

# COMMENTS

## Every Category of Provider: Hindsight Is 20/20 Vision

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### INTRODUCTION

"In Johann Wolfgang von Goethe's 'Faust,' the title character asks the devil for good health. The devil replies:

All right, you need no sorcery  
And no physician and no dough.  
Just go into the fields and see  
What fun it is to dig and hoe;  
Live simply and keep all your thoughts  
On a few simple objects glued;  
Restrict yourself and eat the plainest food.  
That is the surest remedy:  
At 80, you would still be young."<sup>1</sup>

Wouldn't it be nice if the recipe for maintaining good health was that simple? For many Americans, in addition to a healthy diet and regular exercise, striving for and maintaining good health includes (contrary to what Goethe's devil says) regular visits to a physician. For others, maintaining good health may consist of a visit to their massage therapist, chiropractor, acupuncturist, naturopathic physician,

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1. Mary Elizabeth Cronin, *A Simple Regimen You Can Live With—Weil's Latest Book Continues on the Natural Path to Wellness*, THE SEATTLE TIMES, May 7, 1997, at E1.

or other "nontraditional" or alternative health care provider. "To each his or her own," right? Wrong. A dilemma always arises with the provision of health care services: Americans want to choose their health care providers and they want their health insurance to cover visits to any of those providers. This problem is especially acute in the area of natural medicine, or alternative care.

Americans by the millions are turning to nontraditional or alternative means for medical treatment.<sup>2</sup> Alternative medicine, once considered quackery, is rapidly taking root.<sup>3</sup> According to a 1993 study in the *New England Journal of Medicine*, nearly one-third of all Americans have at least once sought some form of alternative medical treatment.<sup>4</sup> This alternative medical treatment came from those who have been compared to the likes of "snake oil salesmen" or "crack-pots."<sup>5</sup> Nowhere is alternative medicine becoming more a part of mainstream medicine than in Washington state.<sup>6</sup>

As an example, in early 1996, the King County Council voted unanimously to establish the nation's first government-subsidized natural medicine clinic, "in which diet, exercise, vitamins and treatments like acupuncture take precedence over drugs and the tools of conventional medicine."<sup>7</sup> Also in early 1996, the state of Washington began requiring health insurers to cover treatments like acupuncture, massage therapy, and other forms of licensed natural health care.<sup>8</sup> It is important to note that "licensed natural health care" means something different in Washington than it does in other states: Washington is one of only ten states that licenses naturopathic doctors.<sup>9</sup> Contrast this with New York, which does not license naturopaths, and with California, where the Legislature has refused to allow naturopaths to rise to the status of licensed practitioners, a far cry from forcing insurers to pay for naturopaths' services.<sup>10</sup> Unlike the government-subsidized natural medicine clinic, the mandate

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2. See Timothy Egan, *Seattle Area Giving Natural Medicine a Chance to Come in From the Fringe*, THE NEW YORK TIMES, January 3, 1996, at A10.

3. See *id.*

4. See *id.*

5. See Larry Stemp, D.C., Editorial, *Alternative Care Isn't Problem—And Could Be Part of Solution*, THE NEWS TRIBUNE, September 16, 1996, at A9.

6. See Egan, *supra* note 2.

7. *Id.*; see also Tom Philp, *Shotgun Wedding Up North*, SACRAMENTO BEE, June 2, 1996, at A10.

8. See Egan, *supra* note 2.

9. *Id.*

10. Egan, *supra* note 2; Philp, *supra* note 7.

requiring insurers to cover "Every Category of Provider," has been steeped in controversy.<sup>11</sup>

The controversy began on December 19, 1995,<sup>12</sup> when the Office of the Insurance Commissioner (OIC) issued a Bulletin<sup>13</sup> to provide guidance to disability insurers,<sup>14</sup> health care services contractors,<sup>15</sup> and health maintenance organizations<sup>16</sup> on the OIC interpretation of title 48, chapter 43, section 45 of the Washington Revised Code, referred to as the "Every Category of Provider" statute.<sup>17</sup> The interpretation, or policy statement, that was presented in the Bulletin

11. See WASH. REV. CODE § 48.43.045 (1996). The statute is entitled "Health Plan Requirements—Annual Reports." *Id.* For purposes of this Comment, the statute will be referred to as "Every Category of Provider" which is taken directly from language included in the statute. See *id.*

12. Actually, the controversy began in 1993 with the passage of global health care reform in 1993. See discussion *infra* Part I. For purposes of this Note, however, "controversy" refers to the events giving rise and leading up to the litigation between the Office of the Insurance Commissioner and health insurers.

13. See Bulletin No. 95-9, issued Dec. 19, 1995 by Deborah Senn, Insurance Commissioner.

14. WASH. REV. CODE § 48.44.010 (12) (1996). Disability insurers are the entities responsible for the payment of health benefits or provision of health care services under a group or individual health insurance contract. See *id.*

15. WASH. REV. CODE § 48.44.010 (3) (1996). Health care service contractors are defined as:

any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services.

*Id.*

16. WASH. REV. CODE § 48.46.020 (1996). Health maintenance organizations are defined as:

any organization receiving a certificate of registration by the commissioner under this chapter which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis . . . either directly or through contractual or other agreements with other institutions, entities, or persons, and which qualifies as a health maintenance organization. . . .

*Id.*

17. WASH. REV. CODE § 48.43.045 states in pertinent part:

Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:

(1) 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:

(a) The provision of such health services or care is within the health care providers' limited scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost effective and clinically efficacious health services.

*Id.*

and subsequently in a Declaratory Order,<sup>18</sup> unleashed a mass of litigation as disability insurers, health care services contractors (HCSCs), and health maintenance organizations (HMOs) sued Deborah Senn, Insurance Commissioner of the State of Washington.<sup>19</sup>

In essence, the Bulletin and the subsequent Declaratory Order interpreting the statute required "every health plan<sup>20</sup> delivered, issued for delivery, or renewed on or after January 1, 1996," to include all categories of providers in every health plan.<sup>21</sup> What this meant for disability insurers, HCSCs, and HMOs was that they had to include every category of alternative health care provider<sup>22</sup> within their health insurance benefits packages.<sup>23</sup> Health insurance policy holders were thereby given an option to select alternative types of providers, as well as traditional medical providers, to treat their health conditions.

In the first lawsuit filed against Senn, the plaintiffs made three allegations: (1) the Bulletin is a rule issued in violation of the Administrative Procedure Act;<sup>24</sup> (2) the Bulletin is contrary to and exceeds the scope of the statute on which it is based; and (3) the Bulletin's application of title 48, chapter 43, section 45 of the Washington Revised Code to every health plan issued in the state renders it preempted by the federal Employee Retirement Income Security Act (ERISA).<sup>25</sup>

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18. See Declaratory Order G96-13, issued on August 21, 1996 by Deborah Senn, Insurance Commissioner. The Declaratory Order reiterated and expanded upon the Insurance Commissioner's position as described in Bulletin 95-9.

19. See *Blue Cross of Washington and Alaska v. Senn*, No. 96-2-00137-3 (Wash. Super. Ct., Thurston County filed Jan. 8, 1996) (eleven health insurance carriers joined Blue Cross of Washington and Alaska in the lawsuit); *Washington Physician Service Ass'n v. Gregoire*, 967 F. Supp. 424 (W.D. Wash. 1997) (eleven health insurance carriers joined Washington Physician Service Ass'n in the lawsuit).

20. Health plan "means any policy, contract, or agreement offered by a Health Carrier to provide, arrange, reimburse, or pay for health care services except . . . (i) Employer-sponsored, self-funded plans." WASH. REV. CODE § 48.43.005(9) (1996).

21. See Bulletin 95-9, *supra* note 13, at 1; Declaratory Order, *supra* note 18, at 2.

22. Alternative health care providers are found and included in title 18, chapter 120, section 020(4) of the Washington Revised Code. The statute includes, among others, licensed massage therapists, chiropractors, naturopaths, and acupuncturists. WASH. REV. CODE § 18.120.020(4). See also Bulletin 95-9 (3) which states, "[i]f a health plan covers rehabilitation therapy, that service must be covered whether treatment is rendered by an osteopathic physician, chiropractor, a registered therapist, or a licensed massage therapist. . . ." Bulletin 95-9, *supra* note 13, at 1-2.

23. See Bulletin 95-9, *supra* note 13, at 1; see also Declaratory Order, *supra* note 13, at 2.

24. WASH. REV. CODE § 34.05 (1996).

25. See Brief of Plaintiff in Support of Motion for Summary Judgment, *Blue Cross of Washington and Alaska v. Senn*, No. 96-2-00137-3, at 2 (Wash. Super. Ct., Thurston County, 1996) [hereinafter *Blue Cross Brief*] (on file with the *Seattle University Law Review*). See also 29 U.S.C. § 1001 et seq.

A Thurston County Superior Court judge ruled on April 8, 1996, that the Insurance Commissioner acted within her authority in issuing the Bulletin which interpreted the "Every Category of Provider" requirements.<sup>26</sup> The judge further ruled that the Bulletin was not a rule, that Senn did not exceed her authority in issuing the Bulletin, and that the plaintiffs had to exhaust their administrative remedies in challenging Senn's action before filing a lawsuit.<sup>27</sup> The ERISA challenge, which focused on the language of the statute and its interpretation, was moved to federal district court.<sup>28</sup> There, the federal judge overturned the statute, holding that the law was rendered preempted under ERISA.<sup>29</sup> The insurance commissioner has appealed the ruling.<sup>30</sup>

What is troubling about the statute, its interpretation, and the litigation is that the policies underlying the initial legislation have been lost in the battles between the Insurance Commissioner and insurers. The "Every Category of Provider" statute was public interest legislation asking insurance carriers to include, while giving policyholders a choice of, alternative care providers. As a result of the Insurance Commissioner's interpretory mandate, and what was probably the proverbial "straw that broke the insurers' back,"<sup>31</sup> Washingtonians have lost statutory support for consumer choice. The unfortunate outcome is that Commissioner Senn, in issuing the mandate, ultimately harmed the consumers she so vehemently fights to protect.<sup>32</sup>

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26. *Judge Upholds Commissioner's Authority to Issue Alternative Provider Bulletin*, HEALTH CARE DAILY REP. (BNA), April 15, 1996, at D-7.

