

Health Law Review

Growing Pains: Can Any Willing Provider Laws Overcome the Challenges of the Teenage Years?

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Any willing provider laws were first enacted in the late 1980's as a way to combat the exclusion of providers from insurer and Health Maintenance Organization (HMO) network panels. Generally, the laws provided that insurers and managed care organizations had to admit to their provider panels any provider who was willing to accept the entity's terms and conditions for participation. These laws face two significant challenges today: how to overcome Employee Retirement Income Security Act (ERISA) preemption and the fact that the legislatures either failed to put limits on the terms and conditions that could be imposed or did not define what reasonable terms and conditions were.

This article gives a basic overview of any willing provider laws, the ERISA statutory and case law that affects them, and the current problem of what terms and conditions im-

posed upon providers can be considered reasonable. It also summarizes many of the current any willing provider laws and notes which laws among those listed have been held by courts to be preempted by ERISA.

Efforts have been taken to make this article current and accurate; however, they should not be construed as legal advice or an opinion on specific situations. Because of the rapid pace with which these laws and the cases affecting them change, you should consult an attorney concerning the existence and validity of any willing provider and similar laws in your state.

Keywords: Any willing provider, freedom of choice, assignment, nondiscrimination, ERISA plans, ERISA preemption, terms and conditions

Historically, insurance companies and managed care organizations were not required to contract with every healthcare provider within their geographical service areas. Antitrust and other common theories used by providers to challenge exclusion from a network were generally unsuccessful. Beginning in the late 1980's, physicians and other healthcare providers successfully lobbied state legislatures for relief in the form of "any willing provider" laws (1).

Any willing provider laws can be viewed as a creative offshoot of the "essential facility" theory developed in the antitrust case law. Simply stated, healthcare providers perceive that access to payors' networks is essential to their ability to stay in business. Under antitrust case law prece-

dent, however, a provider in an essential facility case had to prove that the particular insurer or managed care organization that was excluding him or her had market power amounting to a monopoly, which was extremely hard to do, given the number of insurance companies and managed care organizations in existence. Any willing provider and similar laws, on the other hand, are based on the assumption that all the entities covered by the law, whether they are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), insurers, or non-profit hospital corporations, are essential facilities.

Most any willing provider laws limit an insurer's and/or a managed care plan's discretion to exclude providers (2). These laws have evolved into four permutations: (a) true any willing provider laws, which require the insurer/managed care organization to include in its network any provider willing to accept the terms and conditions imposed by the insurer/managed care organization (2), (b) freedom of choice laws, which mandate that an insured/covered person be allowed to utilize the provider of his or her choice (2), (c) assignment laws, which require insurers/managed care organizations to reimburse non-participating provid-

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ers (i.e., providers not admitted to the network) who have rendered services to an insured/covered person, who have a written assignment of benefits, and who have notified insurer/managed care organization of the assignment (1), and (d) nondiscrimination laws, which provide that insurers/managed care organizations cannot unfairly discriminate against a healthcare provider if the service provided is a covered service and is within the scope of the provider's license.

Table 1 summarizes current any willing provider laws of all four types, except that it excludes statutes relating solely to one or more of the following groups: chiropractors, dentists, pharmacists, nurse midwives, podiatrists, optometrists, and psychiatric services provided in psychiatric hospitals.

As Table 1 shows, insurers and managed care organizations have, with mixed success, used the federal Employee Retirement Income Security Act (ERISA) to challenge any willing provider laws. Three provisions of ERISA have been involved in the legal battles between insurers and managed care organizations on the one hand, and providers on the other: the preemption clause, the savings clause, and the deemer clause. ERISA's preemption clause supersedes state laws insofar as they relate to employee benefit plans, including plans offering health insurance (3). Some employee benefit plans are exempt from ERISA, most notably church plans and government plans. 29 U.S.C. § 1003(b). Consequently, state laws relating to employee benefit plans are preempted (i.e., rendered invalid and unenforceable), unless they fall within ERISA's savings clause, which provides, among other things, that state laws that regulate insurance are saved from preemption (4). Even laws that regulate insurance and are saved from preemption, however, cannot be applied to regulate self-insured plans because they may not be "deemed" to be insurance companies or to be engaged in the business of insurance (5).

