERISA §514”).

44. 29 U.S.C. §1144(a) (2000). This would include, obviously, statutory and common law.

state laws that are associated in any way with employee benefits escape the ERISA umbrella. “Related to” includes any attempt to control benefits, structure, or administration.46

V. SAVINGS CLAUSE

ERISA, however, does not totally eviscerate Federalism. Under what is commonly known as ERISA’s “savings provision,” state “law[s] . . . which regulate[] insurance, banking, or securities” are saved from ERISA’s pre-emption.47 The Savings Clause not only allows the states to maintain some police power over the insurance industry,48 but also reconciles ERISA with the prior federal law allowing states to regulate insurance, specifically through the McCarran-Ferguson Act of 1945.49
As stated, for a statute to be in a saving relationship with ERISA's pre-emption rule, it must "regulate insurance." Historically, the determination of whether an act was saved because it regulated insurance was less straightforward than whether or not a law was "related to" the plan. The Supreme Court decision in Group Life and Health Insurance Co. v. Royal Drug Co. used a three-part test to determine whether a practice qualified as the "business of insurance" under McCarran-Ferguson and consequently saved state insurance regulation from federal preemption. That test asked (1) whether the practice affected the transfer or spreading of a policyholder's risk, (2) whether the practice was an integral part of the relationship between the insured and the insurer, and (3) whether the practice was confined to entities within the insurance industry.

Due to the lack of any other case law directly related to ERISA's savings clause, the Supreme Court relied on the McCarran-Ferguson test in the ERISA arena. In Metropolitan Life Insurance Co. v. Massachusetts, the century until the Court issued its decision in United States v. South-Eastern Underwriters Ass'n., 322 U.S. (1944), which held that congress had the power to regulate insurance. Id. The near panic that ensued resulted in the passage of the McCarran-Ferguson Act in 1945, which stated that the industry could be regulated by the individual states. Id. "The McCarran Ferguson Act was intended primarily to preserve state regulation of the insurance industry." Valerie Witmer, A Patient Perspective: Focusing on Compensating Harm, 13 ANNALS HEALTH L 589, 594 (2004). The Act reversed that federal power, leaving the only federal preemption for laws that expressly preempt an area. Alan M. Anderson, Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond, 25 WM. & MARY L. REV. 81, 88-89 (1983). For more history, see Charles D. Weller, The McCarran-Ferguson Act's Antitrust Exemption For Insurance: History and Policy, 1978 DUKE L.J. 587 (1978).

51. 440 U.S. 205, 210 (1979) (holding that third-party provider arrangements between insurers and pharmacies were not the "business of insurance" under § 2(b) of the McCarran-Ferguson Act).
52. Id.; see also Metro. Life Ins. Co., 471 U.S. at 743.
53. Section 2 of the McCarran-Ferguson Act provides:
(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance; Provided, that after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.
55. See Metro. Life Ins. Co., 471 U.S. at 743; Pilot Life Ins. Co., 481 U.S. at 51; Blue
Supreme Court specifically applied the McCarran-Ferguson three-part test in the ERISA context, reasoning that ERISA’s savings provision, designed to preserve the McCarran-Ferguson reservation of the business of insurance for the states, should be subject to the same “business of insurance standard” in finding if a law “regulates insurance” under ERISA. The test, when interpreting the ERISA savings provision, is called “The Metropolitan Life Test.”

VI. AWPS DEEMED INSURANCE OR NOT?

Federal circuits were split on whether AWP laws were preempted by ERISA or saved by its savings clause. AWP laws were upheld in Virginia, Kentucky, and Massachusetts. In Louisiana, Texas, and Arkansas, they were preempted. The Supreme Court had determined that for a statute to escape preemption under the ERISA savings clause, a state law must be “specifically directed toward” the insurance industry; laws of general application that have some bearing on insurers do not qualify. Not all state laws which were “specifically directed toward” the insurance industry, however, would be covered under §1144(b)(2)(A), which saves laws that regulate insurance, not insurers. As explained in Rush Prudential, insurers must be regulated “with respect to their insurance practices.”

Cross & Blue Shield of Kansas City v. Bell, 798 F.2d 1331, 1335 (10th Cir. 1986).
57. Id. at 744 n.21.
62. Cigna Health Plan v. La., 82 F.3d 642 (5th Cir. 1996).
63. Tex. Pharmacy Ass’n v. Prudential Ins. Co., 105 F.3d 1035 (5th Cir. 1997)
66. 536 U.S. at 366.
VII. THE SIXTH CIRCUIT AND THE KENTUCKY AWP LAW

As of late 2004, nearly half of all states had AWP laws. Kentucky’s provision stated that “health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.” The Kentucky law prohibited medical insurers, HMOs, from discriminating against providers who were willing to meet the insurer’s conditions for participation. MCOs petitioned in state court on the grounds the law was preempted by ERISA.

Both the district court and Sixth Circuit Court of Appeals determined the law was saved from preemption since the law, as a matter of common-sense, regulated insurance. The lower courts’ rationale included the idea that HMOs were “insurance vehicles” and any regulation of them was regulation of insurance. The Sixth Circuit also determined that under the McCarran-Ferguson Act’s “guide post” test, the AWP statute clearly “spreads the cost component of the policyholder’s risk among all insured, directly impacts the insurer-insured relationship because it affects restrictions on the network of providers available for treatment under the plan, and applies only to entities within the insurance industry.” Proponents of the law included not only the providers but also the Bush Administration.

Those seeking to overturn the laws made some compelling observations. They argued that MCOs developed and became popular as cost-cutting organizations. University of Alabama at Birmingham professor Michael A. Morrisey, PhD noted that AWP statutes increase costs since they “[cut] the heart out of what managed care tries to do . . . . Providers who would have been shut out are better off economically. However, providers in the network who would have been in a narrower network are worse off because their patient volume is less. The consumer also pays more.”

67. See infra Appendix for a list of the states and their legislation.
71. Id.
73. Tanya Albert, AM News staff, United States Supreme Court weighs any-willing-provider laws. The high court’s roster of medically related concerns also includes a look at Medicaid drug rebate programs, July 29, 2002. But see BUTLER, supra note 33, at 2 (explaining that industry analysis is unresolved as to the effects of the AWP laws on premiums).
ies estimate administrative costs could increase by anywhere from thirty-four to fifty-two percent. The Health Insurance Association of America strongly opposed the AWP statutes and stressed that they would actually limit competition, "hinder the assurance of high quality care," and increase costs. In litigation, the MCOs argued that AWP statutes did not regulate insurance because MCOs were not "insurance vehicles" and the MCOs were not subject to the McCarran-Ferguson Act since their plans control costs but do not spread the risk or underwrite.

VIII. THE SUPREME COURT EMPOWERS KENTUCKY

It was clear to observers that the Supreme Court, prior to the Miller case, demonstrated a decisive trend to limit the scope of preemption and to empower states in traditional areas of local concern. ERISA was no longer viewed in a vacuum but rather was informed by the notion that statutes exercising the historic police powers of the state should not be preempted unless that is the clear and manifest purpose of Congress. The opportunity for this seminal decision with regard to AWPs and the evolving preemption temperament of the Supreme Court was presented when a Kentucky HMO sued the Commissioner of Kentucky’s Department of Insurance to overturn the AWP provision of the Kentucky Health Care Reform Act under an ERISA preemption theory. The United States District Court for the Eastern District of Kentucky granted summary judgment to the State and the Sixth Circuit affirmed.

74. Albert, supra note 73.
76. Nat’l Conference of State Legislature, supra note 68.
77. Id.
80. Ky. Rev. Stat. Ann. § 304.17A-270 (West 2001) (“A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships”); and § 304.17A-171(2) (“health benefit plan that includes chiropractic benefits shall ... [p]ermit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.”).
In the resulting appeal in *Kentucky Ass'n of Health Plans v. Miller*, the Supreme Court unanimously concluded that Kentucky’s AWP law escaped ERISA preemption because it is a law that regulates insurance practices. The Court recognized that the purpose of an MCO’s closed network of providers was to reduce cost and enhance quality control. In return, the Court noted that the providers got a monopoly—“patient volume higher than that achieved by non-network providers who lack access to petitioners’ subscribers.” The Court explained the obvious concern of the appellant—the loss of that high volume and the resulting increasing of costs to subscribers.