27. *See id.*

28. *See Washington Physician Service Ass'n v. Gregoire*, 967 F. Supp. 424 (W.D. Wash. 1997).

29. On May 2, 1997, United States District Judge Franklin D. Burgess issued an order granting the plaintiffs' motion for summary judgment. *See Order Granting Plaintiffs' Motion for Summary Judgment and Denying Defendants' Cross, Motion for Summary Judgment*, Washington Physician Service Ass'n v. Gregoire, 967 F. Supp. 424 (W.D. Wash. lawsuit filed Sept. 19, 1996; Order granted May 2, 1997) (No. C96-5850FDB) (on file with the *Seattle University Law Review*); *see also* discussion *infra* Part III.

30. *See Washington: Some Insurers Continue Covering Alternative Providers Despite Ruling*, HEALTH CARE DAILY REP. (BNA), September 15, 1997, at D-10.

31. There have been many battles fought between Commissioner Senn and the insurance industry. Some of those disagreements have been over insurers' attempts at rate increases for individual health-care policyholders, medical coverage rates, pollution claims rules, and industry tax write-offs. *See* William DiBenedetto, J. OF COM., March 13, 1996, at A9; *see also* Peter Neurath, *Insurers Again Challenge Senn's Health-Care Actions*, PUGET SOUND BUS. J., Jan. 12, 1996, at sec. 1, p. 5.

32. *See* Lynne K. Varner, *Senn's Reforms Drawing GOP Fire—Rivals Target Rise in Insurance*, THE SEATTLE TIMES, September 8, 1996, at B1 (stating that Senn's initial platform when she ran in 1992 was based on popular consumer-activism; that platform remains her main focus).

In addition, the insurers look like the "bad guys" and appear unsupportive of alternative care and third-party reimbursement for that care. Nothing, however, could be further from the truth.<sup>33</sup> At the time the statute was passed, before issuance of the Bulletin, insurers were trying to figure out how much the newly-authorized services would cost and how to reimburse them.<sup>34</sup> The insurers already had reason to study these services because they had obtained data showing that Washingtonians were spending approximately \$475 million each year out of their own pockets for alternative medicine treatments.<sup>35</sup> As a result of those out-of-pocket expenses, consumers began demanding third-party reimbursement of those services.<sup>36</sup> Insurers understood that the public interest legislation, combined with consumer demand, required action. Rather than ignoring these market forces,

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33. See Tom Paulson, *Insurance Soon To Go Alternative; New Law Will Cover Natural Therapies*, THE HOUSTON CHRONICLE, December 16, 1995, at A22 (citing examples showing Washington health insurance carriers looking at the option of creating an alternative care benefit).

The examples include: a pilot program offered by Blue Cross of Washington and Alaska called "Alternapath," in which the company offered separate insurance for certain alternative therapies; a system whereby subscribers of King County Medical Blue Shield's [now called "Regence"] managed-care programs are allowed to be treated by alternative providers, including massage therapists, acupuncturists, and naturopaths serving as either primary-care physicians or specialists; and similar options under consideration by Group Health Cooperative of Puget Sound and Providence Health Plans. See Paul J. Lim and Susan Byrnes, *Insurers Begin to Cover Alternative Care*, THE SEATTLE TIMES, December 13, 1995, at E1.

34. Discussion with Jill Mehner, Director of Medical Services for Health Washington, May 7, 1997 (her responsibilities include negotiating contracts between Health Washington, (a "health carrier") and providers). "The standard reimbursement for medical services rendered is generally based on CPT [current procedural terminology] codes and submitted on a universal billing statement. These codes tell us [the insurance company] what services were provided by the licensed professionals." *Id.* For example, "we might receive a claim with three CPT codes which would explain, 1) the patient was new to that provider, 2) the patient had an x-ray, and 3) the patient had a lab test." *Id.*

"This billing practice is not typical for most allied [alternative care] professionals. A massage therapist, for example, might submit a billing statement, not the standard universal form, for a one hour massage." *Id.* The problem with this, "is that we have no way to interpret what that means [in our standard CPT language] so that we can reimburse the provider. A massive education process is necessary so that common billing terminology and practices are understood." *Id.*

35. See John Weeks, *Marrying the Medicines After Rocky Start, Experiment in Holistic Care Proving Workable*, THE SEATTLE TIMES, April 6, 1997, at Post-Intelligencer Focus, F1.

36. This is anecdotal information taken from the author's experience of providing information to health plan subscribers at "open enrollment" meetings. Open enrollment takes place once each year for those individuals enrolled in an employer or government-sponsored health plan.

At meetings during the 1995 and 1996 plan years, employees, some from the Northwest's largest corporations, as well as Washington state employees, asked why alternative care was not included in their health benefit packages.

insurers began to research and test ways in which they might cover various treatments.<sup>37</sup>

Another factor compounding the insurers' issue of how to provide coverage for alternative care services in a manner consistent with market demand, is that both health insurers and traditional health providers have had a clear bias against any form of alternative care.<sup>38</sup> Stories making the rounds, for example, told of chiropractors treating liver disease and cancer<sup>39</sup> and of gullible consumers being duped into paying for unnecessary treatments.<sup>40</sup> Insurers, traditional providers, and alternative care providers had to come to some mutual understanding to bridge their different cultures and distinct orientations.<sup>41</sup> "One is high-tech, the other human-intensive. One focuses on attacking disease and microbes with drugs and surgeries, the other on restoring and promoting health through physical therapies, therapeutic nutrition and patient-centered initiatives."<sup>42</sup> The two worlds could not be farther apart. And, just as the two groups were beginning to build the bridge between them, the OIC issued the interpretory mandate enforcing the statute, and the subsequent litigation overturned and preempted both the statute and its interpretation.<sup>43</sup> Unfortunately "the relationship got sidetracked by the litigation."<sup>44</sup>

True, the relationship may have been sidetracked, but it is not completely off course. What is so ironic about this whole process, i.e., statute passage, statute interpretation, litigation, and ultimate preemption, is that all of the aforementioned parties continue to work toward an integrated health care system that provides access to treatments by all licensed providers.<sup>45</sup> The creation of this integrated system, which has been on-going since the statute was passed, has not really been interrupted.<sup>46</sup>

Why then did the insurers and Commissioner Senn litigate over the statute? The answer is simple: they litigated as a result of the

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37. See Lim and Byrnes, *supra* note 33, at E1.

38. See Weeks, *supra* note 35, at F1 (citing decades of antagonism and name-calling between traditional and alternative professions).

39. See Stemp, *supra* note 5.

40. See *id.*

41. See Weeks, *supra* note 35, at F1.

42. *Id.*

43. See discussion *infra* Parts I, III.

44. See Weeks, *supra* note 35, at F1 (citing a health plan medical director's statement).

45. Washington: *Some Insurers Continue Covering Alternative Providers Despite Ruling*, HEALTH CARE DAILY REP. (BNA), September 15, 1997, at D-10.

46. See *id.*

statute's interpretation and not over the statute itself.<sup>47</sup> When the statute was passed, insurers, and at least some of the lawmakers who voted for the provision, thought the intent was to make alternative medicine available under the controls of managed care.<sup>48</sup> Rather than agree with this interpretation, Commissioner Senn mandated the inclusion of alternative health services in all health plans sold in Washington state.<sup>49</sup> In Commissioner Senn's defense, she issued the mandate because she believed the insurers would not comply with any of the statute's provisions.<sup>50</sup>

However, the mandate forced insurers to litigate over the statute's interpretation and ultimately over the statute itself.<sup>51</sup> Without the mandate, this litigation might not have ensued and the relationships would have continued—minus the added cost of litigation. But then, of course, hindsight is 20/20 vision.

Alternative medicine, like it or not, is here to stay. It is in the best interests of all of us to support the insurance industry, the traditional health care industry, and the alternative medicine industry to create a system that provides—in the most cost-effective, quality-based manner—the best of both worlds. The best of both worlds is achieved, from a consumer's perspective, through choice. This means that “people who distrust conventional medicine and prefer, say, the services of an acupuncturist are still free to buy an insurance plan that covers acupuncture.”<sup>52</sup> “But people who question [the effectiveness of alternative or] nontraditional therapies should not be required to pay extra for that coverage.”<sup>53</sup> In order to achieve this consumer choice, the statute must remain intact—not as it was interpreted, but as it was intended. Without minimal statutory support, consumer choice, whether it is for inclusion or exclusion of these services, disappears.

This Comment contends that if the statute had been properly limited, as intended and not as interpreted, it would not have met its

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47. There was no litigation over the language of the statute until after Commissioner Senn issued the Bulletin on December 19, 1995. The first lawsuit was filed on January 8, 1996. See *supra* note 19 and accompanying text.

48. See Second Substitute Senate Bill (SSSB) 5304, entitled Health Services Act—Access and Cost Control, 1993 Wash. Laws ch. 492 § 431 (codified at WASH. REV. CODE § 48.43.170(1) repealed by 1995 Wash. Laws ch. 265 § 27).

49. See Bulletin 95-9, *supra* note 13, at 1. Employer-sponsored, self-funded plans were excluded from the mandate. See WASH. REV. CODE § 48.43.005(a) (1996).

50. See Bulletin 95-9, *supra* note 13, at 1. “Many disturbing reports have reached my office indicating that certain carriers are considering actions which clearly fail to satisfy the requirements of RCW 48.43.045.” *Id.*

51. See discussion *infra* Part III.

52. See Stemp, *supra* note 5, at A14.

53. See *id.*



ultimate fate of ERISA preemption. In order to show how this public interest legislation could remain in effect and provide at least minimal statutory support for consumer choice, an overview of Washington state health care reform, ERISA preemption, and the federal district court decision preempting the statute is necessary. In Part I, this Comment provides a brief history of the “Every Category of Provider” statute and the Bulletin.<sup>54</sup> Part II contains a summary of the subsection of ERISA which governs preemption. Part III gives an overview of the federal district court decision and shows that the decision, rendering both the statute and its interpretation preempted by ERISA, was rightly decided. Finally, Part IV shows how, in hindsight, the litigation preempting the statute was unnecessary, and how the statute can be saved by revising it in accordance with the public policy underlying it.

## I. THE HISTORY OF “EVERY CATEGORY OF PROVIDER” AND BULLETIN 95-9

### A. “*Every Category of Provider*”

The “Every Category of Provider” statute did not just appear in 1995. It was part of Washington’s tortured attempt at health care reform which began in earnest in 1993. An overview of insurance regulation and health care reform is required to understand the context in which this statute emerged.