Almost all the courts addressing whether ERISA preempts an any willing provider law have found that the law in question relates to an employee benefit plan, either because (a) the statute makes a direct reference to ERISA plans or (b) has a connection with employee benefit plans because it affects the benefits available, or both (6). The few laws that have escaped the preemption clause did so because they made no reference to ERISA plans or were worded in such a way that the courts could state that they did not operate directly on ERISA plans, and the courts found that the laws did not mandate the structure of benefit plans (7).

The real battleground in cases challenging the validity of any willing provider laws under ERISA has been whether the laws are considered to regulate insurance or not. If so, they are saved from ERISA preemption by the savings clause. Courts employ a two-part test to determine whether a state law regulates insurance. First, they ask whether, under a common sense view of the matter, the law regulates insurance. Second, they consider three factors employed to determine whether the law constitutes the "business of insurance" under the McCarran-Ferguson Act: (a) does the law have the effect of transferring or spreading the policyholder's risk; (b) is the practice an integral part of the policy relationship between the insurer and the insured; and (c) is the law limited to entities within the insurance industry. Under the common-sense test, courts look at whether the law regulates entities other than insurance companies. Of late, courts have been less willing to accept the argument that an HMO is fundamentally different from an insurance company, and if the statute has been carefully worded so that it does not regulate third-party administrators or ERISA plans, chances are that the law will pass the common-sense test as a law regulating insurance (8).

Courts also appear to be reading the McCarran-Ferguson factors more broadly than in the past. They have found that any willing provider laws affect the policyholder's risk, reasoning that whereas the insured/covered person might have to pay out of his or her own pocket to gain access to a provider in the absence of such a statute, the presence of such a statute spreads the cost component of the policyholder's risk among all the insureds by prohibiting the unreasonable restriction of providers. The second factor, courts have held, is met because the statutes effectively create a mandatory contract term by expanding the pool of providers from a closed to an open pool, thereby directly impacting the insurer-insured relationship. The third factor – the statute's limitation to entities within the insurance industry – will most likely be met if the court has already found that, under the common-sense test, the law does not regulate entities other than companies engaged in the business of insurance (8).

Given the wealth of case law that has developed on the subject, it should not be a difficult task at this stage for providers to craft any willing provider laws that would escape ERISA preemption or at least have a very good chance of doing so. Faced with the uncertainty of whether an ERISA preemption argument will be a winning one, many insurers and managed care organizations have turned

to the language of the statutes and developed “terms and conditions” that may be difficult for many providers to satisfy, thus effectively limiting their panel to a select group of providers (1). At least one state’s insurance department has issued an advisory opinion in which it set forth examples of acceptable terms and conditions (medical licensure, specialty board certification, medical malpractice history, valid DEA number, and hospital privileges) versus examples of unacceptable terms and conditions (required membership in a certain professional organization, professional enhancements, a medical degree from a particular university, a certain age, gender, race, sexual orientation or disability, and limiting the number of providers

in a provider category based on the determination that the insurer’s network is adequate) (9).

Whether any willing provider laws are of value to providers depends, then, on whether the laws themselves are carefully crafted so as to avoid, as much as possible, the risk of ERISA preemption, and whether insurers and managed care organizations will establish “reasonable” terms and conditions of participation. If significant court battles begin to ensue over what terms and conditions are reasonable, providers might want to return to the legislatures and ask them to amend the statutes to define what terms and conditions are *per se* unreasonable.

Table 1. Any willing provider and similar laws

ALABAMA

Type of Law: Ala. Code §27-1-19 Modified FOC/assignment provision

Which Providers Are Covered?: Healthcare providers, including physicians, dentists, pharmacists, podiatrists, chiropractors, optometrists, durable medical equipment, and home care providers.

Which Entities/Types of Policies Must Comply?: Persons, firms, corporations, associations, HMOs, health insurance service or preferred provider organizations, non-profit health service organizations, and employer sponsored health benefit companies providing health, accident, dental, or workers’ compensation insurance coverage.

Description: The contract providing coverage to an insured “may not exclude the right of assignment of benefits to any provider at the same benefit rate as paid to a contract provider.”

ALASKA

Type of Law: Alaska Stat. §21.36.090 Non-discrimination

Which Providers Are Covered?: Physicians, dentists, osteopaths, optometrists, chiropractors, nurse midwives, advanced nurse practitioners, naturopaths, physical therapists, occupational therapists, marital and family therapists, psychologists, psychological associates, or licensed clinical social workers, or certified direct-entry midwives.