The Court then discussed the standards of the insurance regulation exception to ERISA preemption, citing many cases for the idea that for a law to regulate insurance, it must regulate the industry practices and not simply be a law of “general application” directed at insurers. The appellant HMOs argued that the Kentucky law did not specifically regulate the insurance industry because it also restricted providers from entering into networks. The Court determined that insurance regulation often affects other entities and that fact did not place the regulation outside the savings clause. The Court also negated appellants’ argument contending that the regulation did not actually regulate insurance practices since it focused on the contract between the HMO and the provider and not the terms of the policies. The Court differentiated between the limitation on state law preemption under McCarran-Ferguson, as in *Group Life Insurance v. Royal Drug Co.*, and the ERISA savings clause.

The Supreme Court created a new two-part test to decide whether or not a state law is deemed to regulate insurance: The law must be “specifically directed toward entities engaged in insurance” and must “substantially affect the risk pooling arrangement between the insurer and the insured.”

The Court stated:

82. *Id.* at 342.
83. *Id.* at 332.
84. *Id.*
85. *Id.*
86. *Id.* at 334. (citing *Pilot Life Ins. Co.*, 481 U.S. at 50; see also *Rush Prudential HMO*, 536 U.S. at 366; *FMC Corp.*, 498 U.S. at 61).
88. *Id.*
89. *Id.*
90. *Id.* at 338.
91. *Id.* at 342.
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.92

Illustrating the difference, the Court noted that a law requiring insurance companies to pay their janitors minimum wage does not regulate insurance, although it would "be a prerequisite to engaging in the business of insurance[] because it does not substantially affect the risk pooling arrangement."93

According to the Court's opinion, even self-insured plans may be subject to AWP laws.94 The Court also clarified a long-time misdirection and found that McCarran-Ferguson was never essential to examining the ERISA savings clause.95 McCarran-Ferguson regulates the business of insurance versus ERISA's regulation of insurance. The Court stated,

Today we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a 'law... which regulates insurance' under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must 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. Kentucky's law satisfies each of these requirements.96

IX. STATE ATTEMPTS

Obviously, states will find drafting of AWP provisions an easier task post-Kentucky Ass'n of Health Plans.97 States merely need to meet the Miller standard: The law must regulate insurance and alter the scope of permissible bargains between insurers and insureds in a manner that substantially affects the risk pooling arrangement. AWP laws inherently satisfy the second prong and affect the risk pool because they increase the number

92. Id. at 338–39.
94. See id.
95. Id. at 341
96. Id. at 341–42.
97. See Amanda Gardner, No Fast Changes Seen in High Court Ruling on HMOs Allowing States to Regulate Won't Mean a Stampede of Laws, Experts Say, HEALTH SCOUT NEWS REPORTER, April 4, 2003. New York has not yet passed any statutes. Senate Bill 2823 and Assembly Bill 4439 address participation of laboratories, and Assembly Bill 1915 participation of pharmacies. None of the bills have moved from their chamber of origin.
of providers from whom the insured may receive services. This is specifically cited in Miller.

A typical AWP provision "requires all health insurers to be ready and willing at all times to enter into service contracts with all health care providers who are qualified under state law, who practice within the general geographic area served by the insurance company, and who are willing to meet the terms and the conditions set forth by the insurer." To be deemed an insurance regulation, the statutory language should be directed at controlling the insurers by forcing their acceptance of any willing provider instead of being directed at the providers.

X. DECISION RAMIFICATIONS

Arkansas will be the testing ground to see whether its presently overturned AWP law can be revived by Miller. The overturned statute first provides a list of provider practices which it covers. The applicable portion of the statute is,

(a) A health care insurer shall not, directly or indirectly:

(3) Prohibit or limit a health care provider that is qualified under 23-99-203(d) and is willing to accept the health benefit plan's operating terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards, from the opportunity to participate in that plan.

(b) Nothing in this subchapter shall prevent a health benefit plan from instituting measures designed to maintain quality and to control costs, including, but not limited to, the utilization of a gatekeeper system, as long as such measurers are imposed equally on all providers in the same class.

It seems that this statute satisfies the Miller standard because it regulates the health insurance and alters the scope of permissible bargains between insurers and those insured in a manner that substantially affects the risk pooling arrangement.

In February 2004 the United States District Court for the Eastern District of Arkansas lifted an injunction against the state's AWP law, which

99. The case, Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr Inc. (State of Arkansas) DC E. Ark, No. LR-C-95-514 (1/31/97); amended (03/17/97), is currently being considered by the United States Court of Appeals for the Eighth Circuit.
100. ARK. STAT. ANN. § 23-99-201 (LEXIS Repl. 1995) (see infra Appendix for full statute).
required health plans to include within their panels any physician who met their requirements. Of course, Arkansas health plans challenged the ruling, insisting that ERISA still preempts the state attempt at defeating the economic construct. The Eighth Circuit is considering the health plans’ requests in light of Miller. The Arkansas AWP law should not be preempted because it satisfies the Miller criteria for a saving relationship with ERISA.

More recently, the Arkansas state legislature enacted a new and supposedly improved AWP law by passing Acts 490 and 491 of the 85th. Act 490, formerly Senate Bill 43, prohibits health insurers from discriminating against “any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer.” The Act also redefines “health insurer” or “health care insurer” to mean, “any entity that is authorized by the State of Arkansas to offer or provide health benefit plans, policies, subscriber contracts, or any other contracts of similar nature which indemnify or compensate health care providers for the provision of health care services.” This new definition will expand the number of entities that fall under the definition and are controlled by the AWP statute. Act 491 provides agency enforcement mechanisms for the mandates in Act 490, but limits remedies to those provided under ERISA. Act 490 will take effect and repeal Ark. Code Ann. §§ 23-99-201-209, the Patient Protection Act of 1995 currently being considered by the court, if the Eighth Circuit Court of Appeals reverses Judge Moody’s order and invalidates the 1995 AWP statute. Most of the agency enforcement provisions of Act 491, however, went into effect upon passage because they are not contingent on the Eighth Circuit’s decision. The changes implemented by these two recently passed acts will make Arkansas’ AWP statute more closely resemble the Kentucky statute upheld in Miller.

101. Prudential Ins. Co. of Am. (State of Arkansas) DC E. Ark, No. LR-C-95-514 (1/31/97); amended (03/17/97).
102. Id.
103. Id.
106. Id. at sec 1.
107. Id.
109. 2005 Ark. Acts 490. Section 2 states in pertinent part that “[t]his act shall become effective only if the Eighth Circuit Court of Appeals in Prudential Insurance Co., et al. v. HMO Partners, Inc., et al., U.S.C.A. No. 04-1465/04-1644, does not order the injunction against enforcement of the Patient Protection Act of 1995 lifted as to health insurers of private, insured ERISA plans.”
The legislative response, before the resolution of the issue by the judiciary, sends a clear message that the Arkansas Legislature overwhelmingly supports AWP statutes and will continue to seek to mold Arkansas law into compliance with whatever specifications the courts impose on such statutes.

The Court's ruling in Kentucky is vital to the determination of a state's AWP laws, although "it is another loss for the HMO industry, which has continuously sought to use ERISA as a sword to reign in litigation, instead of a shield to protect employees, as was the original intent of the statute." Any state that drafts an appropriate AWP law can require MCOs to admit anyone meeting provider qualifications if the AWP law is drafted to satisfy the Miller standard. Thus, the ability of MCOs to limit the number of providers and contract limited and exclusive relationships with only certain providers, will be curtailed. MCOs cannot, therefore, rely on cost containment for rate and patient volume discounts. MCOs administrative costs are expected to increase due to the need for greater resources to administer a network of indeterminable size. MCOs will also no longer be able to include only select providers in their network unless their provider qualifications contain extremely discriminating provisions. These results could affect the costs to the enrollees.

