On April 2, 2003, the US Supreme Court issued Kentucky Association of Health Plans, Inc. v Miller (538 U.S. ____, (2003)). Kentucky had enacted an “any willing provider” statute, as had a number of other states, that required health insurers to permit any provider located within the geographic-coverage area of a health benefit plan to participate in the plan if the provider was willing to meet the terms and conditions for participation established by the health insurer. Many state legislatures felt that “any willing provider” legislation was necessary to protect those insured who are unwilling to lose their freedom to choose providers. At the same time, “any willing provider” statutes protected providers who might otherwise be excluded from coverage by insurance companies either out of hostility or ignorance. Some insurance companies resented the interference of state legislatures in the insurance companies’ ability to administer their health plans. In recent years, insurance companies began attacking “any willing provider” statutes on the grounds that health plans were regulated by a federal statute and that under the legal doctrine of preemption, a well-known principle of interpretation, once the federal government legislates in an area, federal legislation preempts state regulation. Many nurse anesthetists believed that “any willing provider” statutes could be helpful and were concerned that the Supreme Court would declare them invalid.

The doctrine of preemption comes out of a dilemma inherent in the US Constitution. How can we have a strong federal government and yet recognize the geographic, economic, social, and political diversity of the individual states of the United States? The Constitution replaced the Articles of Confederation. Many thought the Articles of Confederation had not worked because individual states had the power to limit commerce among themselves and other states. The former colonies’ retention of power reflected a distrust of strong, central, monarchal government and severely restricted commerce between the states. The founding fathers of the republic understood that the United States would never grow as a commercial or political power if it depended on local legislatures to ignore local pressure and focus on the good of the country as a whole.

“Federalism,” the balance between state and federal government in the Constitution was an effort to draw a line that recognized the need for strong central power in certain areas and the ability to diversify in others. Certain areas (traditionally, health and safety and, as provided by the Bill of Rights, any areas not “delegated” to the federal government) were reserved for state regulation; while others (foreign policy, interstate commerce) were “delegated” to the federal government. The compromises negotiated in the constitutional drafting sessions worked for a while, but then “interstate commerce” developed in unforeseeable ways and, ultimately, the conflict was resolved by a combination of John Marshall’s vision and the Civil War. When federal initiatives were irreconcilable with state actions, the federal principles prevailed. The Constitution gave the power to regulate interstate commerce to the federal government, not to the states, and when the federal government took action to regulate interstate commerce, federal initiatives could not be thwarted by state legislation or regulation.

This vision developed into the doctrine of preemption. States were free to regulate in the areas reserved to them. But when the federal government determined that an area was essential for the regulation of interstate commerce, the federal law became supreme, even if the area had formerly been believed to be within the power of the state. Like a lot of other things, preemption seems to make sense in the abstract, but your view of whether it is a good or bad thing often depends on whether your issues are helped or hurt.

If your issue is protected by state law and restricted by federal law you are apt to look at preemption statutes as a shabby power grab by a Congress increasingly on a preemption
binge in an effort that will leave state legislatures as useless appendages. If your issue is protected by a federal viewpoint, then you view “federalism” as a quaint, outdated, antibusiness and antiprogress hurdle that has outlived its time. Because interstate commerce has dramatically increased since colonial days and because once it gets involved in an area, Congress rarely turns it back to the states, the perception (and, in fact, the reality) is that every year the scope of federal control increases and less and less is regulated by the states.

The issue of preemption is asserted in 1 of 2 ways. Either a court determines that a federal law or regulatory scheme cannot be carried out if states are permitted to regulate in the same area, or Congress specifically says, when enacting legislation, that it does or does not preempt state law or that it preempts only certain state laws.

**Employee Retirement Income Security Act**

In 1974, Congress adopted the Employee Retirement Income Security Act (ERISA), a statute requiring that certain employee benefit plans be in writing, that written descriptions of eligibility and coverage provisions be distributed, and that plans be operated in compliance with standards enforced by the US Internal Revenue Service and US Department of Labor. Congress provided that ERISA would preempt all state laws “insofar as they may now or hereafter relate to any employee benefit plan” except that those state “laws which regulate insurance, banking or securities are saved from preemption.” The Kentucky Any Willing Provider Act applies to many plans covered by ERISA and prohibits insurance companies from excluding providers. One would think the Kentucky Any Willing Provider Act was exactly the kind of state statute Congress said was not preempted? How did this case get started and why did it get to the Supreme Court? How do the courts determine if a state law “regulates insurance, banking or securities” and, therefore, is saved from preemption? How complicated do we have to make this?

**McCarran-Ferguson Act**

Courts rely on past decisions to justify their current decisions. They do not like going out on a limb where they can be criticized for making the wrong decision. Instead, they move incrementally, basing current decisions on what they decided in the past. If a case was decided in a certain way 2 years ago, then a case that is like it must be decided the same way. But what happens when you face a new statute, such as ERISA, which had not been interpreted before. Even then, it turns out, there can be past decisions to rely on. In addition to ERISA, there was another statute, the McCarran-Ferguson Act, which applied to insurance activities. McCarran-Ferguson made an exception to the antitrust laws for conduct regulated by a state as “the business of insurance.” In determining whether a state law regulates “insurance, banking or securities” and was saved from preemption from ERISA, the courts looked at their decisions, deciding what was the “business of insurance” for purposes of McCarran-Ferguson.