Which Entities/Types of Policies Must Comply?: Companies that issue group health insurance policies that extend coverage on an expense incurred basis, and non-profit organizations that issue group service or indemnity type contracts.

Description: Entity may not practice or permit unfair discrimination against one of the providers listed if the service is covered by the policy in question and is within the scope of the provider’s license.

ARIZONA

Type of Law: A.R.S. §20-833 FOC

Which Providers Are Covered?: Hospitals, dentists, physicians, optometrists.

Which Entities/Types of Policies Must Comply?: Not-for-profit hospital, medical, dental, and optometric service corporations.

Description: Corporations covered by the statute cannot influence subscribers in the subscribers’ free choice of a hospital, physician, dentist, or optometrist other than to limit their benefits to participating hospitals, physicians, dentists and

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Sources: BNA’s Health Law & Business Portfolios No. 1000, Doc. 8 (2000); Vickie Yates Brown, “Provider Credentialing & Termination: What Works?” Paper presented at the 10th Annual Managed Care Law Conference (Apr. 1999); Current statutes and administrative regulations.

optometrists.

Type of Law: A.R.S. §20-1403 AWP

Which Providers Are Covered?: Hospitals, nurses, and physicians (might also be interpreted to include podiatrists, chiropractors, dentists, naturopaths, homeopathic physicians, dispensing opticians, optometrists, osteopaths, pharmacists, physical therapists, psychologists, physician assistants, radiological technologists, midwives, and hearing aid dispensers).

Which Entities/Types of Policies Must Comply?: Any group disability policy.

Description: Policy cannot require that services be rendered by a particular hospital or person.

Type of Law: A.R.S. §20-1406.02 FOC

Which Providers Are Covered?: Psychologists

Which Entities/Types of Policies Must Comply?: Group disability insurance contracts and blanket disability insurance contracts.

Description: If services are within the lawful scope of the practice of a psychologist, the subscriber may choose either a physician or a psychologist to render the services.

ARKANSAS

Type of Law: A.C.A. 23-99-204 AWP

Which Providers Are Covered?: Physicians and surgeons (M.D.'s & D.O.'s), podiatrists, chiropractors, physical therapists, speech pathologists, audiologists, dentists, optometrists, hospitals, hospital-based services, psychologists, licensed professional counselors, respiratory therapists, pharmacists, occupational therapists, long-term care facilities, home health care and hospice care, licensed ambulatory surgery centers, rural health clinics, licensed certified social workers, licensed psychological examiners, advanced practice nurses, licensed dietitians, community mental health centers or clinics, certified orthotists and prosthetists.

Which Entities/Types of Policies Must Comply?: Insurance companies, hospital and medical service corporations, HMOs, PPOs, PHOs, TPAs, and PBMs authorized to administer, offer or provide a health benefit plan.

Description: Covered entities must give health care providers listed the opportunity to participate in their plan if providers are willing to accept the plan's terms and conditions. The U.S. Court of Appeals for the Eighth Circuit ruled that Arkansas' any-willing-provider statute was preempted by ERISA. *Prudential Ins. Co. v. National Park Medical Ctr.*, 154 F.3d 812 (8th Cir. 1998).

Type of Law: A.C.A. 23-79-114 Non-discrimination/FOC

Which Providers Are Covered?: Physicians, chiropractors, optometrists, podiatrists, psychologists, dentists, CRNAs.

Which Entities/Types of Policies Must Comply?: Entities issuing individual or group policies for accident and health insurance or entities issuing policies, contracts, plans, or agreements for hospital or medical service or indemnity.

Description: The person entitled to benefits or the person performing the services is entitled to payment or reimbursement on an equal basis for the service if the policy, contract, plan, or agreement provides for payment or reimbursement for the service if provided by a physician; freedom of choice between physicians and optometrists, podiatrists, psychologists, dentists, or CRNAs.

DELAWARE

Type of Law: 18 Del. Code Ann. §3528 FOC

Which Providers Are Covered?: Hospitals, nurses, and physicians (medical or surgical services).

Which Entities/Types of Policies Must Comply?: Group health insurers.