For the providers, the Supreme Court's decision awards them the freedom to practice—the freedom to practice is what proponents of the AWP laws argued that MCOs were actively restricting. Essentially, the general practice of MCOs is a monopoly of sorts, restricting access of patients to only certain practitioners. The restriction, costumed as freedom to contract, seems to violate the spirit of antitrust policies. The freedom of states to open the gates through AWP laws has restored competition in the capitalist market. Some analysts, however, determined AWP legislation is and has always been really a "toothless tiger," and the lack of state remedial provisions seems to support this idea.

The United States Supreme Court again addressed the Savings Clause in the 2004 case of Aetna Health Inc. v. Davila and maintained its longstanding interpretation that a claim for denial of benefits is preempted on

112. Id.
113. Id.
the grounds that ERISA provides a remedy for denials of benefits. Davila represents a consolidation of cases in which the respondents, Juan Davila and Ruby Calad, suffered injuries that they alleged resulted from decisions by their respective health care providers to withhold coverage for services and treatments recommended by their treating physicians. The respondents each brought suits in Texas state court invoking the Texas Health Care Liability Act (THCLA). The petitioners removed the cases to federal court arguing that ERISA preempted the respondents' claims. The individual district courts each agreed that ERISA controlled and dismissed when the respondents failed to amend their complaints to bring explicit ERISA claims. Respondents appealed, and the United States Court of Appeals for the Fifth Circuit consolidated their cases to determine the propriety of the denials of the motions to remand. The court of appeals found that the respondents' claims did not fall within section 502(a)(1)(B) of ERISA and that the denials of the motions to remand were improper. The MCOs appealed, and the Supreme Court granted certiorari.

The Supreme Court reversed the judgment of the court of appeals, holding that ERISA completely pre-empted the respondents' causes of action. The Court reasoned that the decision to grant or deny benefits under an ERISA-regulated benefit plan falls within the scope of ERISA section 502(a)(1)(B) and is governed by federal law. In writing for the unanimous court, Justice Thomas did not cite Kentucky Ass'n of Health Plans, leading some commentators to speculate that the new analysis for Savings Clause cases employed by the Court in Kentucky Ass'n of Health Plans may be of limited use in future ERISA cases.

The Court emphasized that state-law causes of action duplicating or supplanting the civil enforcement remedy ERISA provides are contrary to the legislative intent to make the ERISA remedy exclusive. Justice Thomas elaborated by stating that the Congressional policy determination to

118. See id.
119. Id at 2493.
120. Id. The THCLA imposes a “duty to exercise ordinary care when making health care treatment decisions.” Id.
121. Davila, 542 U.S. at 200.
122. Id.
123. Id.
124. Id.
125. Id.
126. Id.
127. Davila, 542 U.S. at 201.
129. Id. at 2495.
allow some remedies and exclude others would be frustrated if states were free to allow alternate remedies under state law.\textsuperscript{130} Justice Thomas also noted,

As this Court has recognized in both \textit{Rush Prudential} and \textit{Pilot Life}, ERISA § 514(b)(2)(A) must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a). Under ordinary principles of conflict pre-emption, then, even a state law that can arguably be characterized as “regulating insurance” will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.\textsuperscript{131}

State AWP statutes, consequently, should seek to avoid providing additional remedies not contemplated by ERISA in order to avoid preemption. The recent changes to the Arkansas law are designed in accordance with this analysis and state that civil remedies are provided “to the extent permitted by ERISA.”\textsuperscript{132}

\textbf{XI. CONCLUSION: FUNNEL TO A SIEVE}

At this time, the Supreme Court, by upholding the AWP law, has opened the flow of patients to willing providers and has empowered states to legislate in this area. States could extend this Supreme Court treatment to other attempts at legislating the conduct of MCOs in the area of standards of care.\textsuperscript{133} Of course, others are concerned that this balkanization will defeat any contemplated national health policy.\textsuperscript{134} Arkansas Attorney General Mike Beebe is confident: “I know that the legal fight over this law is not over. However, with the strength of our position reinforced by Judge Moody’s order, I’m encouraged that our any-willing-provider law will withstand any continued legal challenges.”\textsuperscript{135} Economically, no statistics absolutely prove that AWP laws will increase premiums to those insured.\textsuperscript{136} In fact, the AWP laws may be the panacea for the one economically questionable aspect of managed care. Managed care was a means to reduce the cost of healthcare resulting from the fee-for-

\begin{itemize}
  \item \textsuperscript{130} \textit{Id.} at 2500.
  \item \textsuperscript{131} \textit{Id.}
  \item \textsuperscript{132} Ark. Acts 491 at sec 1.
  \item \textsuperscript{133} Of course, one should not ignore the larger picture: The Supreme Court has made a decision to uphold Federalism. This trend is something to be watched, obviously.
  \item \textsuperscript{135} Tanya Talbert, \textit{Injunction Lifted Against AWP Law}, AMEDNEWS.COM, at www.ama-assn-orm/amednews/2004/03/15/gvsc0315.htm (March 15, 2004).
  \item \textsuperscript{136} See BUTLER, supra note 33.
\end{itemize}
service system. Managed care not only spread the risk among insureds, thereby lowering the cost to those insureds, but also provided oversight for treatment necessity and provider skill. AWP laws include provisions that require those willing providers to maintain certain qualifications and standards of care. Therefore, the oversight should not be sacrificed.

The only true sacrifice will be for the providers who are used to the convenient managed care funnel of patients forced to use their services. This funnel is a cleverly disguised monopoly and cannot really serve the customer. Managed care has forced the patient to seek services from, maybe, a provider he or she does not care to patronize. Although the competition created by the AWP sieve—driving the same patients to more providers—will not drive costs down because contracted rates will, in all likelihood, remain the same, opening up the market to any provider willing to maintain the managed care organization’s requirements will result in competition for quality. Sounds like a good thing for all concerned.

APPENDIX

The statutes are classified by the broadness of their application.

A. Pharmacist Specific Statutes

The following states have statutes that appear to satisfy the Miller Standard because they all, as stated above, affect the risk pool and regulate the insurance industry: Alabama, Connecticut, Delaware, Indiana, Massachusetts, Mississippi, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, and South Carolina. Louisiana’s attempted AWP law was overturned, although it appears to satisfy

137. ALA. CODE § 27-45-3 (1975).
138. CONN. GEN. STAT. ANN. 38a-471(f) (West 2000).
139. DEL. CODE ANN. tit. 18, § 7303(b) (1994).
140. IND. CODE ANN. § 27-8-11-3(b)-(c) (West 2005).
141. MASS. GEN. LAWS ANN. ch. 176D, 3(B)(5) (West 2005).
143. N.H. REV. STAT. ANN. § 420-B:12(V) (1998) (While not as strict as other AWP statutes, this statute still regulates the insurance industry in forcing health maintenance organizations to list all pharmacies that meet the acceptable bids. Therefore, this law also passed the first prong of Miller).
144. N.J. STAT. ANN. § 26:2J-4-7(a)(2) (West 2005).
147. OKLA. STAT. ANN. Tit. 36, § 3634.3 (West 2005 ).
149. LA. REV. STAT. ANN. § 22:1214(15)(a)(ii) (West 2005); Cigna Health Plan of La.,
the *Miller* standard. Louisiana may reconsider its law and escape appeal to the federal courts in lieu of satisfying *Miller*. Florida's AWP law was repealed in October of 2000.

