

Kentucky Association of Health Plans, Inc. v. Miller, 123 S.Ct. 1471(2003) is the Supreme Court's third attempt in four years to bring clarity to ERISA's insurance saving clause, which shields (most) state laws that regulate insurance from ERISA's preemptive scope. 29 U.S.C. § 1144(b)(2)(A). The decision is notable for two reasons: First, because the Court candidly acknowledges that the tests it enunciated in earlier decisions were flawed and had to be discarded. Second, because it paves the way for states to enact "any willing provider" ("AWP") statutes, which prevent health plans from creating exclusive provider networks. In an AWP state a plan member is not limited to receiving care from a network of plan-approved healthcare providers. The plan must pay any provider who is willing to provide care in accordance with the plans terms, conditions, and reimbursement rates. This is entirely incompatible with the traditional notion of the HMO, which, by definition, restricts its members to a closed network of doctors and hospitals.

The Court's recent attempts to clarify the saving clause began with *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), where the Court held that California's common-law notice-prejudice rule, which generally prevents insurers from denying claims because they were submitted late, was saved from ERISA preemption because it regulated insurance. In synthesizing its earlier decisions concerning the scope of ERISA's saving clause, the Court formulated a two-part test. The Court first asked whether the law in question regulated insurance from the standpoint of common sense. Laws specifically directed toward insurance and the insurance industry generally meet this test. The Court then checked its conclusion using three factors drawn from cases construing the McCarran-Ferguson Act, 15 U.S.C. § 1012(b).

The factors are whether the practice addressed by the law spreads risk, whether the practice is an integral part of the policy relationship between the insurer and the insured, and whether the practice is limited to entities within the insurance industry. This three-factor test was borrowed from cases construing the federal antitrust exemption within the McCarran-Ferguson Act for "the business of insurance." When an insurer would engage in a business practice that was alleged to violate the antitrust laws, the question presented was whether the practice constituted "the business of insurance" or merely a business practice that happened to be carried out by an insurance company. Applying these tests, in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), the Court held that contracts between Blue Cross and pharmacies that paid the pharmacies the cost of the prescription plus \$2.00 were not "the business of insurance." Similarly, in *Union Labor Life Ins. v. Pireno*, 458 U.S. 119 (1982), the Court held that an insurer's use of a panel of chiropractors to decide which chiropractic claims to pay was not "the business of insurance."

Before *Ward* was decided, many circuits had held that in order to fall within the saving clause, a state law had to satisfy each of the three factors. *Ward* rejected this approach, making clear that the factors were merely relevant, not determinative, and that all three factors need not be satisfied.

Last year, in *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002), the Court held that an Illinois statute mandating independent medical review of adverse medical necessity determinations made by HMOs was also a law that regulated insurance under the *Ward* analysis, which it applied without criticism. *Rush* held that HMOs were in the business of insurance, and therefore laws regulating their conduct fell within the saving clause in ERISA. As in *Ward*, *Rush* first held that the Illinois law regulated insurance as a matter of common sense, and also under the three-factor McCarran-Ferguson test, although, as in *Ward*, not all three factors were met.

While the Court in *Kentucky Association of Health Plans, Inc. v. Miller* also held that Kentucky's AWP statute regulated insurance within the meaning of ERISA's saving clause, it changed the test. Justice Scalia's opinion for a unanimous court candidly admits that, "our use of the McCarran-Ferguson Act case law in the ERISA context has misdirected attention, failed to provide clear guidance to lower federal courts, and . . . added little to the relevant analysis." The Court acknowledged for the first time that the three-factor test was developed to answer a different question than the one posed in cases arising under the saving clause. The test was devised to identify what conduct by private parties constituted the business of insurance and was therefore exempt from the antitrust laws; but in ERISA cases, the question is whether the state law in question regulates insurance.

The decision almost pokes fun at *Ward* and *Rush Prudential*, which held that not all three factors needed to be met. The Court said that these decisions "raise more questions than they answer and provide wide opportunities for divergent outcomes." These include whether a state law can satisfy any two of the three factors and still regulate insurance? Just one? What if two of three factors are satisfied, but not "securely satisfied" as they were in *Ward*? And does the law itself have to satisfy the factors, or simply the conduct it regulates?

To forestall these questions, the Court decided to make what it termed "a clean break from the McCarran-Ferguson factors" and adopted a new two-part test. Now, in order for a law to satisfy the saving clause, it must be specifically directed toward entities engaged in insurance and must "substantially affect the risk pooling arrangement between the insurer and the insured."

The decision does not explain exactly what the Court means by "risk pooling." But in *Royal Drug* and *Pireno*, the Court explained that the essence of insurance is the transfer of risk from the insured to the insurance company. With health insurance, the risk that is transferred is the cost of paying for the medical care required by the insured. This risk is transferred by means of the insurance contract. The new requirement that the law must substantially affect the risk pooling arrangements between the insured and the insurer appears to mean that the law must affect the insurance contract.

The Court made clear in a footnote that a law need not actually spread risk in order to affect risk pooling. The notice prejudice rule that was held saved in *Ward* did not spread risk. But because it operated to make insurers pay late claims that they could otherwise

deny, it did substantially affect risk pooling. The Court also explained that not every law affecting what insurers do would fall within the saving clause. For example, a law mandating that insurers pay their janitors twice the minimum wage might be limited to entities within the insurance industry, but would not be saved because it would not affect risk pooling.

The Court held that Kentucky's AWP statute satisfied the new test and was saved. Because it was targeted at managed care plans, it was directed at entities engaged in insurance. And it affected the insurers' risk pooling arrangements because it prevented insurers from creating closed provider networks and forcing its plan members to obtain all care within those networks. Hence, it affected the kind of risk pooling arrangements that insurers in Kentucky could offer.

The impact of *Kentucky Association of Health Plans* in California will depend on how courts construe the new test, and on whether the decision might spur advocates of AWP legislation to renew their efforts to make California an AWP state. More than half the states enacted AWP laws in the early and mid-1990s. A study of those statutes found that the states most likely to enact an AWP law were those with minimal managed care activity, suggesting that the laws are enacted to curb the growth of managed care. California, by contrast, is at the forefront of managed care activity, and attempts to enact AWP legislation in California in the mid-1990s failed.

If the battle is renewed, it will likely pit groups representing medical providers and patient advocates against groups representing health plans. Advocates of AWP laws argue that they provide plan members with freedom of choice, by allowing them to select any provider who will abide by the plan's terms. AWP laws also make it easier for members to switch plans, because they can often maintain continuity of providers regardless of the plan they are enrolled in.

But plans argue that AWP statutes increase the cost of health care and health insurance. They argue that their use of closed networks allows plans to negotiate substantial discounts with the providers, which the providers accept in order to obtain the high patient volume that comes from being in a closed network. Critics of AWP statutes argue that without the guarantee of higher patient volume, providers will not be willing or able to provide care at a discount, and that the price of care and of health insurance will inevitably rise.

In the wake of *Kentucky Association of Health Plans*, the head of California's Department of Managed Health Care, Daniel Zinglale, said that the decision creates a safer environment for the State to strengthen the rights of HMO patients. But he did not call for the Legislature to enact an AWP law. At this point, the only thing certain about AWP legislation in California is that if the Legislature decides to enact it, it will not be preempted by ERISA.

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