Description: Policy cannot require that services be rendered by a particular hospital or person.

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Sources: BNA's Health Law & Business Portfolios No. 1000, Doc. 8 (2000); Vickie Yates Brown, "Provider Credentialing & Termination: What Works?" Paper presented at the 10th Annual Managed Care Law Conference (Apr. 1999); Current statutes and administrative regulations.

GEORGIA

Type of Law: Ga. Code Ann. 33-20-16 AWP

Which Providers Are Covered?: Physicians, dentists, podiatrists, health care providers.

Which Entities/Types of Policies Must Comply?: Health care corporations.

Description: Appropriately licensed providers who are reputable and in good standing shall have the right to become participating physicians or approved health care providers or both under terms or conditions imposed on other participating physicians or approved health care providers.

Type of Law: Ga. Code Ann. §33-30-25 AWP

Which Providers Are Covered?: Health care providers.

Which Entities/Types of Policies Must Comply?: Insurers, fraternal benefit societies, health care plans, nonprofit medical service or hospital corporations, or HMOs that are authorized to sell accident and sickness insurance contracts and that are offering preferred provider arrangements.

Description: Entities covered may impose “reasonable limits” on the number or classes of preferred providers that meet the entities’ standards. However, a covered entity must not discriminate on the basis of religion, race, color, national origin, age, sex, or marital or corporate status, and must give all licensed and qualified providers within a defined service area who satisfy the entity’s standards an opportunity to become a preferred provider.

Type of Law: Ga. Code Ann. §33-18-17 FOC

Which Providers Are Covered?: Physicians, dentists and podiatrists.

Which Entities/Types of Policies Must Comply?: Not-for-profit medical service corporations.

Description: Contracts issued by corporations cannot limit freedom of choice with the respect to the providers covered.

Type of Law: Ga. Code Ann. §33-18-18 AWP

Which Providers Are Covered?: Physicians, dentists, podiatrists.

Which Entities/Types of Policies Must Comply?: Not-for-profit medical service corporations.

Description: Physicians, dentists, and podiatrists licensed to practice in Georgia who are reputable and in good standing shall have the right to become a participating physician in the medical service corporation operating in the county in which s/he resides or practices, under such terms and conditions as are imposed on other participating physicians under similar circumstances.

Type of Law: Ga. Code Ann. §33-24-54 Modified FOC/assignment

Which Providers Are Covered?: Non-participating or non-preferred providers, including physicians, pharmacists, dentists, chiropractors, optometrists, physician assistants, podiatrists, acupuncturists, and psychologists.

Which Entities/Types of Policies Must Comply?: Entities issuing/administering accident and sickness insurance policies, subscriber contracts or self-insured health benefit plans.

Description: Entities issuing accident and sickness insurance policies, subscriber contracts, or self-insured health benefit plans that provide benefits payable to participating or preferred providers shall be required to pay benefits either directly to licensed non-participating or non-preferred providers who have rendered health care services, have a written assignment of benefits, and have given written notice of such assignment to the entity or jointly to such non-participating or non-preferred providers and to the insured, subscriber, or other covered person.

IDAHO

Type of Law: Idaho Code §41-3927 AWP

Which Providers Are Covered?: Health care providers.

Which Entities/Types of Policies Must Comply?: Managed care organizations.

Description: Organizations issuing benefits must be willing to contract with all qualified providers who meet the require-

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ments of the organization, practice within the general area served by the organization, wish to become participating providers, and are qualified to practice under Idaho law.

Type of Law: Idaho Code §41-2872 AWP

Which Providers Are Covered?: Health care providers.

Which Entities/Types of Policies Must Comply?: Stock or mutual insurers.

Description: Insurers issuing benefits must be willing to contract with all qualified providers who meet the requirements of the insurer, practice within the general area served by the insurer, wish to become participating providers, and are qualified to practice Idaho law.

Type of Law: Idaho Code §41-3408 AWP

Which Providers Are Covered?: Chiropractors, dentists, optometrists, osteopaths, pharmacists, physicians, and podiatrists.

Which Entities/Types of Policies Must Comply?: Hospital and professional service corporations (provide all or part of one or more health care services for prepayments).

Description: Corporation must be willing to contract with designated providers who are qualified to practice under Idaho law, who desire to become participant licensees, and who practice within the general area served by the corporation.