1. *ALA. CODE § 27-45-3 (1975)*. *Choice of pharmaceutical services; right to participate as contracting provider.*

No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall:

(1) Prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the pharmacy or pharmacist of his choice to furnish the pharmaceutical services, including without limitation, prescription drugs, offered by said policy or plan or interfere with said selection provided the pharmacy or pharmacist is licensed to furnish such pharmaceutical services in this state; or

(2) Deny any pharmacy or pharmacist the right to participate as a contracting provider for such policy or plan provided the pharmacist is licensed to furnish pharmaceutical services, including without limitation, prescription drugs offered by said policy or plan.


(a) As used in this section, a “third party prescription program” means a system of providing for reimbursement for the cost of drugs or pharmaceutical services under a contractual arrangement or agreement with a provider of such drugs or services. Such programs shall include, but not be limited to, employee benefit plans under which a consumer receives prescription drugs or pharmaceutical services and such drugs or services are paid for in part by an agent of the consumer's employer or others. An “administrator” means the program administrator of a third party prescription program.

(b) Any agreement or contract entered into in this state between an administrator and a pharmacy shall include a statement of the method and amount of reimbursement to the pharmacy for drugs or services pro-

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Inc. v. La., 82 F.3d 642 (5th Cir. 1996); Murphy vs. Cmty. Health Network of La., 712 So. 2d 296 (La. Ct. App. 1998).

vided to persons enrolled in the program, and the frequency of payment by the administrator to the pharmacy for such drugs or services.

c) (1) Each administrator of a program shall notify all pharmacies enrolled in such program of any cancellation of coverage or benefits of any group enrolled in the program at least thirty days prior to the effective date of such cancellation or, within ten business days following the date on which he receives notice of a cancellation, if he receives such notice less than forty days prior to its effective date.

(2) Each employer shall give written notice to all persons enrolled in such program of the cancellation of the plan and written notice to any person whose enrollment is terminated. Such notice shall be given as soon as is practicable but in no case later than thirty days after cancellation or termination. Such notice shall include a demand for the return of any plan identification cards such persons may have been issued by reason of their enrollment in such program.

(3) Any person who uses a program identification card to obtain drugs or services from a pharmacy after having received notice of the cancellation of his program shall be liable to the administrator for all moneys paid by the administrator for any drugs or services obtained by the illegal use of such card.

d) (1) No administrator shall deny payment to any pharmacy for drugs or services which were provided as the result of the fraudulent or illegal use of an identification card by any person to whom an identification card was issued, unless the pharmacy was notified of the cancellation of such card.

(2) No administrator shall withhold payments for uncontested claims to any pharmacy beyond the time period specified in the payment schedule provisions of the agreement.

e) Each administrator shall mail to any pharmacist, upon written request, a copy of each contract or agreement form in use in this state between such administrator and a pharmacy.

f) No administrator shall prohibit a pharmacy from enrolling in a program except for cause, including, but not limited to, previous fraudulent use of program identification cards.

g) The provisions of this section shall not apply to the providing of drugs or services under the provisions of Title XIX of the Social Security Act.

(a) Any person in the State may select the pharmacy of the person's choice as long as the pharmacy has agreed to participate in the plan according to the terms offered by the insurer.

(b) Any pharmacy or pharmacist has the right to participate as a contract provider under a plan or policy if the pharmacy or pharmacist agrees to accept the terms and reimbursement set forth by the insurer.

(c) No insurer shall impose on a beneficiary any co-payment or condition that is not equally imposed with all contracting pharmacy providers the beneficiary may utilize.

(d) No insurer shall require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy.

(e) A pharmacist or pharmacy shall not interfere with the control of over-utilization of a plan's covered services and may not waive, discount, rebate or distort in any way the designated co-payment of any insurer plan or patient's co-insurance portion of a prescription drug coverage plan.

(f) At least 60 days prior to the effective date of any health benefit plan or renewal of any pharmacy contract network which provides for coverage of pharmacy services, including prescription drug coverage, to Delaware residents, and restricts pharmacy participation, the entity providing the health benefit plan shall provide notice to all pharmacies within the State and shall offer to the pharmacies the opportunity to participate in the health benefit plan. Such notice and offer shall be considered given upon delivery of written notice to the Delaware Pharmaceutical Society, Inc. or its successor, and upon publication of such notice in a newspaper of general circulation throughout the State. All pharmacies within the State shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The health benefit insurer shall inform the plan beneficiaries of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services.

(g) Any provision in a health benefit plan which is executed, delivered or renewed, or otherwise contracted for in this State that is contrary to any provision of this section shall, to the extent of the conflict, be void.

(h) It shall be a violation of this section for any insurer of any person to provide any health benefit plan that provides for pharmaceutical services to residents of this State that does not conform to the provisions of this section.

Sec. 3.

(a) An insurer may:

(1) enter into agreements with providers relating to terms and conditions of reimbursement for health care services that may be rendered to insureds of the insurer, including agreements relating to the amounts to be charged the insured for services rendered or the terms and conditions for activities intended to reduce inappropriate care;

(2) issue or administer policies in this state that include incentives for the insured to utilize the services of a provider that has entered into an agreement with the insurer under subdivision (1); and

(3) issue or administer policies in this state that provide for reimbursement for expenses of health care services only if the services have been rendered by a provider that has entered into an agreement with the insurer under subdivision (1).

(b) Before entering into any agreement under subsection (a)(1), an insurer shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1). These terms and conditions may not discriminate unreasonably against or among providers. For the purposes of this subsection, neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiation nor price difference among other providers in different geographical areas or different specialties constitutes unreasonable discrimination. Upon request by a provider seeking to enter into an agreement with the insurer under subsection (a)(1), the insurer shall make available to the provider a written statement of the terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1).

(c) No hospital, physician, pharmacist, or other provider designated in . . . willing to meet the terms and conditions of agreements described in this section may be denied the right to enter into an agreement under subsection (a)(1). When an insurer denies a provider the right to enter into an agreement with the insurer under subsection (a)(1) on the grounds that the provider does not satisfy the terms and conditions established by the insurer for providers entering into agreements with the insurer, the insurer shall provide the provider with a written notice that:

(1) explains the basis of the insurer’s denial; and
(2) states the specific terms and conditions that the provider, in the opinion of the insurer, does not satisfy.

(d) In no event may an insurer deny or limit reimbursement to an insured under this chapter on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an agreement with the insurer.

5. MASS GEN. LAWS ch. 176D, § 3B(5) (West 2005). Requirements for carriers offering pharmacy networks; arrangements between carriers and non-network pharmacies; definitions.

A carrier that offers insureds a restricted pharmacy network shall, in soliciting, arranging, competitively bidding and contracting for such a network, comply with the following requirements for the purpose of promoting fair and competitive bidding:

(5) open all bids (a) at a previously specified time, which shall not be more than thirty days after the bid submission deadline, and (b) in a public manner, provided that certain information contained in said bids may be held as confidential from public review consistent with regulations promulgated by the commissioner regarding the disclosure of proprietary data or information submitted by any bidders.

A carrier shall neither exclude nor favor any individual pharmacy, or group or class of pharmacies, in the design of a competitive bid involving restricted or nonrestricted pharmacy networks in compliance with the requirements of this section. An entity that assists a carrier in the development or management of said design, network contracts, bid specifications or the bid process, or assists in the review or evaluation of said bids, shall be prohibited from bidding on such a contact.

A retail pharmacy registered pursuant to sections thirty-eight and thirty-nine of chapter one hundred twelve, or an association of such pharmacies whose purpose is to promote participation in restricted pharmacy networks, which are not offered or are not participating in a carrier's restricted pharmacy network contract shall nevertheless have the right to provide drug benefits to the carrier's insureds provided that such non-network pharmacies reach the following agreements with the carrier:

(1) to accept as the carrier's payment in full the lowest price required of any pharmacy in the carrier's restricted pharmacy network;

(2) to bill to the insured up to and not in excess of any copayment, coinsurance, deductible or other amount required of an insured by the carrier;
(3) to be reimbursed on the same methodological basis, including, but not limited to capitation or other risk-sharing methodology, as required of any pharmacy in the carrier’s restricted pharmacy network;

(4) to participate in the carrier’s utilization review and quality assurance programs, including utilization and drug management reports as required of any pharmacy in the carrier’s restricted pharmacy network;

(5) to provide computerized on-line eligibility determinations and claims submissions as required of any pharmacy in the carrier’s restricted pharmacy network;

(6) to participate in the carrier’s satisfaction surveys and complaint resolution programs for its insureds;

(7) to protect the carrier’s proprietary information and an insured’s confidentiality and privacy;

(8) to abide by the carrier’s performance standards with respect to waiting times, fill rates and inventory management, including formulary restrictions;

(9) to comply with the carrier’s claims audit provisions; and

(10) to certify, using audit results or accountant statements, the fiscal soundness of the non-network pharmacy.