Beginning in 1983, the Washington Legislature raised concerns about the rights of health insurance policy holders in the state as follows:

The legislature finds and declares that there is a paramount concern that the right of the people to obtain access to health care in all its facets is being impaired. . . . It is, therefore, declared to be in the public interest that [health insurance] be regulated under the police power of the state to assure that all the people have the greatest access to health care services.<sup>55</sup>

As a result, the Legislature enacted provisions of title 48 of the Washington Revised Code to govern all insurance and insurance

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54. All references to the interpretation of the statute will be to the Bulletin; the Declaratory Order is substantially similar in language to the Bulletin. Further, the ruling in Thurston County on the Bulletin has already occurred, while the ruling on the Declaratory Order is pending. Any further references to the Declaratory Order will be to illustrate the Insurance Commissioner’s statements in the Bulletin.

55. WASH. REV. CODE § 48.43.309 (1996); *see also* WASH. REV. CODE § 48.44.299 (1996).

transactions in Washington.<sup>56</sup> There are four components of health insurance coverage regulation contained in title 48. First, a "health carrier" or "carrier" means a disability insurer, an HCSC, or an HMO.<sup>57</sup> Carriers develop and market "health plans" or "health benefit plans."<sup>58</sup> These health plans or health benefit plans are in the form of policies, contracts, or agreements to provide health care services.<sup>59</sup> A "health care service" means a service offered or provided by health care facilities and providers relating to the prevention, cure, or treatment of illness, injury, or disease.<sup>60</sup>

A second component of health regulation is "health care providers."<sup>61</sup> A provider is an individual who is licensed to practice health or health-related services according to the licensing requirements for its respective field, as set out in title 18.<sup>62</sup> Alternative care providers are among the professions included in title 18.<sup>63</sup>

The third component of health regulation is OIC oversight of the health insurance industry.<sup>64</sup> Title 48, chapter 44, section 20 of the Washington Revised Code requires the OIC to examine every contract for health insurance to make sure its contents contain no ambiguities, inconsistencies, deceptive advertising, unreasonable benefits in relation to cost of benefits, unreasonable treatment restrictions, violations of title 48, violations of OIC regulations, or violations of state law.<sup>65</sup>

The fourth and final component of health care insurance regulation is the purchasing and consuming public. The OIC is charged with protecting insurance consumers in Washington.<sup>66</sup>

Finding, *inter alia*, that existing regulation of the health insurance industry was not sufficient to address the crisis recognized in 1983,<sup>67</sup> a Democratic legislature and Democratic governor spoke again in 1993 by enacting global health care reform. The 1993 reform package was

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56. See WASH. REV. CODE § 48.01.020 (1996).

57. See WASH. REV. CODE § 48.43.005(8) (1996).

58. Reply Brief of State Defendant in Opposition to Motion for Summary Judgment, *Blue Cross of Washington and Alaska v. Senn*, No. 96-2-00137-3 at 4 (Wash. Super. Ct., Thurston County, 1996) [hereinafter Reply Brief, State Defendant] (on file with the *Seattle University Law Review*).

59. See *id.*

60. See WASH. REV. CODE § 48.43.005(7) (1996).

61. See Reply Brief, State Defendant, *supra* note 58, at 5.

62. See WASH. REV. CODE § 18.120.020(4) (1996) (defining "health professions").

63. See *id.*

64. See Reply Brief, State Defendant, *supra* note 58, at 5.

65. See *id.* See also WASH. REV. CODE § 48.44.020(2) (a-h) (1996).

66. See WASH. REV. CODE § 48.30.010 (1996); see also WASH. REV. CODE § 48.30A (1996).

67. See 1993 Wash. Laws ch. 492 § 101.

where the "Every Category of Provider" language first appeared in a statute.<sup>68</sup> To fully grasp the policies underlying the Legislature's intent in enacting the statute, a summary of the 1993 health care reform and its 1995 demise is essential.

## 1. Washington State Health Care Reform 1993-1996

### a. 1993 Legislation

In 1993, the Legislature enacted global health care reform because it found that Washington's "health and financial security are jeopardized by our ever increasing demand for health care and by current health insurance and health system practices."<sup>69</sup> In addition, "too many of our state's residents are without health insurance [and] each year many families are forced into poverty because of serious illness, and . . . leave gainful employment to be eligible for publicly funded medical services."<sup>70</sup> Furthermore they stated, "businesses find it difficult to pay for health insurance and remain competitive in a global economy, and . . . individuals, the poor, and small business bear an inequitable health insurance burden."<sup>71</sup> As such, "immediate steps must be taken [and] a long-term plan for reform is . . . needed."<sup>72</sup>

The legislature's intent in enacting global health care reform was outlined as follows:

- (1) . . . [T]o establish structures, processes, and specific financial limits to stabilize the overall cost of health services within the economy, reduce the demand for unneeded health services, provide access to essential health services, improve public health, and ensure that health system costs do not undermine the financial viability on nonhealth care businesses.<sup>73</sup>

Substantively, this health care reform law mandated that certain health plans contain a uniform benefits package, and certain employer-sponsored health plans provide a minimum uniform benefits package with mandated essential health services.<sup>74</sup> What the Legislature did,

68. See discussion, *infra* Part I (A)(1)(a).

69. 1993 Wash. Laws ch. 492 § 101.

70. *Id.*

71. *Id.*

72. *Id.*

73. *Id.* at § 401 (repealed by 1995 Wash. Laws ch. 265 § 27).

74. See *id.* at §§ 425, 449, 464 (repealed by 1995 Wash. Laws ch. 265 § 27). Essential health services were mandated in order to emphasize proven preventive and primary health care and include:

- (a) primary and specialty health services;
- (b) inpatient and outpatient hospital services;

for the first time, was mandate a uniform benefits package for employers.<sup>75</sup> The uniform benefits package was separate and distinct from the Washington State Basic Health Plan (BHP) already in effect.<sup>76</sup>

The "Every Category of Provider" language first appeared in former title 43, chapter 72 of the Washington Revised Code and stated that a certified health plan<sup>77</sup> shall:

(1) Permit every category of health care provider to provide health services or care for conditions included in the uniform benefits package to the extent that:

- (a) The provision of such health services or care is within the health care providers' permitted scope of practices; and
- (b) The providers agree to abide by the standards related to:

- (i) Provision, utilization review, and cost containment or health services;
- (ii) Management and administrative procedures; and

(c) prescription drugs and medications;

(d) reproductive services;

(e) services necessary for maternity and well-child care, including preventive dental services for children; and

(f) case-managed chemical dependency, mental health, short-term skilled nursing facility, home health, and hospice services, to the extent that such services reduce inappropriate utilization of more intensive or less efficacious medical services.

*Id.* at § 449(1) (repealed by 1995 Wash. Laws ch. 265 § 27).

75. See 1993 Wash. Laws ch. 492 § 464 (repealed by 1995 Wash. Laws ch. 265 § 27).

76. The uniform benefits package was modeled after the Washington State Basic Health Plan (BHP). See 1993 Wash. Laws ch. 492. The Washington State Basic Health Plan was enacted by 1987 Wash. Laws 1st Ex. Sess., ch. 5 § 4, eff. June 10, 1987, later codified at title 70, chapter 47, section 20 of the Washington Revised Code. The BHP means the "system of enrollment and payment on a prepaid capitated basis for the basic health care services." WASH. REV. CODE § 70.47.020(1) (1996). Basic Health Services are similar to the essential health services enumerated *supra*. See WASH. REV. CODE § 70.47. The BHP is the plan administered by the Washington State Health Care Authority (HCA) through participating health care providers, insurers, health care maintenance organizations or any such combinations. WASH. REV. CODE § 70.47.060 (3) (1996). The HCA is authorized to design and revise a schedule of covered basic health care services, including physician services, prescription medications, and other services which may be necessary for basic health care. See WASH. REV. CODE § 70.47.060(1) (1996).

In addition, the "Every Category of Provider" statute makes reference to the BHP in that it requires health carriers to "[p]ermit every category of health care provider to provide health services or care for conditions included in the basic health plan. . . ." WASH. REV. CODE § 48.43.045 (1996).

77. Certified health plans were part of the reform package. See former WASH. REV. CODE § 43.72.010 (1993) (repealed by 1995 Wash. Laws ch. 265 § 27). A certified health plan meant "a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020 . . . ." *Id.*

(iii) Provision of cost-effective and clinically efficacious health services.<sup>78</sup>

What this legislation required was that “all licensed health care providers . . . irrespective of the type or kind of practice, should be afforded the opportunity for inclusion in the certified health plans consistent with the goal of health care reform.”<sup>79</sup> However, just as the breadth of this legislation was being understood, including its “Every Category of Provider” language, the landscape of health care reform took a dramatic turn.

#### b. 1995 Legislation

In 1995, the Legislature repealed almost all of the 1993 legislation which enacted global health care reform, including the uniform benefits package.<sup>80</sup> All 1995 versions of title 48, chapter 43, entitled “Insurance Reform,” were new.<sup>81</sup> The only piece of legislation from the 1993 health care reform that remained was the “Every Category of Provider” language taken from the former title 43, chapter 72, section 100 of the Washington Revised code.<sup>82</sup>

The newly enacted Wash. Rev. Code § 48.43.045 states in pertinent part:

Every health plan delivered, issued for delivery, or renewed by a health carrier on or after January 1, 1996, shall . . .

78. Former WASH. REV. CODE § 43.72.100 (1993) (repealed by 1995 Wash. Laws ch. 265 § 27).

79. Reply Brief, State Defendant, *supra* note 58, at 7 (citing former WASH. REV. CODE § 48.43.170(2) (1993) (repealed by 1995 Wash. Laws ch. 265 § 27)). The statute also provided: Balancing the need for health care reform and the need to protect health care providers, as a class and as individual providers, from improper exclusion presents a problem that can be satisfied with the creation of a process to ensure fair consideration of the inclusion of health care providers in managed care systems operated by certified health plans. It is therefore the intent of the legislature that the health services commission in developing rules . . . balance the need for cost-effective and quality delivery of health services with the need for inclusion of both individual health care providers and categories of health care providers in managed care programs. . . .