McCarran-Ferguson drew a distinction between the “regulation of insurers” and the “regulation of insurance.” Only the “regulation of insurance” was exempt from the antitrust laws. In 1979, the Supreme Court had decided Group Life and Health Insurance Company v Royal Drug Company (44 U.S. 205, 210), holding that third-party provider arrangements between insurers and pharmacies were not “the business of insurance” under the McCarran-Ferguson Act. In Kentucky Association of Health Plans v Miller, the insurance companies who brought the suit were hoping that the Supreme Court would agree that the relationship between insurers and “any willing provider” was similar to the relationship between insurers and providers in the Royal Drug case. They were hoping that the Supreme Court would rule, as it had in Royal Drug, that the relationship between insurers and providers was not “the business of insurance” but the “regulation of insurers,” and that under the court’s prior decisions the Kentucky statute would have been preempted by ERISA.

**Decision based on common sense**

Does that sound confusing? Well, if you are confused, you are not alone. The Sixth Circuit Court of Appeals had found it so confusing that it had based its decision on “common sense.” It upheld Kentucky’s right to require insurance companies to accept “any willing provider” because “the ‘basic test’ under ERISA’s savings clause is whether, from a common sense view, the Kentucky AWP [any willing provider] laws regulate insurance.” That may not sound like a leap to many readers, but from a legal standpoint it is very rare for an appellate court to base a decision on “common sense” rather than extensive legal analysis. Courts almost always find it more comforting to be able to say that their current decisions reflect the distilled wisdom of past decisions, no matter how obtuse, rather than to interpret a statute so that it makes common sense.

The Supreme Court agreed to hear the appeal and attempted to provide the analysis that the Sixth Circuit had avoided. To determine whether something was the busy-
ness of insurance under McCarranFerguson, the court had to look at 3 factors: “first, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.”

The third test was the key. The plaintiffs argued that Kentucky’s Any Willing Provider Act went beyond the regulation of insurance because it regulated not only entities within the insurance industry but also doctors who might seek to form and maintain limited provider networks. The Supreme Court admitted that a consequence of the Kentucky statute was that entities outside of the insurance industry could be affected. However, the court said the statute by its terms did not impose any prohibition or requirement on these entities. The statute imposed obligations on health insurers not to discriminate against any willing provider. The obligation, might affect healthcare providers, but it was imposed only on insurers. It regulated insurance by imposing conditions on the right to engage in the business of insurance. A statute that imposed conditions on the right to be an insurer regulated the “business of insurance.”

**Supreme Court adopts new test**

After having engaged in the difficult analysis of whether the Kentucky Any Willing Provider Act was the business of insurance that its prior decisions had required, the Supreme Court stood back and said that it was dissatisfied with the process it had required for the past 24 years. “We believe that our use of the McCarran-Ferguson case law in the

ERISA context has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis.” Instead, the court adopted a totally new test:

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...[ERISA], it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance...Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky’s law satisfies each of these requirements.

You might think that this case would attract a lot of attention because of the court’s remarkable and unusual candor in saying that the analysis it had required for the past 24 years was too confusing to be justified. However, immediate reaction to the decision made little, if any, reference to the court’s candor or approach. (Maybe there were not a lot of people who thought this approach would end up being any simpler than trying to decide whether something regulated the business of insurance.) Instead, analysts looked at the case as an exception to the gathering of power in the hands of the federal government. One analyst saw this case as another in a series of Supreme Court decisions holding that regulation of managed care is the business of the states, not of the federal government.

**The affect of the contemporary developments**

There are other levels on which to analyze the case. In a very real way, managed care and the economic realities of healthcare had a lot to do with the case, if not the decision. The issue for the insurance companies who brought the case was an effort to allow them to discriminate among practitioners. If an insurance company could promise increased volume to a particular practitioner or to a small group of practitioners, surely the practitioner would be willing to grant economic concessions to the insurance company in return. For example, if an insurance company could require that all participants in its health maintenance organization use a particular chain of pharmacies, the increased volume might enable the pharmacy to reduce its profit margin giving the insurance company lower prices. Insurance companies saw “any willing provider” statutes as frustrating their efforts to guarantee volume in exchange for lower prices. A pharmacy chain entering into negotiations with an insurance company in a state with an “any willing provider” statute would have to accept the fact that once it negotiated its very best rate, any other pharmacy willing to accept the same rate would be able to participate in the insurance company’s program, depriving the chain of at least some of the volume that it expected to obtain and that it relied on in reducing its prices in the first place.

What happened to discourage this divide and conquer approach? The court never says, and readers are free to give their own answer. Mine would be that the public did not like being told which providers they could and could not use. Apparently, they felt strongly enough about this that state legislatures reacted to their concerns. In this instance, politicians turned out to be more responsive to “customer demand” than the insurance companies. Second, neither the public nor state legislatures believed that insurance premiums would be reduced, even if insurance companies succeeded in reducing their costs. Third, as another analyst pointed out, the economic reality is that many insurance companies are offering so little in the way of reim-
bursement that insurance companies feel lucky if they can find “any willing provider” to participate in their plans and do not often get the ability to discriminate against a willing provider when 2 or more providers are willing to participate.

But for CRNAs, the most important aspect of “any willing provider” legislation was the fact that it prohibited insurance companies from discriminating against them. At the height of the managed care movement, there was a lot of concern that insurance companies might push a great number of qualified willing providers out of the marketplace simply because some insurance executive was not sufficiently familiar with their qualifications or capabilities. Certified Registered Nurse Anesthetists become one of the beneficiaries of the case of Kentucky Association of Health Plans v Miller.