A carrier may waive any of the aforementioned agreements in arranging for the provision of pharmaceutical drug benefits to insureds through a non-network pharmacy. A carrier may impose a cost-sharing charge for the use of a non-network pharmacy not to exceed five percent more than the charge for using any pharmacy in the carrier’s restricted pharmacy network. A carrier shall not impose any agreements, terms or conditions on any non-network pharmacy, or on any association of pharmacies, which are more restrictive than those required of any pharmacy in the carrier’s restricted pharmacy network. The failure of a non-network pharmacy to abide by the aforementioned agreements may, at the option of the carrier, serve as the basis for cancellation of the non-network pharmacy’s participation agreement.

The provisions of this section shall not apply to arrangements for the provision of pharmaceutical drug benefits to insureds between a carrier and a mail order pharmacy, a hospital-based pharmacy which is not a retail pharmacy, a pharmacy maintained by a physician group practice or clinic which is not a retail pharmacy or a pharmacy wholly-owned by a carrier.

Nothing in this section shall be construed to require or preclude the provision of pharmacy services to insureds through a restricted pharmacy network nor any other arrangement for the provision of prescription drug benefits.
The provisions of this section shall not apply to the establishment of any restricted pharmacy network in a geographical area, approved by the commissioner, which is served solely by a single provider of pharmaceutical services.

For purposes of this section, the term "carrier" shall mean an insurer operating pursuant to the provisions of chapter one hundred and seventy-five, a hospital service corporation operating pursuant to the provisions of chapter one hundred and seventy-six A, a medical service corporation operating pursuant to the provisions of chapter one hundred and seventy-six B, a health maintenance organization operating pursuant to the provisions of chapter one hundred and seventy-six G, and a preferred provider arrangement operating pursuant to the provisions of chapter one hundred and seventy-six I, or a wholly-owned subsidiary or affiliate under common ownership thereof. The term "insured" shall mean a person whose health care services and benefits are provided by, or indemnified by or otherwise covered by a carrier’s group or individual insurance policy, or certificate, agreement or contract and shall include subscribers, enrollees or members. The term "eligible bidder" shall mean a retail pharmacy, community pharmacy or pharmacy department registered pursuant to sections thirty-eight and thirty-nine of chapter one hundred and twelve, irrespective of corporate structure or number of locations at which it conducts business, located within the geographical service area of a carrier and willing to bid for participation in a restricted pharmacy network contract. The term "restricted pharmacy network" shall mean an arrangement for the provision of pharmaceutical drug benefits to insureds which under the terms of a carrier’s policy, certificate, contract or agreement of insurance or coverage requires an insured or creates a financial incentive for an insured to obtain prescription drug benefits from one or more participating pharmacies that have entered into, a specific contractual relationship with the carrier pursuant to a competitive bidding process.

The commissioner of the division of insurance shall have authority to enforce the provisions of this section.


A health maintenance organization as defined in Section 83-41-303, and a managed care entity as defined in Section 83-41-403, shall establish procedures to give interested health care providers located in the geographic area served an opportunity to apply for participation.
I. No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this chapter:

(a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrolled participant of, or person considering enrolling in, a health maintenance organization;

(b) A statement or item of information shall be deemed to be misleading, whether or not it may be literally true, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information reasonably may be understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrolled participant of, or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;

(c) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans or evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrolled participants covered under such evidence of coverage.

II. RSA 406-A and RSA 417 shall be construed to apply to health maintenance organizations and evidences of coverage, except to the extent that the commissioner determines that the nature of the health maintenance organizations, and evidences of coverage render such statutes inappropriate.

III. No health maintenance organization, unless licensed as an insurer, may use in its name, evidences of coverage, contracts, or literature, any of the words "insurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

IV. No health maintenance organization shall exclude part-time employees or refuse to offer the same insurance benefits to part-time employees as it offers to the employee groups of which the part-time employees
would be members if they were full-time employees. The insurer shall offer to include the part-time employees as part of the employer’s employee group, at the full rate to be paid by the employer, at a rate prorated between the employer and the employee, or at the employee’s expense. A part-time employee shall be any employee who regularly works at least half of the weekly hours of the full-time employee in the employee group of which the part-time employee would be a member if he were a full-time employee, but who works a minimum of at least 15 hours per week.

V. Every health maintenance organization which solicits bids from pharmacies for contracts to be preferred providers shall accept and list as preferred providers all pharmacies which meet the bid acceptable to the health maintenance organization.

VI. No health maintenance organization shall, when issuing or renewing a policy or contract of insurance or any certificate under such policy or contract covered by this chapter, deny coverage or limit coverage to any resident of this state on the basis of health risk or condition except that a waiting period consistent with insurance department rules may be imposed for pre-existing medical conditions. If a health maintenance organization accepts an application for group coverage, such acceptance shall be subject to the following:

(a) If the group has coverage in effect through another plan, the health maintenance organization shall accept all persons covered under the existing plan. If the group does not have coverage in effect through another plan, the health maintenance organization shall accept all persons for which the group seeks coverage.

(b) Once a group policy has been issued, any person becoming eligible for coverage shall become covered by enrolling within 31 days after first becoming eligible. Any person so enrolling shall not be required to submit evidence of insurability based on medical conditions. If a person does not enroll at this time, he is a late enrollee.

(c) Once a group policy has been issued, the health maintenance organization shall provide the group with an annual open enrollment period for late enrollees. During the open enrollment period, any late enrollee shall be permitted to enroll without submitting any evidence of insurability based on medical conditions. For late enrollees only, the pre-existing condition provisions shall apply for 18 months from the date of enrollment.

VII. An insurer issuing policies of group insurance shall allocate the costs associated with maternity and childbirth over both males and females covered by its entire block of business in this state. In cases in which, because of the amount written in the state, allocation to an entire block of
business needs to occur, the carrier may apply for a waiver from the insurance commissioner.

8. **N.J. STAT. ANN. § 26:2J-4.7 (West 2005). Issuance or continuation of health maintenance organizations providing pharmacy services, prescription drugs, or prescription drug plans; conditions.**

(a) Notwithstanding any provision of law to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this act for a health maintenance organization which provides pharmacy services, prescription drugs, or a prescription drug plan, unless the coverage for health care services:

(1) Permits the enrollee, at the time of enrollment, to select benefit coverage allowing the enrollee to choose a pharmacy or pharmacist for the provision of prescription drugs or pharmacy services, provided that any pharmacist or pharmacy selected by the enrollee is registered pursuant to . . . et seq.;

(2) Provides that no pharmacy or pharmacist shall be denied the right to participate as a preferred provider or as a contracting provider, under the same terms and conditions currently applicable to all other preferred or contacting providers, if the health maintenance organization provides for coverage by contracted or preferred providers for pharmaceutical services, provided the pharmacy or pharmacist is registered pursuant to . . . et seq., and accepts the terms and conditions of the health maintenance organization;

(3) Provides that no copayment, fee, or other condition shall be imposed upon an enrollee selecting a participating or contracting pharmacist or pharmacy that is not also equally imposed upon all enrollees selecting a participating or contracting pharmacist or pharmacy;

(4)(a) Provides that no enrollee shall be required to obtain pharmacy services and prescription drugs from a mail service pharmacy;