Former WASH. REV. CODE § 48.43.170(1) (1993) (repealed by 1995 Wash. Laws ch. 265 § 27).

Health care providers were defined as: “A person regulated under title 18 RCW and chapter 70.127 RCW, to practice health or health related services or otherwise practicing health care services in this state consistent with state law. . . .” 1993 Wash. Laws ch. 492 § 402(12)(a) (repealed by 1995 Wash. Laws ch. 265 § 27); *see also* WASH. REV. CODE §§ 18.70.020; 70.127.

80. Engrossed Substitute House Bill (ESHB) 1046, entitled Health Care Reform Revision and Simplification, 1995, Wash. Laws ch. 265 § 8, codified at WASH. REV. CODE § 48.43.045 (1996). Title 48, chapter 43 replaced former title 48, chapter 43 “certified Health Plans.” *Id.*

81. *See* WASH. REV. CODE § 48.43; former WASH. REV. CODE § 48.43.

82. *See* Reply Brief, State Defendant, *supra* note 58, at 7 (citing WASH. REV. CODE § 48.43.045 (1996) and former WASH. REV. CODE 48.43.100 (1993)).

(1) 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:

- (a) The provisions of such health services or care is within the health care providers' limited scope of practice; and
- (b) The providers agree to abide by standards related to:
  - (i) Provision, utilization review, and cost containment of health services;
  - (ii) Management and administrative procedures; and
  - (iii) Provision of cost effective and clinically efficacious health services.<sup>83</sup>

The differences between the former "Every Category of Provider" statute and the newly enacted statute are twofold.<sup>84</sup> First, coverage under the 1995 law applies to every health insurance plan<sup>85</sup> delivered, issued for delivery, or renewed by a health carrier on or after January 1, 1996, rather than to certified health plans.<sup>86</sup> Second, instead of the uniform benefits package as the minimum requirement or health plan, every provider must be allowed to provide health care services or care for conditions included in the BHP.<sup>87</sup>

The "Every Category of Provider" statute states that carriers must allow providers to care for conditions or provide services which are covered under the BHP. In the *Blue Cross* lawsuit,<sup>88</sup> the State of Washington, in its Opposition to Plaintiff's Motion for Partial Summary Judgment, gave an example of what this coverage entails, as well as its interpretation of the statute:

[I]f the BHP covers treatment for a low back injury caused in an auto accident, the carrier's health plan must allow a primary care physician to refer a patient for treatment for the low back injury to a provider which is licensed for this type of treatment. Such referral, in the discretion of the primary care physician, may be to

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83. WASH. REV. CODE § 48.43.045 (1996).

84. See Reply Brief, State Defendant, *supra* note 58, at 7.

85. It is important to note that WASH. REV. CODE § 48.43.005(9) (1996), part of the newly enacted legislation, excludes employer-sponsored self-funded health plans from WASH. REV. CODE § 48.43.050 (1996). These self-funded plans are governed by ERISA and are excluded from compliance with the statute.

86. See Reply Brief, State Defendant, *supra* note 58, at 7 (citing WASH. REV. CODE § 48.43.045).

87. See *id.* at 7-8. See also discussion *supra* at note 76.

88. *Blue Cross of Washington and Alaska v. Senn*, No. 96-2-00137-3 (Wash. Super. Ct., Thurston County, 1996).

a chiropractor, a naturopath, physician, a physical therapist or massage therapist, or other appropriate provider.

This subsequent treatment by a chiropractor is *dependent* on the chiropractor's actual treatment to be within his/her scope of practice per the licensing requirements of Title 18, the chiropractor's agreement to abide by the carrier's standards for 'provision and utilization review, cost containment decisions, management and administrative procedures, and the carrier's standards for cost-effective and clinically efficacious health services.' RCW 48.43.045(1) (a), (b), (i-iii).

In short, the law is not a mandate that every willing provider must be included in every health plan. Rather, it is a mandate that if a consumer has a condition for which coverage exists, a primary care physician must be able to treat or refer a patient to a provider who can provide prevention, cure, or treatment of an injury or disease. The provider must comply with the above referenced statutory obligations.<sup>89</sup>

In their briefing to the court, the carriers expressed their understanding of how the legislative history of Engrossed Substitute House Bill 1046 should be used to interpret "Every Category of Provider."<sup>90</sup> They believed that some of the provisions included in ESHB 1046 required "all carriers offering individual or small group coverage plans to offer a health plan with benefits identical to the [BHP] but also permit the sale of other plans with different coverages."<sup>91</sup> In addition, the carriers quoted the language in the bill that required them to:

market to all individuals a health benefit plan providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the Basic Health Plan . . . nothing in this subsection(s) shall preclude a [carrier] from offering, or an individual from purchasing, other health benefit plans that may have more or less comprehensive benefits than the Basic Health Plan, provided such plans are in accordance with this chapter.<sup>92</sup>

Clearly, these are two differing views on how to interpret the statute. One view posits that the statute mandated an option for consumers whereby alternative therapies could be accessed either directly or through a referral by their primary care physician if they

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89. Reply Brief, State Defendant, *supra* note 58, at 8-9.

90. See Blue Cross Brief, *supra* note 25, at 4 (citing 1995 Wash. Laws, ch. 265 §§ 15-18).

91. *Id.*

92. Blue Cross Brief, *supra* note 25, at 4-5. See also 1995 Wash. Laws ch. 265 § 8.

had a condition that was treatable by an alternative care provider.<sup>93</sup> The other view is that insurers are only obligated to provide access to alternative care providers through an individual or small group plan identical to the BHP—a “BHP look-alike” plan.<sup>94</sup>

As shown by these differing views, considerable confusion surrounded the interpretation of the statute. This confusion is an example of what contributed to the interpretation offered by the Insurance Commissioner in Bulletin 95-9.<sup>95</sup>

### B. Bulletin 95-9

On December 19, 1995, the Insurance Commissioner issued Bulletin 95-9. In the Bulletin she outlined the following requirements:

1. Inclusion of all categories of providers is required in every health plan. The requirement applies to fee-for-service plans<sup>96</sup> and managed care plans.<sup>97</sup> This requirement is not limited to the Model Plan or in any other single plan or plan supplement for alternative care.
2. Carriers must actually cover claims for service by all categories of providers, not merely contract with these providers.
3. Carriers may not exclude a category of provider by asserting that the category fails to meet its standards for “cost effective and clinically efficacious health services.” Services within the provider’s permitted scope of practice must be covered, without discrimination on the basis of provider type. For example, if a health plan covers rehabilitation therapy, that service must be covered whether treatment is rendered by an osteopathic physician, a chiropractor, a registered physical therapist, or a licensed massage therapist, so long as the health care practitioner is operating within his or her scope of practice.
4. A category of provider may not be excluded even if that category of provider is excluded by the Basic Health Plan of Washington. RCW 48.43.045 requires carriers to

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93. See Reply Brief, State Defendant, *supra* note 58, at 8-9.

94. See Blue Cross Brief, *supra* note 25, at 4-5. Legislative history of ESHB 1046, however, does not indicate that the statute is restricted to BHP look-alike plans. See 1995 Wash. Laws ch. 265, § 8.

95. There were other reasons that led to the interpretation offered by the Insurance Commissioner in Bulletin 95-9 at 1. See *supra* note 50; *infra* note 100 and accompanying text.

96. Fee-for-service plans include those plans offered by disability insurers. See WASH. REV. CODE § 48.43.005(8) (1996).

97. Managed care plans include those plans offered by HCSCs and HMOs. See WASH. REV. CODE § 48.43.005(8) (1996).



provide this access to services for any condition covered by the Basic Health Plan. Thus, for example, even if acupuncturists are excluded by the Basic Health Plan, carriers must cover services by acupuncturists if the condition treated is one covered by the Basic Health Plan and the acupuncturist is acting within the permitted scope of his or her practice.

5. The law does not limit the types of providers who may be designated by a carrier as a "Primary Care Provider" (PCP). The Department of Health has determined that a broad range of provider categories may function as PCPs.
6. The law requires carriers to permit every category of provider to provide services for health care conditions covered by the basic health plan services. If carriers impose a limitation, such as number of visits or maximum benefit amount, on a type of service covered by a health plan, that limitation must be applied without regard to the type of provider performing the service . . . .<sup>98</sup>

The Commissioner further threatened enforcement actions if necessary to prevent any other practices that would circumvent the statute.<sup>99</sup>

According to the Insurance Commissioner, the Bulletin was issued in response to letters and questions from providers and carriers about the OIC's approach and practices concerning what health plans were required to allow and provide under the new statute.<sup>100</sup> Unfortunate-

98. Bulletin 95-9, *supra* note 13, at 2. See also Declaratory Order, *supra* note 18, at 2. Declaratory Order findings provide further support for the Insurance Commissioner's interpretation in the Bulletin as follows:

*Finding #1 - Conditions Covered.* All services or care rendered by licensed providers acting within the scope of practice, for conditions covered by the BHP must be covered by a health plan.

A health plan may exclude a particular service unless, by so doing, it substantially excludes an entire category of providers. As long as the condition is covered by the BHP, every category of treatment must be provided, even if the treatment is excluded by the BHP, such as acupuncture.

*Finding #2 - Health Plans Covered.* All health plans, except Model Plans, must comply with RCW 48.43.045. The every category of provider statute applies to every health plan and not just model plans. Model plans are plans which carriers are required to market which provide benefits identical to the schedule of services provided by the BHP. The Model Plans are an exception to the general requirement contained in RCW 48.43.045.

*Finding #3 - Cost-effective and Clinically-efficacious Services.* A health plan may not exclude an entire category of providers based on their determination that certain of the providers' services are not cost effective or clinically efficacious.

Declaratory Order, *supra* note 18, at 1-2.

99. *Id.* See also Bulletin 95-9, *supra* note 13, at 2.

100. See Reply Brief, State Defendant, *supra* note 58, at 9.

ly, this interpretation, mandating every fee-for-service and managed plan issued by a health carrier in the state to cover treatments provided by licensed alternative care providers, ultimately dooms the statute.<sup>101</sup> The end result, ERISA preemption, would not necessarily have occurred if the statute had been narrowly interpreted. In order to understand how ERISA preempts the statute, it is important to outline and discuss the main features of preemption.