ILLINOIS

Type of Law: 215 Ill. Comp. Stat. 5/370h AWP

Which Providers Are Covered?: Noninstitutional providers (persons licensed under Medical Practice Act).

Which Entities/Types of Policies Must Comply?: Insurance companies, health service corporations, and administrators.

Description: Entities regulated must be willing to contract with any noninstitutional providers who meet the established terms and conditions. The terms and conditions may not “discriminate unreasonably against or among noninstitutional providers.”

INDIANA

Type of Law: Ind. Code §27-8-11-3 AWP

Which Providers Are Covered?: Hospitals, physicians, pharmacists, dentists, psychologists, podiatrists, osteopaths, optometrists, chiropractors.

Which Entities/Types of Policies Must Comply?: Insurers.

Description: Hospitals, physicians, pharmacists, and other providers who agree to comply with established terms and conditions cannot be denied the right to enter into contracts with insurers for the provision of healthcare services. Terms and conditions established by insurers may not “discriminate unreasonably against or among providers.”

KENTUCKY

Type of Law: KRS 304.17A-270 AWP

Which Providers Are Covered?: Facilities or services required to be licensed under KRS 216B, pharmacists, physicians, osteopaths, podiatrists, chiropractors, dentists, optometrists, physician assistants, nurse practitioners, and other health care practitioners as determined by administrative regulations promulgated under KRS Chapter 13A.

Which Entities/Types of Policies Must Comply?: Health insurers (insurance companies, HMOs, self-insurer or MEWA not exempt from state regulation by ERISA, provider-sponsored integrated health delivery network, self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation).

Description: “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

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health insurer, including the Kentucky State Medicaid program and Medicaid partnerships.” The Sixth Circuit has found that this statute regulates insurance and is therefore saved from ERISA preemption. *Kentucky Ass’n of Health Plans v. Nichols*, 227 F.3d 352 (6th Cir. 2000).

LOUISIANA

Type of Law: La. Rev. Stat. Ann. §40:2202(5) AWP

Which Providers Are Covered?: Individuals or groups of physicians, individuals or groups of psychologists, nurse midwives, ambulance service companies, and other health care entities.

Which Entities/Types of Policies Must Comply?: Group purchasers (organization or entity that contracts with providers for the purpose of establishing a preferred provider organization).

Description: “No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health services within the limits of his or her license. However, nothing in this Part shall be construed to require any hospital to grant any provider or class of providers medical staff membership.” In *Cigna Healthplan of La. v. Louisiana*, 82 F.3d 642 (5th Cir.), cert. denied, 519 U.S. 964 (1996), the court held that ERISA preempts the Louisiana statute insofar as it relates to third-party administrators and health care plans that provide services to ERISA-qualified benefit plans.

Type of Law: La. Rev. Stat. Ann. §40:1300.145 (Rural Hospital Preservation Act) AWP

Which Providers Are Covered?: Rural hospitals and physicians practicing in such hospitals.

Which Entities/Types of Policies Must Comply?: Managed care organizations including but not limited to HMOs, PPOs, and other entities authorized by law to bear risk for the payment of health care services.

Description: Managed care organizations must “offer rural hospitals and hospitals located in parishes with a population of sixty-five thousand or less, and physicians practicing at such hospitals, participation as providers in the managed care organizations on terms and conditions that are no more restrictive than [those] applicable to other hospitals and physicians practicing at such hospitals.”

MICHIGAN

Type of Law: M.C.L.A. §500.3529 Non-discrimination

Which Providers Are Covered?: Health professionals.

Which Entities/Types of Policies Must Comply?: HMOs.

Description: HMOs may contract with or employ health professionals on the basis of cost, quality, availability of services to the membership, conformity to the administrative procedures of the HMO, and other factors relevant to delivery of economical, quality care, but shall not discriminate solely on the basis of the class of health professionals to which the health professional belongs.

MINNESOTA

Type of Law: Minn. Stat. §62Q.095 AWP

Which Providers Are Covered?: Allied independent health providers (independently enrolled audiologists, chiropractors, dietitians, home health care providers, licensed marriage and family therapists, nurse practitioners or advanced practice nurses, occupational therapists, optometrists, opticians, outpatient chemical dependency counselors, pharmacists (not employed by or based on the premises of the health plan company), physical therapists, podiatrists, licensed psychologists, psychological practitioners, licensed social workers, speech therapists).