(b) Provides for no differential in any copayment applicable to any prescription drug of the same strength, quantity and days' supply, whether obtained from a mail service pharmacy or a non-mail service pharmacy, provided that the non-mail service pharmacy agrees to the same terms, conditions, price and services applicable to the mail service pharmacy; and

(c) Provides that the limit on days' supply is the same whether the prescription drug is obtained from a mail service pharmacy or a non-mail [sic] service pharmacy, and that the limit shall not be less than 90 days
except for any health care-related programs funded in whole or in part with State funds, including, but not limited to, the Medicaid program established pursuant to P.L. 1968, c. 413 (C.30:4D-1 et seq.) and the "Children's Health Care Coverage Program" established pursuant to P.L. 1997, c. 272 (C.30:4I-1 et seq.);

(5) Sets forth the auditing procedures to be used by the health maintenance organization and includes a provision that any audit shall take place at a time mutually agreeable to the pharmacy or pharmacist and the auditor, unless authorized by the Division of Medical Assistance and Health Services in the Department of Human Services with regard to any health care-related programs funded in whole or in part with State funds, including, but not limited to, the Medicaid program and "Children's Health Care Coverage Program". No audit by a health maintenance organization shall include a review of any document relating to any person or prescription plan other than those reimbursable by the health maintenance organization, unless authorized by the Division of Medical Assistance and Health Services in the Department of Human Services with regard to any health care-related programs funded in whole or in part with State funds, including, but not limited to, the Medicaid program and "Children's Health Care Coverage Program";

(6) Provides that the health maintenance organization, or any agent or intermediary thereof, including a third party administrator, shall not restrict or prohibit, directly or indirectly, a pharmacy from charging the enrollee for services rendered by the pharmacy that are in addition to charges for the drug, for dispensing the drug or for prescription counseling. Services rendered by the pharmacy for which additional charges are imposed shall be subject to the approval of the Board of Pharmacy. A pharmacy shall disclose to the purchaser the charges for the additional services and the purchaser's out-of-pocket cost for those services prior to dispensing the drug. A pharmacy shall not impose any additional charges for patient counseling or for other services required by the Board of Pharmacy or the Division of Medical Assistance and Health Services in the Department of Human Services or State or federal law;

(7) The provisions of P.L. 1999, c. 395 shall apply to all health maintenance organization contracts delivered. [sic] issued or renewed on or after the effective date of P.L. 1999, c. 395.

b. Nothing in this section shall be construed to operate to add any coverage for health care services, to increase the scope of any coverage for health care services, or to increase the level of any health care services provided by a health maintenance organization.

c. This section shall apply to health maintenance organization plans in which the right to change the enrollee charge has been reserved.

(a) This section shall apply to all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of North Carolina. This section shall also apply to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. This section shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses, and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and to enrollees of its health benefit plan; provided, however, this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services. This section shall not apply to any federal program, clinical trial program, hospital or other health care facility licensed pursuant to Chapter 131E or Chapter 122C of the General Statutes, when dispensing prescription drugs to its patients.

(b) As used in this section:

(1) "Copayment" means a type of cost sharing whereby insured or covered persons pay a specified predetermined amount per unit of service with their insurer paying the remainder of the charge. The copayment is incurred at the time the service is used. The copayment may be a fixed or variable amount.

(2) "Contract provider" means a pharmacy granted the right to provide prescription drugs and pharmacy services according to the terms of the insurer.

(3) "Health benefit plan" is as that term is defined in G.S. 58-50-110(11).

(4) "Insurer" means any entity that provides or offers a health benefit plan.

(5) "Pharmacy" means a pharmacy registered with the North Carolina Board of Pharmacy.

(c) The terms of a health benefit plan shall not:

(1) Prohibit or limit a resident of this State, who is eligible for reimbursement for pharmacy services as a participant or beneficiary of a health benefit plan, from selecting a pharmacy of his or her choice when the pharmacy has agreed to participate in the health benefit plan according to the terms offered by the insurer;

(2) Deny a pharmacy the opportunity to participate as a contract provider under a health benefit plan if the pharmacy agrees to pro-
vide pharmacy services that meet the terms and requirements, including terms of reimbursement, of the insurer under a health benefit plan, provided that if the pharmacy is offered the opportunity to participate, it must participate or no provisions of G.S. 58-51-37 shall apply;

(3) Impose upon a beneficiary of pharmacy services under a health benefit plan any copayment, fee, or condition that is not equally imposed upon all beneficiaries in the same benefit category, class, or copayment level under the health benefit plan when receiving services from a contract provider;

(4) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary’s choice of pharmacy. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods.

(5) Reduce allowable reimbursement for pharmacy services to a beneficiary under a health benefit plan because the beneficiary selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area; or

(6) Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy.


1. No third-party payer, including a health care insurer as defined in section 26.1-47-01, providing pharmacy services and prescription drugs to any beneficiary may:

a. Prevent a beneficiary from selecting the pharmacy or pharmacist of the beneficiary’s choice to provide pharmaceutical goods and services, provided that pharmacist or pharmacy is licensed in this state;

b. Impose upon any beneficiary selecting a participating or contracting provider a copayment, fee, or other condition not equally imposed upon all beneficiaries in the plan selecting a participating or contracting provider; or

c. Deny any pharmacy or pharmacist the right to participate as a preferred provider under chapter 26.1-47 or as a contracting provider for any policy or plan, provided the pharmacist or pharmacy is
licensed in this state, and accepts the terms of the third-party payer's contract.

2. Notwithstanding the provisions of subsection 1, the department of human services may exclude, from participation in the medical assistance program administered under chapter 50-24.1 and title XIX of the Social Security Act [Pub. L. 89-97; 79 Stat. 343; 42 U.S.C. § 1396 et seq.], as amended, any provider of pharmacy services who does not agree to comply with state and federal requirements governing the program, or who, after so agreeing, fails to comply with those requirements.

3. Any provision in a health insurance policy in this state which violates the provisions in subsection 1 is void.

4. Any person who violates this section is guilty of a class A misdemeanor and each violation is a separate offense. The commissioner may levy an administrative penalty not to exceed ten thousand dollars for a violation of this section.

5. The insurance commissioner shall enforce the provisions of this section.


A. A health insurance plan or policy or health maintenance organization providing prescription drugs as a covered benefit shall provide a pharmacy or group of pharmacies with the right to bid on a periodic basis, but not less than every three (3) years, on any pharmacy contract to provide pharmacy services, including, but not limited to, prescription drugs.

B. Nothing in this act shall be interpreted to preclude a health insurance plan or policy or health maintenance organization from establishing an open pharmacy network for the provision of pharmacy services, including, but not limited to, prescription drugs.

C. The provisions of this section shall not apply to a health insurance plan or policy or health maintenance organization that maintains an open pharmacy network.

An individual or group accident and health or health insurance policy or health maintenance organization plan may not:

(1) prohibit or limit a person who is a participant or beneficiary of the policy or plan from selecting a pharmacy or pharmacist of the person’s choice who has agreed to participate in the plan according to the terms offered by the insurer; or

(2) deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services including, but not limited to, prescription drugs that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer.

13. LA. REV. STAT. ANN. tit. 22, § 1214(15)(a) (West 2005). Methods, acts, and practices which are defined herein as unfair or deceptive.

(15)(a) The issuance, delivery, issuance for delivery, or renewal of, or execution of contract for, a health benefits policy or plan which:

(i) Prohibits or limits a person who is an insured or other beneficiary of the policy or plan from selecting a pharmacy or pharmacist of the person’s choice to be a provider under the policy or plan to furnish pharmaceutical services or pharmaceutical products offered or provided by that policy or plan or in any manner interferes with that person’s selection of a pharmacy or pharmacist, provided that the chosen pharmacy or pharmacist agrees in writing to provide pharmaceutical services and pharmaceutical products that meet all the terms and requirements, including the same administrative, financial, and professional conditions and a minimum contract term of one year if requested, that apply to all other pharmacies or pharmacists who have been designated as providers under the policy or plan or as participating providers in a pharmacy network established by the policy or plan.