## II. EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

### A. A Brief Summary of ERISA Preemption

The Employee Retirement Income Security Act of 1974 is a comprehensive federal statute that imposes minimum standards on employee welfare benefit plans,<sup>102</sup> which, through the purchase of insurance, provide medical, surgical, or hospital care or benefits to policyholders.<sup>103</sup> In 1982, as part of the comprehensive regulation of employee benefit plans, and to prevent conflicting state regulation, Congress enacted a broad preemption provision in ERISA.<sup>104</sup> Under this preemption provision, state laws which "relate to" an employee health benefit plan are preempted unless "saved" from preemption as a law regulating insurance.<sup>105</sup> The statute states in pertinent part:

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any

101. See discussion *infra* Part IV.

102. "Employee Welfare Benefit Plan" and "Welfare Plan" 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.

29 U.S.C. 1002(1) (1988 & Supp. V 1993).

103. See 29 U.S.C. §§ 1001-1461 (1988 & Supp. V 1993). In ERISA, Congress set out to [P]rotect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts . . . as set forth in 29 U.S.C. § 1001(b).

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987).

104. See Robert S. McDonough, *ERISA Preemption of State Mandated Provider Laws*, 1985 DUKE L.J. 1194 (1985).

105. See 29 U.S.C. § 1144 (1988 & Supp. V 1993).

and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .

(b) (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . .<sup>106</sup>

A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.<sup>107</sup> "Congress uses the term 'relates to' in section 514(a) in its broadest sense."<sup>108</sup> The preemption clause does not apply only to

106. *Id.* Subparagraph (B) is known as the "deemer clause." 29 U.S.C. § 1144(b)(2)(B) (1988 & Supp. V 1993). The deemer clause states: Neither an employee benefit plan . . . nor any trust established under such plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any state law purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. *Id.*

Analyzing "Every Category of Provider" under the deemer clause is not necessary because the statute does not, in its attempt to regulate insurance, does not impliedly or explicitly deem an employee benefit plan to be an insurance company. *See id.*

107. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 87 (1983) (determining that a New York law prohibiting discrimination by private employers on the basis of sex related to employee benefit plans). *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (deciding that mandated benefits were laws relating to insurance).

108. *Shaw*, 471 U.S. at 98-99. The legislative history cited in *Shaw* provides information that the preemption language was initially narrow in scope as follows:

ERISA would supersede state laws 'relating to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which Part 1 [of ERISA] applies.

*Id.* The Conference Committee rejected this narrow interpretation. It decided to preempt state laws relating to benefit plans, rather than those laws relating to those subjects covered by ERISA. *Id.*

Since the decision in *Shaw*, however, this very broad interpretation of "relates to" has been narrowed by the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). Prior to the *Travelers* decision, preemption cases held that in determining whether a federal statute preempts state law, Congress' intent controls. *See FMC Corp. v. Holliday*, 498 U.S. 52 (1990). In *Travelers*, however, the Court indicated that courts should decide whether ERISA preempts state law, not by asking whether the language requires it or whether Congress intended it, but by asking whether preemption makes sense as a matter of ERISA policy. *Travelers*, 514 U.S. at 646. The Court held, as a matter of ERISA policy, that any indirect economic effect of a statute is not sufficient to cause preemption; however, preemption still applies to any state law that attempts to regulate benefit structures or their administration. *Id.*

Commentators have had a "field-day" with this decision. *See, e.g., Margaret G. Farrell, ERISA and Managed Care: The Law Abhors a Vacuum*, 29 J. HEALTH & HOSP. L. 268, 269 (1996). Ms. Farrell posits, "[n]arrower interpretation of the 'relates to' provision means that state managed care regulation is less likely to be held preempted by ERISA where it only has an indirect economic impact or influence on ERISA plans." *Id.* *See also Karen A. Jordan, Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255, 335 (1996). Ms. Jordan argues the *Travelers* decision is sending a strong signal that the scope of ERISA preemption generally should be more restrained than many courts are concluding. *Id.* She also argues that the analytical framework for resolving ERISA preemption issues, as

state laws dealing with the subject matters covered by ERISA, such as reporting, disclosure, and fiduciary duties.<sup>109</sup> A state law may "relate to" an employee benefit plan even if the law is not specifically designed to affect employee benefit plans.<sup>110</sup> In other words, a state law is preempted unless saved from preemption under ERISA § 514(b)(2)(a) as a law regulating insurance.

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derived from *Travelers*, can effectively restrain findings of preemption if appropriate arguments are presented to the courts. *Id.*

As such, the *Travelers* decision does not affect the discussion in Part III because the issue, as determined by the federal district court, was not the economic impact of the statute on insurers, but the direct regulation that binds health insurance plans to specific administrative requirements. See discussion *infra* Part III. See also California Division of Labor Standards Enforcement, et al., v. Dillingham Construction, N.A., Inc., 117 S. Ct. 832 (1997) (holding that California's prevailing wage law neither makes "reference to" nor has "connection with" ERISA plans and, therefore, does not "relate to" ERISA plans and is not preempted by ERISA).

*Dillingham* is the most recent Supreme Court case dealing with ERISA preemption. In deciding whether California's prevailing wage and hour law was preempted by ERISA, the Court reiterated and further discussed the *Travelers* holding. *Dillingham*, 117 S. Ct. at 838-40. In discussing the *Travelers* decision, the Court stated that previous decisions in *Shaw*, *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), were based on state statutes that "mandated employee benefit structures or their administration." *Dillingham*, 117 S. Ct. at 839. In those cases, the Court restated that the statutory requirements that were at issue amounted to "connections with" ERISA plans. *Id.* (citing *Travelers*, 514 U.S. at 657-58). They found that the issue in *Travelers*, however, was a considerable contrast. See *Dillingham*, 117 S. Ct. at 839.

It is important to show how the *Travelers* issue of an "indirect economic impact" is not involved in the analysis of ERISA preemption of the "Every Category of Provider" statute. The state law at issue in *Travelers* was a statute that regulated hospital rates and required hospitals to exact surcharges from patients whose hospital bills were paid by any of a variety of non-Blue Cross/Blue Shield providers. See *Dillingham*, 117 S. Ct. at 839 (outlining the facts of *Travelers*). Because ERISA plans were predominant among the purchasers of insurance, the statute was asserted to run afoul of ERISA's preemption provision. See *id.* at 840 (same). The differential rates charged to commercially insured patients and to patients insured by "the Blues" made commercial insurance relatively more expensive—and less attractive. See *id.* (same). The resulting cost variations encouraged insurance purchasers, including ERISA plans, to provide insurance benefits through the Blues. See *id.* Commercial insurers argued that these cost variations and their subsequent effects had a connection with those ERISA plans, requiring preemption of the law that dictated them. See *id.* (same).

The Court upheld the statute on the grounds that the indirect economic influence of the surcharge did not "bind plan administrators to any particular choice and thus function as a regulation of and ERISA plan itself." *Id.* (citing *Travelers*, 115 S. Ct. at 1679). In addition, the indirect influence of the surcharge did not "preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishe[d] to provide one." *Id.* (same). This finding makes it clear that "ERISA will still be held to preempt managed care regulation that binds health plan administrators to a particular benefit configuration or administrative requirements." Farrell, *supra*, at 269.

109. *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990).

110. *Id.*

In *Metropolitan Life Insurance v. Massachusetts*,<sup>111</sup> the U.S. Supreme Court used a two-part test to determine whether a state law falls into ERISA's savings clause.<sup>112</sup> First, the Court must determine whether there was guidance available from a "common sense view" of the language of the savings clause itself.<sup>113</sup> Second, the statute is analyzed to determine whether it regulates insurance under the McCarran-Ferguson Act<sup>114</sup> in interpreting the savings clause.<sup>115</sup>

There are three criteria used to determine whether a practice falls under the "business of insurance" for purposes of the McCarran-Ferguson Act: "[F]irst, whether the practice has the effect of transferring or spreading policy holder's risk; second, whether the practice is an integral part of the policy holder's relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."<sup>116</sup>

For a state law to be saved from preemption, it must satisfy both parts of the *Metropolitan* test, including the three McCarran-Ferguson criteria.<sup>117</sup> Accordingly, a state law is preempted by ERISA if it relates to insurance.<sup>118</sup> Furthermore, the law can only be "saved" from preemption if it satisfies both parts of the *Metropolitan Life* test. As the following overview of the federal district court decision will show, the "Every Category of Provider" statute (1) relates to insurance and (2) is not saved from preemption because it fails both parts of the *Metropolitan Life* test.<sup>119</sup>

### III. WHY THE "EVERY CATEGORY OF PROVIDER" STATUTE IS RENDERED PREEMPTED BY ERISA

As it was effectively argued by the Plaintiffs in *Washington Physician Service Association v. Gregoire*, both the Washington State Insurance Commissioner's interpretation of the statute, and the statute

111. 471 U.S. 724 (1985).

112. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987) (outlining the *Metropolitan Life* two-part test).

113. *Id.*

114. 15 U.S.C. § 1011 (1988).

115. See *Pilot Life Ins. Co.*, 481 U.S. at 48 n.2. "The McCarran-Ferguson Act provides, in relevant part: '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.' 15 U.S.C. § 1012(a)." *Id.*

116. *Pilot Life Ins. Co.*, 481 U.S. at 48-49 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1983)).

117. See *Pilot Life Ins. Co.*, 481 U.S. at 47-48.

118. See *Shaw*, 463 U.S. at 87.

119. See *Washington Physicians Service Ass'n v. Gregoire*, 967 F. Supp. 424, 427 (W.D. Wash. 1997).

itself, is preempted by ERISA because the statute "relates to" employee health benefit plans.<sup>120</sup> Furthermore, the statute is not saved from preemption under the two-part *Metropolitan Life* test.<sup>121</sup>

A. "Every Category of Provider" Is Preempted as a Law Which Relates to Employee Benefit Plans

There are four ways in which the statute and its interpretations relate to ERISA governed plans: (1) by interfering with a carrier's ability to administer its health benefit plans, (2) by regulating the structure of employee health benefit plans, (3) by regulating the content of health benefit plans, and (4) by regulating plan requirements that vary from state to state.<sup>122</sup>

The statute interferes with a carrier's ability to administer its health benefit plans because carriers are forced to contract with, to pay claims for, and not to exclude a category of provider by asserting that the "category fails to meet the carrier's standards for provision of 'cost effective and clinically efficacious health services.'"<sup>123</sup>

Provider contracting, claims payment, quality assurance, and utilization review are all considered part of a health plan's administrative function.<sup>124</sup> Case law shows that state laws which interfere with the administration of health benefit plans have a relationship to such plans for purposes of ERISA preemption.<sup>125</sup> Accordingly, because the interpretation of the "Every Category of Provider" statute interferes with health plan administration by proscribing contracting and claims payment requirements, the law relates to employee benefit plans.

