Supreme Court’s “Clean Break” Further Weakens ERISA Preemption of State Healthcare Regulation: Kentucky Association of Health Plans v. Miller Ramifications for Health Plans and Employers

By Eric R. Keller & Laura E. Bandini

Continuing its trend of narrowing ERISA preemption of state healthcare regulation,¹ the Supreme Court unanimously concluded earlier this month that ERISA does not prevent Kentucky from requiring health insurers and HMOs to accept any qualified doctor who wants to be a participating provider in the insurer’s or HMO’s managed care network.

Kentucky Association of Health Plans v. Miller, No. 00-1471.² Roughly half the states have these so-called “any willing provider laws.”

The remarkably brief Miller opinion is likely to enhance the ability of states to regulate insurers and HMOs by expanding the type of state laws that will escape ERISA preemption. The Court announced that it was making a “clean break” from its prior precedent applying factors under the McCarran-Ferguson Act³ and developing a new test for determining whether a state law “regulates insurance,” the characteristic essential for surviving ERISA preemption. Under the new test, a state law will be deemed to “regulate insurance,” and thus be saved from ERISA preemption, if (1) it is specifically directed toward entities engaged in insurance, and (2) it substantially affects the risk pooling arrangement between the insurer and the insured.

In addition, the opinion appears to distinguish between self-funded plans on the one hand and HMOs and insurers who administer self-funded plans on the other. ERISA prevents states from regulating self-funded employee benefit plans as insurers.

Thus, in a footnote to its opinion, the court acknowledged that the Kentucky law would not apply to self-funded employee benefit plans. In the same footnote, however, the court stated that Kentucky’s “any willing provider law” applied to HMOs, including those that only provide administrative services to self-insured plans.⁴ Accordingly, although a Kentucky employer that maintains a self-funded plan would be free to design a health plan that did not accept any willing provider, the Court’s opinion draws into question whether a Kentucky HMO could actually administer the self-funded plan on behalf of the employer in that fashion.⁵

From a practical standpoint, Miller is likely to erode further the ability of managed care arrangements to contain rising health care costs. Managed care networks are able to negotiate discounts from providers because, among other things, the networks offer member providers exclusive access to a large patient population. State laws that force managed care networks to accept any willing provider undermine networks’ ability to negotiate these discounts because they can no longer limit access to their patient population to a select number of providers.

Even before Miller, employers were looking beyond traditional managed care in favor of more innovative methods to contain health costs, such as defined contribution health plans, which usually involve a higher deductible indemnity type of coverage, accompanied by a health reimbursement account funded by employer contributions. After Miller, employers may have even more incentive to explore alternatives to traditional managed care arrangements.

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See e.g., Rush Prudential HMO, Inc. v. Moran, 122 S. Ct. 2151 (2002) (holding that an Illinois law providing participants in insured health plans and HMOs with the right to binding independent medical review of certain benefit claim denials was not preempted by ERISA).


Previously under the McCarren-Ferguson Act, the Court asked whether the practice at issue under the state law (i) had the effect of transferring or spreading a policyholder’s risk, (ii) was an integral part of the policy relationship between the insurer and the insured, and (iii) was limited to entities within the insurance industry. See id; UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999).

The Court made a similar statement in its Moran decision. See 122 S. Ct. at 2162-63, n.6.

The United States Court of Appeals for the Sixth Circuit concluded in dictum that Kentucky’s any willing provider law would not apply to an HMO to the extent that it was administering a self-insured plan. Kentucky Ass’n of Health Plans v. Nichols, 227 F.3d 352, 356 (6th Cir. 2000).