(ii) Denies a pharmacy or pharmacist the right to participate as a contract provider of pharmaceutical services or pharmaceutical products under the policy or plan, or under a pharmacy network established by the policy or plan, if the pharmacy or pharmacist
agrees in writing to provide pharmaceutical services and phar-maceutical products that meet all the terms and requirements, including the same administrative, financial and professional conditions and a minimum contract term of one year, if requested, which apply to pharmacies and pharmacists which have been designated as prov-iders under the policy or plan or as participating providers in a pharmacy network established by the policy or plan.

(b) This Paragraph shall not, however, require a health benefits policy or plan to provide pharmaceutical services or pharmaceutical products.

(c) As used in this Paragraph, the following terms shall be given these meanings:

(i) “Drug” and “prescription” have the meanings assigned by R.S. 37:1171 and regulations of the Louisiana Board of Pharmacy.

(ii) “Health benefits policy or plan” means any and all health and accident insurance policies or contracts, including but not limited to individual, group, family, family group, blanket, and association health and accident insurance policies, as well as health maintenance organizations and preferred provider organizations, and any and all other third-party payment plans or contracts, and any and all other health care or health benefits plans, policies, contracts, or funds that either in whole or in part provide benefits for pharmaceutical services and pharmaceutical products that are necessary as a result of or to prevent an accident or sickness.

(iii) “Interferes” or “interferes with” means and includes but is not limited to the charging to or imposing on an insured or other beneficiary who does not utilize a specified or designated pharmacy or pharmacist, a copayment fee or other condition not equally charged to or imposed on all insureds or other beneficiaries in or under the same program or policy or plan. However, “interferes” or “interferes with” does not mean or include the advertisement, or periodic dissemination, to all insureds or other beneficiaries of current lists of all pharmacies or pharmacists who have agreed to participate as a contract provider pursuant to the requirements of R.S. 22:1214(15)(a)(ii).

(iv) “Pharmaceutical product” means a “drug” and “prescription”, as defined in this Paragraph, and home intravenous therapies.

(v) “Pharmaceutical services” means services that are ordinarily and customarily rendered by a pharmacy or pharmacist, including the preparation and dispensing of pharmaceutical products.

(vi) “Pharmacist” means a person licensed to practice pharmacy under the Pharmacy Law and Board of Pharmacy regulations of the state of Louisiana.
(vii) "Pharmacy" has the meaning assigned by R.S. 37:1171 and regulations of the Louisiana Board of Pharmacy.

(d) This Paragraph shall be cited as the "Patient Pharmacy Preference Act"

B. General AWP statutes

The general AWP statutes are similar in form to the Kentucky statute upheld in Miller, and for the same reasons cited in Miller will also be upheld under the new test. Each statute prohibits HMOs from discriminating against willing providers. As a result, the statutes regulate insurance by preventing discriminatory health care practices, and opening up the provider networks to all those willing to accept the terms and conditions of the network. Under these laws, insurers and administrators shall not refuse services from providers who are willing to meet the terms or conditions of the plan: Idaho, Illinois, Indiana, Kentucky, Minnesota, Utah, Virginia, Wisconsin, and Wyoming.


(1) Any managed care organization issuing benefits pursuant to the provisions of this chapter shall be ready and willing at all times to enter into care provider service agreements with all qualified providers of the category or categories which are necessary to provide the health care services covered by an organization if the health care providers: are qualified under the laws of the state of Idaho, desire to become participant providers of the organization, meet the requirements of the organization, and practice within the general area served by the organization.

(2) Nothing in this section shall preclude an organization from refusing to contract with a provider who is unqualified or who does not meet the

151. IDAHO CODE § 41-3927 (Michie 1998).
152. 215 ILL. COMP. STAT. ANN. 5/370h (West 2005).
153. IND. CODE ANN. 27-8-11-3(b)-(c) (West 2005).
157. VA. CODE ANN. § 38.2-3407(B) (Michie 1986).
158. WIS. STAT. ANN. § 628.36 (West 1999).
terms and conditions of the organization’s participating provider contract or from terminating or refusing to renew the contract of a health care provider who is unqualified or who does not comply with, or who refuses to comply with, the terms and conditions of the participating provider contract including, but not limited to, practice standards and quality requirements. The contract shall provide for written notice to the participating health care provider setting forth any breach of contract for which the organization proposes that the contract be terminated or not renewed and shall provide for a reasonable period of time for the participating health care provider to cure such breach prior to termination or nonrenewal. If the breach has not been cured within such period of time the contract may be terminated or not renewed. Provided however, that if the breach of contract for which the organization proposes that the contract be terminated or not renewed is a willful breach, fraud or a breach which poses an immediate danger to the public health or safety, the contract may be terminated or not renewed immediately.

(3) Every managed care organization issuing benefits pursuant to this chapter shall establish a grievance system for providers. Such grievance system shall provide for arbitration according to chapter 9, title 7, Idaho Code, or for such other system which provides reasonable due process provisions for the resolution of grievances and the protection of the rights of the parties.

(4) No managed care organization may require as an element of any provider contract that any person agree:

(a) To deny a member access to services not covered by the managed care plan if the member is informed that he will be responsible to pay for the noncovered services and the member nonetheless desires to obtain such services;

(b) To refrain from treating a member even at that member’s request and expense if the provider had been, but is no longer, a contracting provider under the managed care plan and the provider has notified the member that the provider is no longer a contracting provider under the managed care plan;

(c) To the unnegotiated adjustment by the managed care organization of the provider’s contractual reimbursement rate to equal the lowest reimbursement rate the provider has agreed to charge any other payor;

(d) To a requirement that the provider adjust, or enter into negotiations to adjust, his or her charges to the managed care organization if the provider agrees to charge another payor lower rates; or

(e) To a requirement that the provider disclose his or her contractual reimbursement rates from other payors.
(5) A managed care organization shall not refuse to contract with or compensate for covered services an otherwise eligible provider or non-participating provider solely because the provider has in good faith communicated with one (1) or more current, former, or prospective patient regarding the provisions, terms or requirements of the organization's products as they relate to the needs of the provider's patients.

(6) As part of a provider contract, a managed care organization may require a provider to indemnify and hold harmless the managed care organization under certain circumstances so long as the managed care organization also agrees to indemnify and hold harmless the provider under comparable circumstances.

(7) On request and within a reasonable time, a managed care organization shall make available to any party to a provider contract any documents referred to or adopted by reference in the contract except for information which is proprietary or a trade secret or confidential personnel records.

(8) A managed care organization shall permit a contracting provider who is practicing in conformity with community standards to advocate for his patient without being subject to termination or penalty for the sole reason of such advocacy.

(9) Subsections (1) and (2) of this section shall apply to provider participation contracts entered into after July 1, 1994.


Sec. 370h. Noninstitutional providers. Before entering into any agreement under this Article an insurer or administrator shall establish terms and conditions that must be met by noninstitutional providers wishing to enter into an agreement with the insurer or administrator. These terms and conditions may not discriminate unreasonably against or among noninstitutional providers. Neither difference in prices among noninstitutional providers produced by a process of individual negotiation nor price differences among other noninstitutional providers in different geographical areas or different specialties constitutes unreasonable discrimination.

An insurer or administrator shall not refuse to contract with any noninstitutional provider who meets the terms and conditions established by the insurer or administrator.

A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the limited health benefit plan and who is willing to meet the terms and conditions for participation established by the insurer.


Subd. 3. Mandatory offering to enrollees. (a) Each health plan company shall offer to enrollees the option of receiving covered services through the expanded network of allied independent health providers established under subdivisions 1 and 2. This expanded network option may be offered as a separate health plan. The network may establish separate premium rates and cost-sharing requirements for this expanded network plan, as long as these premium rates and cost-sharing requirements are actuarially justified and approved by the commissioner. This subdivision does not apply to Medicare, medical assistance, general assistance medical care, and MinnesotaCare.


Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78-14-3 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

(a) A health care provider contract may require the health care provider to accept the specified payment as payment in full, relinquishing the right to collect additional amounts from the insured person.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;
(iv) other copyaments; or

(v) any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection 31A-27-311.5(1)(f):

(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

(A) require the health care provider to continue to provide health care services under the contract until the earlier of:

(I) 90 days after the date of the filing of a petition for rehabilitatin or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);

(ii) the provider is required to:

(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization’s enrollee, as defined in Subsection 31A-27-311.5(1)(b);

(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

(A) sums owed by the insolvent managed care organization; or

(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):

(A) a provider;
(B) an agent;

(C) a trustee; or

(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and

(v) notwithstanding Subsection (1)(c)(i):

(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider’s regular fee set forth in the contract; and

(B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:

(I) a petition for rehabilitation; or

(II) a petition for liquidation.

(7)(a) A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) Any health care provider licensed to treat any illness or injury within the scope of the health care provider’s practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

19. VA. CODE ANN. § 38.2-3407 (Michie 1986), Health benefit programs.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed
unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.


(1) Payment methods. Any corporation operating a voluntary health care plan may pay health care professionals on a salary, per patient or fee-for-service basis to provide health care to policy holders or beneficiaries of the corporation.

(2) Discrimination against professionals.

(a) In this section:

1. “Health care plan” means an insurance contract providing coverage of health care expenses.

2. “Provider” means a health care professional, a health care facility or a health care service or organization.

(b) 1. Except for health maintenance organizations, preferred provider plans and limited service health organizations, no health care plan may prevent any person covered under the plan from choosing freely among providers who have agreed to participate in the plan and abide by its terms, except by requiring the person covered to select primary providers to be used when reasonably possible.

2. No provider may be required to participate exclusively in a health care plan as a condition of participation in it.

3. Except as provided in subd. 4., no provider may be denied the opportunity to participate in a health care plan, other than a health maintenance organization, a limited service health organization or a preferred provider plan, under the terms of the plan.

4. Any health care plan may exclude a provider from participation in the health care plan for cause related to the practice of his or her profession.

5. All health care plans, including health maintenance organizations, limited service health organizations and preferred provider plans are subject to s. 632.87(3).


(a) Notwithstanding any other provision of law to the contrary:
(i) Any provider may enter into a written agreement with any group or insurer relating to health care services which may be rendered to insureds, including amounts to be charged the insured for services rendered;

(ii) Any group or insured may contract with insurers to issue policies which:

(A) Include incentives for the insured;

(B) Limit reimbursement for health care services.

(iii) Before entering into any written agreement under paragraph (a)(i) of this section, the group or insurer shall establish terms and conditions to be required of any provider interested in entering into the agreement. In no event shall the established terms and conditions discriminate against any Wyoming provider nor shall any Wyoming provider willing to meet the established terms and conditions be denied the right to enter into any written agreement;

(iv) This section shall not be construed to expand the scope of coverage as defined by any agreement.

(b) In no event may an insurer deny or limit reimbursement to an insured under this article on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an agreement with the insurer.

(c) Any group may contract with an insurer, preferred provider organization or health maintenance organization for provision of medical services outside of Wyoming for the insured's of that group, provided the insureds are not restricted from utilizing any Wyoming provider who provides the same health care services.

C. Statutes that apply to a delineated and articulated set of providers offer testing ground

Both Arkansas and Georgia have drafted statutes that apply to a limited set of providers. Georgia's two laws apply only to Blue Cross Blue Shield contracts or rural health care providers participation in plans in their geographic regions. The Georgia laws appear to satisfy the Miller standard, so they will escape preemption.


§ 33-20-16. Certain physicians and health care providers may participate in corporations.
Every doctor of medicine, every doctor of dental surgery, every podiatrist, and every health care provider with a class approved by the health care corporation who is appropriately licensed to practice and who is reputable and in good standing shall have the right to become a participating physician or approved health care provider for medical or surgical care, or both, as the case may be, under such terms or conditions as are imposed on other participating physicians or approved health care providers within such approved class under similar circumstances in accordance with this chapter.

§ 33-30-25. Health care insurers authorized to place reasonable limits on number or classes of preferred providers which satisfy insurer's standards.
Subject to the approval of the Commissioner under such procedures as he may develop, health care insurers may place reasonable limits on the number of classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against providers on the basis of religion, race, color, national origin, age, sex, or marital or corporate status, and provided, further, that all health care providers within any defined service area who are licensed and qualified to render the services covered by the preferred provider arrangement and who satisfy the standards set forth by the health care insurer shall be given the opportunity to apply and to become a preferred provider.


(a)(1) "Copayment" means a type of cost sharing whereby insured or covered persons pay a specified predetermined amount per unit of service or percentage of health care costs with their health care insurer paying the remainder of the charge.

(2) The copayment is incurred at the time the service is rendered.

(3) The copayment may be a fixed or variable amount.

(b) "Gatekeeper system" means a system of administration used by any health benefit plan in which a primary care provider furnishes basic patient care and coordinates diagnostic testing, indicated treatment, and specialty referral for persons covered by the health benefit plan.

(c) "Health benefit plan" means any entity or program that provides reimbursement, including capitation, for health care services, except and
excluding any entity or program that provides reimbursement and benefits pursuant to Arkansas Constitution, Amendment 26, Acts 1993, No. 796, or the Public Employee Workers’ Compensation Act, § 21-5-601 et seq., and rules, regulations, and schedules adopted thereunder.

(d) “Health care provider” means those individuals or entities licensed by the State of Arkansas to provide health care services, limited to the following:

(1) Physicians and surgeons (M.D. and D.O.); (2) Podiatrists; (3) Chiropractors; (4) Physical therapists; (5) Speech pathologists; (6) Audiologists; (7) Dentists; (8) Optometrists; (9) Hospitals; (10) Hospital-based services; (11) Psychologists; (12) Licensed professional counselors; (13) Respiratory therapists; (14) Pharmacists; (15) Occupational therapists; (16) Long-term care facilities; (17) Home health care; (18) Hospice care; (19) Licensed ambulatory surgery centers; (20) Rural health clinics; (21) Licensed certified social workers; (22) Licensed psychological examiners; (23) Advanced practice nurses; (24) Licensed dieticians; (25) Community mental health centers or clinics; (26) Certified orthodontists; and (27) Prosthetists.

(e) “Health care services” means services and products provided by a health care provider within the scope of the provider’s license.

(f) “Health care insurer” means any entity, including, but not limited to: (1) Insurance companies; (2) Hospital and medical services corporations; (3) Health maintenance organizations; (4) Preferred provider organizations; (5) Physician hospital organizations; (6) Third party administrators; and (7) Prescription benefit management companies, authorized to administer, offer, or provide health benefit plans.


(a) A health care insurer shall not, directly or indirectly:

(1)(A) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary’s choice among those health care providers who participate in the health benefit plan according to the terms offered.

(B) “Monetary advantage or penalty” includes:

   (i) A higher copayment;

   (ii) A reduction in reimbursement for services; or

   (iii) Promotion of one (1) health care provider over another by these methods;
(2) Impose upon a beneficiary of health care services under a health benefit plan any copayment, fee, or condition that is not equally imposed upon all beneficiaries in the same benefit category, class, or copayment level under that health benefit plan when the beneficiary is receiving services from a participating health care provider pursuant to that health benefit plan; or

(3) Prohibit or limit a health care provider that is qualified under § 23-99-203(d) and is willing to accept the health benefit plan’s operating terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards, from the opportunity to participate in that plan.

(b) Nothing in this subchapter shall prevent a health benefit plan from instituting measures designed to maintain quality and to control costs, including, but not limited to, the utilization of a gatekeeper system, as long as such measures are imposed equally on all providers in the same class.