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120. See *id.* at 427; see also discussion *infra* at Part III, section A.

121. See *id.* at 427-30; see also discussion *infra* at Part III, section A.

122. See *id.* at 426 (citing *Travelers*, 514 U.S. at 656-57).

123. See Bulletin 95-9, *supra* note 13, at 1; *Washington Physicians Service Ass'n*, 967 F. Supp. at 427 (finding that the statute relates to the administration of employee benefit plans because it interferes with the plan administrator's discretion of whom to contract with and whom to pay).

124. If an employer were to contract for "administrative services only, for example," these are the functions that would be included. Discussion with Jill Mehner, Director of Medical Management, Health Washington, December 18, 1996.

125. See *Travelers*, 514 U.S. at 656-657 (holding that preemption still applies to any state law that attempts to regulate their administration); *Fort Halifax Packing Company, Inc. v. Coyne*, 482 U.S. 1, 9 (1987) (stating that plan administration is a central feature of ERISA); *Hayden v. Blue Cross and Blue Shield of Alabama*, 843 F. Supp. 1427, 1432 (N.D. Ala. 1994) (finding that an Alabama statute requiring direct payment to nurse anesthetists had a direct affect on administration by mandating who they must pay, and therefore "relates to" employee benefit plans); *General Motors Corp. v. Caldwell*, 647 F. Supp. 585, 587 (N.D. Georgia 1994) (finding that a law establishing a pricing formula for prescription drugs related to employee benefit plans because it created an administrative procedure with which plan administrators, plan beneficiaries, and participating pharmacies must comply).

Another way in which the statute relates to employee benefit plans is by regulating the structure of employee benefit plans.<sup>126</sup> The Bulletin requires employee health benefit plans to permit every category of provider to provide health services for conditions included in the Basic Health Plan (BHP).<sup>127</sup> The Declaratory Order states that as long as the condition is covered by the BHP, every category of treatment by every category of provider must be covered.<sup>128</sup> This requirement does not allow ERISA governed plans to *exclude* a health plan benefit structure which does not include every category of provider.<sup>129</sup> Furthermore, “[t]he [statute] relates to content because a health plan is required to cover provider services that it did not cover previously.”<sup>130</sup> This requirement directly regulates the structure of employee benefit plans.

A recent case in Louisiana examined a statute similar to Washington’s “Every Category of Provider,” entitled “Any Willing Provider.”<sup>131</sup> The Court found that such arrangements were related to the structure of the plan and were preempted as follows:

Unlike the New York statute at issue in *Travelers*, Louisiana’s Any Willing Provider statute specifically mandates that certain benefits available to ERISA plans must be constructed in a particular manner. In other words, the Louisiana statute does not merely raise the cost of the implicated benefits; it delineates their very structure. As such, the statute falls outside the purview of the limited *Travelers* holding: the Court there repeatedly recognized that ERISA preempts state laws that mandate employee benefit structures.<sup>132</sup>

The Washington statute substantially resembles the Louisiana statute because the benefits must be constructed in a particular

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126. See *Travelers*, 514 U.S. at 656-657 (holding that preemption still applies to any state law that attempts to regulate benefit structures).

127. See Bulletin 95-9, *supra* note 13, at 1.

128. See Declaratory Order G96-13, *supra* note 18, Finding #1.

129. See *Washington Physicians Service Ass’n*, 967 F. Supp. at 427; see also Plaintiffs’ Memorandum in Support of Summary Judgment of ERISA Preemption of State Law at 5, *Washington Physicians Service Ass’n*, 967 F. Supp. at 424 (No. C96-5850FDB) [hereinafter Plaintiffs’ Memorandum] (on file with the *Seattle University Law Review*).

130. *Id.* at 5 (citing *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir. 1993)) (stating that a statute which restricts the ability of an insurance company to limit the choice of providers “relates to” an employee benefit plan).

131. See *Cigna Healthplan of Louisiana, Inc. v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996).

132. *Id.* at 649 (citing *Travelers*, 514 U.S. at 657).

manner.<sup>133</sup> Further, “[t]here is also the risk of conflicting and inconsistent state and local regulation, as, for example, an Oregon employer who contracts with a health carrier in Washington to cover employees in Washington would have to comply with the [statute] even if there were no such mandate for the employer in Oregon.”<sup>134</sup> Thus, the “Every Category of Provider” statute relates to employee benefit plans and ERISA preempts it unless it is saved from preemption as a law regulating insurance.<sup>135</sup>

B. “Every Category of Provider” Is not Saved from Preemption as a Law Regulating Insurance

The statute relates to employee benefit plans, and thus is preempted unless saved from preemption under ERISA § 514(b)(2)(A) as a law regulating insurance.<sup>136</sup> A statute is not saved from preemption merely because it is part of the state insurance code.<sup>137</sup> Furthermore, the statute must meet both the common sense view and each of the McCarran-Ferguson<sup>138</sup> criteria in order to be saved from preemption.<sup>139</sup>

1. Common Sense View

To the extent that the statute applies to HMOs, it fails the “common sense view” of the *Metropolitan Life* test. This first tier of the *Metropolitan Life* test analyzes, under a “common sense view,” whether the law at issue “regulates insurance,” that is, whether the law

133. The plaintiffs in the federal district court case argued this point as follows: Like the Louisiana statute, the ‘every category of provider’ Alternative Provider Mandate Statute and State Interpretations affect the very structure of employee benefit plans. The . . . Statute and . . . [i]nterpretations annul provisions in existing employee benefit plans that are designed to take advantage of Limited categories of providers that are chosen by the plan. The Insurance Commissioner has indicated that employee benefit plans must be modified and provider contracts expanded to meet its interpretation by October 1, 1996. The fact that [these insurance contracts] now in existence must be re-written to cover a wide variety of additional providers conclusively establishes a change in the structure of employee benefit plans.

Plaintiffs’ Memorandum, *supra* note 129, at 7; *accord* Order, *supra* note 119, at 5.

134. *Washington Physicians Service Ass’n*, 967 F. Supp. at 427.

135. See *Cigna Healthplan of Louisiana*, 82 F.3d at 649. (holding that a state law, which prohibited a plan from excluding any willing provider, related to an ERISA plan, citing *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985)).

136. See 29 U.S.C. § 1144 (1988 & Supp. V 1993).

137. See *Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105, 109 (5th Cir. 1993).

138. See *Pilot Life Ins. Co.*, 481 U.S. at 48.

139. *Cigna Health Plan of Louisiana*, 82 F.3d at 649; *Tingle*, 996 F.2d at 107.



is specifically directed at the insurance industry.<sup>140</sup> The common sense view excludes from that savings clause entities that are not involved in the business of insurance.<sup>141</sup> The statute is directed at "health carriers," which are defined as "disability insurer[s] regulated under chapter 48.20 or 48.21 RCW, health services contractor[s] as defined in RCW 48.44.010, and health maintenance organization[s] as defined in RCW 48.46.020."<sup>142</sup> "Thus, on its face, the [Every Category of Provider] statute is not directed simply at insurers, but also at HMOs."<sup>143</sup> In Washington, HMOs are not considered insurers.<sup>144</sup> Title 48, chapter 46, section 60 of the Washington Revised Code states in pertinent part:

(1) Any health maintenance organization may enter into agreements with or for the benefit of persons or groups of persons, which require prepayment for health care services by or for such persons in consideration of the health maintenance organization providing health care services to such persons. Such activity is not subject to the laws relating to insurance if the health care services are rendered directly by the health maintenance organization or by any provider which has a contract or other arrangement with the health maintenance organization to render health services to enrolled participants.<sup>145</sup>

However, in *Physicians Health Plan, Inc. v. Citizens Insurance Co. of America*,<sup>146</sup> an HMO was held to be an insurer for purposes of the ERISA savings clause. The court stated:

HMOs and insurance companies share the indicia of the 'business of insurance.' Both assume the risk that their members or insurers will require benefits in excess of the consideration paid. An HMO accepts the risk as an obligation to directly provide benefits to its members. An insurance company accepts the risk as an obligation to indemnify its insurers for the cost of such benefits. The difference is not material. In either scheme the principle is the

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140. See *Washington Physicians Service Ass'n*, 967 F. Supp. at 427; Plaintiffs' Memorandum, *supra* note 129, at 15 (citing *Pilot Life Ins. Co.*, 481 U.S. at 48).

141. See *Pilot Life Ins. Co.*, 481 U.S. at 48.

142. *Washington Physicians Service Ass'n*, 967 F. Supp. at 428; Plaintiffs' Memorandum, *supra* note 129, at 18-20.

143. *Id.*; Plaintiffs' Memorandum, *supra* note 129, at 18.

144. See WASH. REV. CODE § 48.46.060(1) (1996).

145. *Id.*

146. 673 F. Supp. 903 (1987).

same: for a fixed fee, the risk and responsibility of providing benefits is shifted from a beneficiary to a third party insurer.<sup>147</sup>

In order to settle the conflict of whether an HMO is in the business of insurance, looking at a widely accepted definition of insurance is necessary. Insurance is a "contract by which one party, for a consideration . . . promises to make a certain payment of money upon the destruction or injury of something in which the other party has an interest."<sup>148</sup> In a health insurance contract, the risk insured against is the risk of illness or injury suffered by the beneficiary.<sup>149</sup> In contrast, in Washington an HMO is neither an insurer nor an entity within the insurance industry, but rather a health care delivery system.<sup>150</sup> The legislature has spoken in the HMO Act as to what it considers to be the function or definition of an HMO:

The Legislature declares that the establishment of a qualified prepaid group and individual practice health care delivery systems should be encouraged in order to provide all citizens of the state with the freedom of choice between competitive, alternative health care delivery systems necessary to realize their right to health. It is the purpose and policy of this Chapter to provide for the development and registration of prepaid group and individual practice health care plans as health maintenance organizations, which the Legislature declares to be in the interest of the health, safety and welfare of the people.<sup>151</sup>

Unlike an insurer, whose obligation is to indemnify another,<sup>152</sup> an HMO is an organization "which provides comprehensive services to enrolled participants . . . either directly or through contractual or other arrangements with other institutions, entities or persons."<sup>153</sup> Accord-

147. *Id.* at 907. See also *Ocean State Physicians Health Plan v. Blue Cross & Blue Shield*, 883 F.2d 1101, 1107-09 (1st Cir. 1989) (stating that HMOs are in the business of insurance under the McCarran-Ferguson test in the context of the service contracts offered to subscribers).