Which Entities/Types of Policies Must Comply?: Health plan companies, except any health plan company with 50,000 or fewer enrollees and those exempt under subdivision 6. (Subdivision 6 exempts staff-model health plan companies as defined in §295.50, subdivision 12b.) Health plan companies include insurance companies, nonprofit health service plan corporations, HMOs, fraternal benefit societies, joint self-insured employee health plans, integrated service networks, and

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community integrated service networks.

Description: Health plan company must “establish an expanded network of allied independent health providers, in addition to a preferred network.” For acceptance into the expanded network, a provider must (1) meet the company’s credentialing standards; (2) agree to the terms and requirements of the company’s provider agreement and (3) agree to adhere to the “managed care protocols” of the health plan company.

MISSISSIPPI

Type of Law: Miss. Code §83-41-417 AWP

Which Providers Are Covered?: Health care providers.

Which Entities/Types of Policies Must Comply?: HMOs and managed care entities.

Description: HMOs and managed care entities must establish procedures to give interested health care providers located in the geographic area served an opportunity to apply for participation.

Type of Law: Miss. Code §83-41-211 FOC

Which Providers Are Covered?: Psychologists, licensed professional counselors, and licensed clinical social workers.

Which Entities/Types of Policies Must Comply?: Insurance policies, medical service plans, hospital service contracts, or hospital and medical service contracts that provide for reimbursement for any diagnosis and treatment of mental, nervous or emotional disorders only.

Description: Insured is entitled to reimbursement for services rendered by duly licensed physician or by duly licensed psychologist, professional counselor, or clinical social worker provided that the diagnosis and treatment is within the lawful scope of practice of the licensee.

MONTANA

Type of Law: Mont. Code Ann. §33-22-1704 AWP

Which Providers Are Covered?: Health care providers.

Which Entities/Types of Policies Must Comply?: Health care insurers (insurer that provides disability coverage, a health service corporation, a fraternal benefit society, and any other entity providing health coverage except an HMO) entering into preferred provider agreements.

Description: A preferred provider agreement must provide all healthcare providers with the opportunity to participate on the basis of a competitive bid or offer.

NEW MEXICO

Type of Law: NMS §59A-22-32 FOC

Which Providers Are Covered?: Hospitals, physicians, optometrists, psychologists, podiatrists, certified nurse-midwives, registered lay midwives, or registered nurses in expanded practice, chiropractors, dentists, osteopaths, acupuncturists.

Which Entities/Types of Policies Must Comply?: Health insurance policies, contracts, or health care plans.

Description: Insured shall have full freedom of choice in the selection of the covered providers within the area and limits of coverage offered.

NEW YORK

Type of Law: New York Insurance Code §4235 FOC

Which Providers Are Covered?: Physical therapists, podiatrists, optometrists, dentists, licensed health professionals, speech-language pathologists or audiologists, psychiatrists or psychologists, and chiropractors.

Which Entities/Types of Policies Must Comply?: Group accident, group health or group accident and health insurance.

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Sources: BNA’s Health Law & Business Portfolios No. 1000, Doc. 8 (2000); Vickie Yates Brown, “Provider Credentialing & Termination: What Works?” Paper presented at the 10th Annual Managed Care Law Conference (Apr. 1999); Current statutes and administrative regulations.

Description: Subscribers shall be entitled to reimbursement whether a service is performed by a physician or one of the covered providers.

OKLAHOMA

Type of Law: Okla. Stat. tit. 36, §3634 FOC

Which Providers Are Covered?: Podiatrists, psychologists, licensed and certified clinical social workers.

Which Entities/Types of Policies Must Comply?: Health insurers.

Description: Beneficiaries may select any licensed/qualified practitioner to perform podiatry services, psychological services, or licensed and certified clinical social work services covered by an insurance policy, provided that in the case of a PPO, the podiatrist, psychologist, or clinical social worker is a contracting provider.

Type of Law: Okla. Stat. tit. 36, §6055 FOC

Which Providers Are Covered?: Health care practitioners.

Which Entities/Types of Policies Must Comply?: Accident and health insurance policies.