148. *Washington Physicians Service Ass'n*, 967 F. Supp. at 428 (citing *COUCH ON INSURANCE*, 2D, § 1:2 (1984)). See also *WASH. REV. CODE* § 48.01.040 (1996) (insurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies).

149. See *Plaintiffs' Memorandum*, *supra* note 129, at 18 (citing *Jordan v. Group Health Ass'n*, 107 F.2d 239, 245 (D.C. Cir. 1934)).

150. See *Washington Physicians Service Ass'n*, 967 F. Supp. at 428; *Plaintiffs' Memorandum*, *supra* note 129, at 19.

151. *Plaintiffs' Memorandum*, *supra* note 129, at 19 (citing *WASH. REV. CODE* § 48.46.020(1) (1996)).

152. See *Washington Physicians Service Ass'n*, 967 F. Supp. at 428 (citing *WASH. REV. CODE* § 48.01.040 (1996)).

153. *Plaintiffs' Memorandum*, *supra* note 129, at 19 (citing *WASH. REV. CODE* § 48.46.020(1) (1996)).

ingly, the defining feature of an HMO is to provide service and not insurance.<sup>154</sup> Therefore, in concurrence with the legislative intent,<sup>155</sup> health services, as provided by an HMO are not subject to insurance laws.

Under the common sense view, those entities that do not provide insurance, but provide services, are excluded from the laws regulating insurance.<sup>156</sup> Therefore, the common sense view of the *Metropolitan Life* test fails because an HMO is subject to the statute and "this alone would be enough to remove the [statute] and its interpretations from savings clause protection leaving them preempted by ERISA section 514, 29 U.S.C. § 1144."<sup>157</sup> "But assuming, *arguendo*, that the [statute] passes the 'common sense' test, The McCarran-Ferguson 'business of insurance' test must be satisfied."<sup>158</sup>

The statute also fails the second tier or the "business of insurance" test under *Metropolitan Life*. The statute does not meet any one of the three factors of the McCarran-Ferguson test.<sup>159</sup>

## 2. The McCarran-Ferguson Criteria

The first factor in the McCarran-Ferguson test is whether the practice has the effect of transferring or spreading a policyholder's risk.<sup>160</sup> "The risk spreading principle concerns the nature of the coverage of the policy—in other words, the risks of injury that the insurance company will bear for the insured."<sup>161</sup> Accordingly, risk transfer occurs as a result of the contract between the policyholder and the carrier or insurance company.<sup>162</sup> The contract spells out what

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154. See *Washington Physicians Service Ass'n*, 967 F. Supp. at 428.

155. See WASH. REV. CODE § 48.46.020(1) (1996).

156. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 48.

157. *Washington Physicians Service Ass'n*, 967 F. Supp. at 428. I recognize that it is because the Washington Legislature has determined that HMOs offered to Washington residents will not be subject to the laws relating to insurance (WASH. REV. CODE § 48.46.060(1)) that the argument from the *Ocean State Physicians Health Plan, Inc.* case fails. See *supra* note 147 and accompanying text. The argument that HMOs are in the business of insurance, whether in Washington or anywhere else, is beyond the scope of this Comment (but worthy of mention and perhaps another topic for publication).

158. *Id.*

159. See *id.*

160. See *Pilot Life Ins. Co.*, 41 U.S. at 48.

161. *Washington Physicians Service Ass'n*, 967 F. Supp. at 429 (citing *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 569 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 57 (1994); see also *Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d at 108 n.13 ("we must focus on the actual risks that were transferred from the insured to the insurer and determine if the practice acts to alter the contractual apportionment of the risks").

162. See *id.*

conditions are covered and what conditions are excluded.<sup>163</sup> The insurance company accepts the risk for those conditions enumerated in the policy; the policyholder or subscriber pays the insurance company to accept that risk. The contract for insurance is between the policyholder and the insurance company.

"Every Category of Provider" is part of title 48, or the Insurance Code, and is directed at entities within the insurance industry.<sup>164</sup> However, the statute does not have the effect of transferring policyholder risk, and is not an integral part of the relationship between the policyholder and the carrier, or the insured and the insurer.<sup>165</sup> Risk is transferred by the contract between the carrier and the policyholder, not by the carrier's contract with a provider. The provider simply provides services for those covered conditions enumerated in the policyholder's contract.<sup>166</sup> The effect of the statute is on the relationship between the insurer and the service provider, not on risk transfer.<sup>167</sup>

In *Hayden v. Blue Cross and Blue Shield of Alabama*,<sup>168</sup> the court applied the McCarran-Ferguson factors to an Alabama statute which mandated payment for some of the services within the scope of practice of a certified registered nurse anesthetist (CRNA), if performed by the CRNA.<sup>169</sup> The CRNAs brought a class action seeking a declaration that Blue Cross and Blue Shield of Alabama was required to pay the CRNAs directly under certain circumstances.<sup>170</sup> Blue Cross and Blue Shield of Alabama refused to pay the CRNAs.<sup>171</sup>

The court in *Hayden* concluded that the statute was not saved from preemption as a law regulating insurance<sup>172</sup> because the Alabama statute did not transfer policyholder risk.<sup>173</sup> The plaintiffs argued that the beneficiary [of services] would be required to pay for services

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163. See *Sample Certificate of Coverage for the BHP* (on file with the *Seattle University Law Review*). This certificate, or contract, tells the subscriber what conditions are covered by the BHP and what conditions are excluded. The State, or the contracted "carrier," assumes the risk for those covered conditions. In the case of the BHP, the State or the individual subscriber depending upon whether that subscriber is subsidized, pays a premium to the carrier for assuming the risk of those covered conditions.

164. See WASH. REV. CODE § 48.43.045 (1996).

165. See Plaintiffs' Memorandum, *supra* note 129, at 21-24.

166. See *id.* at 22.

167. See *id.*

168. 843 F. Supp. 1427 (Ala. 1994).

169. See *id.* at 1429.

170. See *id.* at 1428.

171. See *id.*

172. See *id.* at 1439.

173. See *id.* at 1434.

under the statute as it exists now, and not have to pay under the plan as enforced by the statute at issue: the statute has the effect of transferring the risk of payment.<sup>174</sup> The court rejected the plaintiffs' argument, holding that the statute did not expand the treatment available.<sup>175</sup> The statute merely imposed liability upon Blue Cross by requiring payment for a certain category of provider providing the treatment.<sup>176</sup> Since the primary effect of the statute was on the relationship between Blue Cross and the CRNAs, it did not affect the relationship between the carrier and the policy holder.<sup>177</sup>

The *Hayden* court relied upon *Group Life and Health Insurance v. Royal Drug Co.*<sup>178</sup> In *Royal Drug*, the Court concluded that agreements between an insurer and pharmacies limiting the amount a pharmacy could charge the insurer's policyholders for prescription drugs, were not the business of insurance under the McCarran-Ferguson Act.<sup>179</sup> The agreements did not spread risk but were arrangements defining the scope of covered goods and services.<sup>180</sup>

Similarly, the "Every Category of Provider" statute does not transfer or spread policyholder risk because it is not an integral part of the policy relationship between the carrier and the policyholder.<sup>181</sup> The statute and its interpretation impact the relationship between the carrier and the provider, not the carrier and the policyholder.<sup>182</sup>

An interesting counterargument, however, was asserted by the defendant State<sup>183</sup> which posited that the statute and its interpretation does spread and transfer risk.<sup>184</sup> The main thrust of the argument was that a mandatory provider law, like the one at issue, requires that the contract between the policyholder and the carrier permit the policyholder the choice among all categories of providers for treatment of a

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174. See *id.* at 1435.

175. See *id.*

176. See *id.*

177. See *id.*

178. See *id.*, (citing, *Royal Drug*, 440 U.S. at 212-14).

179. See *Hayden*, 843 F. Supp. at 1435.

180. See *id.*

181. See *Washington Physicians Service Ass'n*, 967 F. Supp. at 429-30; Plaintiffs' Memorandum, *supra* note 129, at 22-23.

182. See *Washington Physicians Service Ass'n*, 967 F. Supp. at 429-30; Plaintiffs' Memorandum, *supra* note 129, at 22-23.

183. *Washington Physicians Service Ass'n v. Gregoire*, 967 F. Supp. 424 (W.D. Wash. 1997).

184. See State Defendant's Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment and In Support of Defendant's Cross Motion for Summary Judgment at 32, *Washington Physician Service Ass'n*, 967 F. Supp. 424 (No. C96-5850FDB) (on file with the *Seattle University Law Review*).

particular ailment.<sup>185</sup> This choice among all categories of providers shifts the risk and cost of treatment delivered by such providers from the policyholder to the insurer.<sup>186</sup> The State argued that this is done by forcing the carrier to bear the risk that the policyholder will exercise the benefit option of securing treatment from alternative providers.<sup>187</sup> As a result, carriers are forced to accept and be subject to a greater universe of benefit demands because policyholders can choose any type of provider to treat their ailment.<sup>188</sup>

What this argument fails to recognize is that the traditional definitions of risk transfer are between carrier and policyholder. Just because a policyholder chooses an alternative provider to treat an ailment, the risk transferring arrangement does not change. The carrier assumes the risk for the policyholder's ailments, not the risk for the type of treatment rendered by an alternative provider. Further, policyholders often do not make their own treatment decisions. In a managed care system, policyholders do not automatically get the choice of what kind of provider will treat their ailments. Through the process of managing care, primary care providers make referrals, but insurers must approve and certify treatment, as well as approve who will provide that particular treatment. Risk, therefore, is transferred because of the policyholder's relationship with the carrier, not because of the carrier's relationship with the provider. Accordingly, because the interpretation of "Every Category of Provider" governs the contracts with providers and does not involve spreading risk, the statute as interpreted is not saved from preemption as a law regulating insurance under the first McCarran-Ferguson criterion.<sup>189</sup>

The second of the McCarran-Ferguson criteria, whether the practice is an integral part of the policy relationship between the insurer and the insured,<sup>190</sup> is also not met in this instance. This criterion requires that the interpretation of the statute define, and be

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185. See *id.* at 33.