Description: Insured may select practitioners to perform service as long as the service falls within the licensed scope of practice of the practitioners.

RHODE ISLAND

Type of Law: R.I. Gen. Laws §23-17.13-3 modified AWP

Which Providers Are Covered?: Health care providers.

Which Entities/Types of Policies Must Comply?: Health plans.

Description: (c) Issuance of certification—(7) A health plan shall not exclude a provider of covered services from participation in its provider network based solely on: (a) The provider's degree or license as applicable under state law; or (b) The provider's lack of affiliation with, or admitting privileges at a hospital, if such lack of affiliation is due solely to the provider's type of license.

SOUTH DAKOTA

Type of Law: SDCL §58-17-54 modified FOC

Which Providers Are Covered?: Physicians, CRNAs, psychologists, dentists, osteopaths, licensed social workers, optometrists, chiropractors, podiatrists, physician assistants, advanced life support personnel, respiratory care practitioners, dental hygienists, registered and practical nurses, and nurse practitioners and midwives.

Which Entities/Types of Policies Must Comply?: Health insurance policies and contracts.

Description: Reimbursement may not be denied for a covered service it is rendered by a provider that is covered by the statute.

TEXAS

Type of Law: Tex. Ins. Code Ann. §20A.14(g), (h) FOC/AWP (see also 28 TAC §11.1402)

Which Providers Are Covered?: Health care providers.

Which Entities/Types of Policies Must Comply?: Health maintenance organizations.

Description: (g) Licensed providers or providers otherwise authorized to practice in Texas who comply with terms and conditions set by an HMO may not be denied participation "on the sole basis of type of license or authorization." (h) HMOs shall provide a 20-day period during each year in which providers or physicians in the geographic service area may apply to participate in providing health care services.

Type of Law: 28 TAC §3.3704 FOC

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Which Providers Are Covered?: Hospitals, physicians and practitioners.

Which Entities/Types of Policies Must Comply?: Preferred provider benefit plans.

Description: Plan cannot require that a service be rendered by a particular hospital, physician, or practitioner. Insureds must be provided with reasonable access to all classes of physicians and practitioners licensed to treat illness or injuries and to provide services covered by the plan. The insurer cannot restrict the rights of an insured to exercise full freedom of choice in the selection of a physician or a provider.

UTAH

Type of Law: Utah Code Ann. §31A-22-617 AWP

Which Providers Are Covered?: Health care providers (defined in §78-14-3 as hospitals, physicians, registered nurses, licensed practical nurses, nurse-midwives, dentists, dental hygienists, optometrists, clinical laboratory technologists, pharmacists, physical therapists, podiatrists, psychologists, chiropractic physicians, naturopathic physicians, osteopathic physicians and surgeons, audiologists, speech-language pathologists, clinical social workers, certified social workers, social service workers, marriage and family counselors, practitioners of obstetrics or others rendering similar care or services)

Which Entities/Types of Policies Must Comply?: Insurers, third-party administrators.

Description: Insurers cannot unfairly discriminate between classes of providers. Insurers must allow providers to apply for and be designated as preferred providers if they agree to meet established terms and conditions. Nevertheless, “reasonable limitations” may be placed on the number of designated preferred providers based on substantial economic grounds, or expected use of particular services based on prior provider-patient profiles.

VIRGINIA

Type of Law: Va. Code Ann. §38.2-3407 AWP

Which Providers Are Covered?: Hospitals, physicians, chiropractors, optometrists, opticians, professional counselors, psychologists, clinical social workers, podiatrists, physical therapists, chiropodists, clinical nurse specialists, audiologists, speech pathologists, certified nurse midwives, acupuncturists.

Which Entities/Types of Policies Must Comply?: Insurers offering or administering preferred provider policies or contracts that limit the providers eligible for payment as preferred providers.

Description: Insurers shall establish terms and conditions that must be met in order to receive payment as a preferred provider. The terms and conditions “shall not discriminate unreasonably against or among such health care providers.” Insurers must not exclude any hospital, physician, or other type of provider listed who is willing to meet the terms and conditions. The U.S. Court of Appeals for the Fourth Circuit found that Va. Code Ann. §38.2-3407 regulates the business of insurance and thus escapes preemption by ERISA. *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), cert. denied, 510 U.S. 1003 (1993).

Type of Law: Va. Code Ann. §38.2-4209 modified AWP

Which Providers Are Covered?: Hospitals, physicians, other health care providers (podiatrists, chiropodists, optometrists, opticians, chiropractors, professional counselors, psychologists, physical therapists, clinical social workers, clinical nurse specialists who render mental health services, certified nurse midwives, acupuncturists, audiologists or speech pathologists).

Which Entities/Types of Policies Must Comply?: Non-stock corporations.

Description: Providers who are willing to accept established terms and conditions may qualify for payment under preferred provider subscription contracts.

WASHINGTON

Type of Law: RCWA 48.43.045 AWP

Which Providers Are Covered?: Health care providers.

AWP = Any Willing Provider Law FOC = Freedom of Choice Law This table excludes statutes relating solely to one or more of the following groups: chiropractors, dentists, pharmacists, nurse midwives, podiatrists, optometrists, and psychiatric services provided in psychiatric hospitals.

Sources: BNA's Health Law & Business Portfolios No. 1000, Doc. 8 (2000); Vickie Yates Brown, “Provider Credentialing & Termination: What Works?” Paper presented at the 10th Annual Managed Care Law Conference (Apr. 1999); Current statutes and administrative regulations.

Which Entities/Types of Policies Must Comply?: All health plans.

Description: All health plans must permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that the provision of such health services or care is within the health care providers' permitted scope of practice and the providers agree to abide by standards related to the provision, utilization review, and cost containment of health services, management and administrative procedures, and provision of cost effective and clinically efficacious health services. The Ninth Circuit has held that this law is not preempted by ERISA. *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), cert. denied, 525 U.S. 1141 (1999).

WISCONSIN

Type of Law: W.S.A. 628.36 FOC/AWP

Which Providers Are Covered?: Health care professionals, health care facilities, health care services and organizations.

Which Entities/Types of Policies Must Comply?: Health care plans, except for HMOs, PPOs, and limited service health organizations.

Description: Plans may not prevent any person covered 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. No provider may be denied the opportunity to participate in a health care plan other than an HMO, a limited service health organization or a preferred provider plan, except for cause related to malpractice.

WYOMING

Type of Law: Wyo. Stat. §26-22-503 AWP

Which Providers Are Covered?: Providers.

Which Entities/Types of Policies Must Comply?: Groups, insurers.

Description: Groups or insurers must grant any provider willing to meet the established requirements the right to enter into contracts relating to health care services.

Type of Law: Wyo. Stat. §26-34-134 AWP

Which Providers Are Covered?: Providers (any physician, hospital, HMO, or other person licensed or otherwise authorized to furnish health care services in the state in which the services are rendered).

Which Entities/Types of Policies Must Comply?: HMOs.

Description: Providers willing to meet an HMO's established terms shall not be denied the right to contract with the HMO. ("This subsection shall not be construed to require any health maintenance organization to involuntarily employ any person....") An HMO may not discriminate against a provider on the basis of the provider's academic degree.

AWP = Any Willing Provider Law FOC = Freedom of Choice Law This table excludes statutes relating solely to one or more of the following groups: chiropractors, dentists, pharmacists, nurse midwives, podiatrists, optometrists, and psychiatric services provided in psychiatric hospitals.

Sources: BNA's Health Law & Business Portfolios No. 1000, Doc. 8 (2000); Vickie Yates Brown, "Provider Credentialing & Termination: What Works?" Paper presented at the 10th Annual Managed Care Law Conference (Apr. 1999); Current statutes and administrative regulations.

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- tional Park Med. Center, Inc.*, 154 F.3d 312 (8th Cir. 1998); *Texas Pharmacy Ass'n v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir.), *cert. denied*, 522 U.S. 820 (1997); *CIGNA Healthplan of Louisiana, Inc. v. Louisiana ex rel. Ieyoub*, 82 F.3d 642 (5th Cir.), *cert. denied*, 519 U.S. 964 (1996); *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993).
7. *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998); *cert. denied*, 525 U.S. 1141 (1999); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.* 973 F. Supp. 60 (D. Mass. 1997).
8. *Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000); *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998); *cert. denied*, 525 U.S. 1141 (1999); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.* 973 F. Supp. 60 (D. Mass. 1997).
9. Kentucky Department of Insurance Advisory Opinion 99-108.