186. See *id.* at 36.

187. See *id.*

188. See *id.*

189. One federal circuit court case concluded that a state statute mandating the inclusion of providers did regulate insurance. See *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), *cert. denied*, 114 S. Ct. 579 (1993); see also Plaintiffs' Memorandum, *supra* note 129, at 24. The statute in question applied only to insurance companies, not to ERISA plans. *Stuart Circle Hospital Corp.*, 995 F.2d at 502. In addition, a recent decision has expressly rejected the reasoning of *Stuart Circle* on the basis that *Stuart Circle* was simply mistaken in its assumption that "any willing provider" statutes spread or transfer risk or increase covered benefits. See *Blue Cross & Blue Shield of Alabama v. Neilson*, 917 F. Supp. 1532, 1541 (N.D. Ala. 1996); see also *Washington Physicians Service Ass'n*, 967 F. Supp. at 429-30.

190. See *Pilot Life Ins. Co.*, 481 U.S. at 48-50.

integral to, the terms of the policy relationship between the insurer and the insured.<sup>191</sup> The policyholder/carrier or insured/insurer relationship is defined by the terms of the contract between them.<sup>192</sup>

As discussed above, the interpretation of the "Every Category of Provider" statute regulates the terms of the relationship between the carrier and the providers, not the relationship between the carrier and policyholders. The focus of the statute, as interpreted, is primarily on the kind of providers with which the carriers must contract, not how carriers or policyholders carry out their obligations under the insurance contract.<sup>193</sup> This statute does not mandate benefits that would be considered interference with the contractual relationship between the carrier and policyholder.<sup>194</sup> It mandates the inclusion of alternative providers who may provide services for covered benefits.<sup>195</sup> Therefore, the second McCarran-Ferguson criterion is not satisfied because the practice being regulated is a practice that is exclusively between the carrier and the provider and is not integral to the carrier-policyholder relationship.<sup>196</sup>

In order to meet the third criterion of the McCarran-Ferguson analysis, the statute must be limited solely to the insurance industry.<sup>197</sup> As discussed above, the interpretation of the "Every Category of Provider" statute reaches beyond insurers to include HMOs.<sup>198</sup> HMOs are not considered insurers under the Washington Revised Code.<sup>199</sup> An HMO is a health care delivery system, not an insurance company. Its primary focus is on health care and not insurance.<sup>200</sup>

In summary, in order for the "Every Category of Provider" statute and its interpretations to avoid preemption, it must represent the regulation of insurance under both a common sense view and each of the three criteria of the McCarran-Ferguson test as presented in *Metropolitan Life*.<sup>201</sup> The interpretation of the statute fails to satisfy any of these four requirements. Therefore, as written and interpreted

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191. See Plaintiffs' Memorandum, *supra* note 129, at 25.

192. See *id.* (citing *Jefferson Pilot*, 14 F.3d at 570); see also Order, *supra* note 119, at 10.

193. See *Washington Physicians Service Ass'n*, 967 F. Supp. at 430; Plaintiffs' Memorandum, *supra* note 129, at 25.

194. See *Washington Physicians Service Ass'n*, 967 F. Supp. at 430; Plaintiffs' Memorandum, *supra* note 129, at 25.

195. See Bulletin, 95-9, *supra* note 13.

196. See Plaintiff's Memorandum, *supra* note 129, at 26.

197. See *id.* (citing *Pilot Life*, 481 U.S. 49; *Jefferson Pilot*, 14 F.3d 569).

198. See Bulletin 95-9, *supra* note 13, at 1.

199. See *supra* notes 145-46 and accompanying text.

200. See *id.*

201. See *supra* Part II.

by the Insurance Commissioner the "Every Category of Provider" statute is preempted and may not be saved under the exception. There is no way around this result. Therefore, the federal district court decision rendering the statute and its interpretations preempted was rightly decided. As such, the only way to save the statute is to rewrite it in accordance with the Legislature's intent.

#### IV. A DIFFERENT INTERPRETATION WOULD HAVE RENDERED A DIFFERENT RESULT

There are two ways in which a different interpretation would not have rendered the statute preempted by ERISA. The first, which can be disposed of rather quickly, is that if the Insurance Commissioner had issued a mandate different from the one issued in Bulletin 95-9, the statute would not be preempted because the litigation would not have ensued. The second argument is that the "Every Category of Provider" statute is not a law that "relates to" insurance if it is rewritten as it should have been in 1995 when the 1993 Reform Act was repealed.

##### A. *A Different Interpretation by Commissioner Senn Would Have Preempted the Litigation*

As discussed above, there was no litigation over the language of the statute until after issuance of the Bulletin.<sup>202</sup> Furthermore, the second lawsuit regarding the statute was not filed until September 19, 1996, which was after the Thurston County Superior Court rulings were issued in support of the Commissioner.<sup>203</sup> The only alternative that remained for the carriers after the ruling was to remove the ERISA claim and file it in federal court.<sup>204</sup> In so doing, the carriers added the argument that the statute itself, including and not limited to its interpretations, was preempted by ERISA.<sup>205</sup>

This timeline is evidence that if another less-restrictive mandate had been issued, ultimate preemption would probably not have occurred. For example, rather than applying the statute to "every plan delivered, issued for delivery, or renewed in Washington on or after January 1, 1996, to include all categories of providers in every health

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202. See *supra* notes 48-50 and accompanying text.

203. See *supra* notes 26-27 and accompanying text.

204. See *Washington: Carriers Sue Insurance Commissioner On Alternative Provider Requirement*, HEALTH CARE DAILY REP. (BNA), Jan. 11, 1996, at D-8.

205. See *supra* note 28 and accompanying text.



plan,"<sup>206</sup> Commissioner Senn could have stated that the law was not a mandate that every category of provider be included in every health plan. Rather, it was a "mandate that if a consumer has a condition for which coverage exists, a primary care physician must be able to treat or refer a patient to a provider who can provide prevention, cure, or treatment of an injury or disease."<sup>207</sup> This is not a mandate that a primary care physician must refer a patient; it is an option to refer a patient who has a specific injury or disease to an appropriate licensed provider, which might include a referral to an alternative care provider. In fact, Commissioner Senn, in her brief submitted to Thurston County Superior Court, put forth this more permissive interpretation as her actual interpretation of the statute.<sup>208</sup> If this was indeed the interpretation, carriers would have had an easier time integrating all categories of providers and their services into their existing systems.<sup>209</sup> Again, what is so ironic and so troubling about this whole process is that the system defined by the more permissive interpretation is the one that is in place now, and it has been in place since the litigation over the statute began.<sup>210</sup> Hopefully, hindsight will serve as a lesson for future interpretory mandates and prevent unnecessary expense and litigation for all affected parties.

The second argument, focusing on a different interpretation, is that the "Every Category of Provider" statute is not a law that "relates to" employee benefit plans if it is written as it should have been in 1995 when the 1993 Act was repealed.

*B. An Analysis of the Statute's History Shows That the Law Was Written Incorrectly by the 1995 Legislature*

As discussed in Part I, when the "Every Category of Provider" language first appeared in former title 43, chapter 72 of the Washington Revised Code, it required certified health plans to:

permit every category of health provider to provide health services or care for conditions included in uniform benefits package to the extent that:

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206. Bulletin 95-9, *supra* note 13, at 1.

207. See *supra* notes 83-84 and accompanying text; see also Reply Brief, State Defendant, *supra* note 58, at 8-9.

208. See Reply Brief, State Defendant, *supra* note 58, at 8-9.

209. See discussion *supra* at note 34.

210. See *supra* notes 45-46 and accompanying text.

- (a) The provision of such health services or care is within the health care providers' permitted scope of practices; and
- (b) The providers agree to abide by the standards related to:
  - (i) Provision, utilization review, and cost containment or health services;
  - (ii) Management and administrative procedures; and
  - (iii) Provision of cost-effective and clinically efficacious health services.<sup>211</sup>

The legislature clearly wanted Washingtonians to have the option to choose health services from a full range of providers, including licensed alternative care practitioners.<sup>212</sup> What is important about the above language is that the law applied to *certified health plans*—not to *health carriers*.<sup>213</sup> It is true that certified health plans included disability insurers, HSCSs, and HMOs, but the health care system under which certified health plans were to operate is quite different from the system that exists today.

Under the 1993 Reform Act, health carriers had the option of becoming certified health plans.<sup>214</sup> Being designated as a certified health plan was significant because individuals and employers were, in some instances, required to purchase health insurance through those certified health plans.<sup>215</sup> In order to become a certified health plan, disability insurers, HSCSs, and HMOs had to meet certain standards, which included, *inter alia*, providing benefits equal to the uniform benefits package, managing the provision of health care services, and permitting all categories of providers to provide their licensed services.<sup>216</sup> Washington residents and Washington employers were required to participate.<sup>217</sup> Individuals not enrolled in an employer or government-sponsored plan, for example, were required to purchase a uniform benefits package from a certified health plan by July 1, 1999.<sup>218</sup> Those disability insurers, HSCSs, and HMOs that wanted to sell insurance benefits to individuals had to do so through a certified

211. See former WASH. REV. CODE § 43.72.100 (1993).

212. See former WASH. REV. CODE § 48.43.170(2) (1993).

213. See former WASH. REV. CODE § 43.72.100 (1993); WASH. REV. CODE § 48.43.005(8) (1996).

214. See former WASH. REV. CODE § 48.43.

215. See 1993 Wash. Laws ch. 492 § 464 (repealed by 1995 Wash. Laws ch. 265 § 27).

216. See 1993 Wash. Laws ch. 492 § 427 (repealed by 1995 Wash. Laws ch. 265 § 27).

217. See 1993 Wash. Laws ch. 492 §§ 463-64 (repealed by 1995 Wash. Laws ch. 265 § 27).

218. See 1993 Wash. Laws ch. 492 § 463 (repealed by 1995 Wash. Laws ch. 265 § 27).

Individuals are not subject to ERISA laws because they do not purchase or receive insurance through an employer-sponsored health benefit plan. Title I, ERISA Sec. 3(1).

health plan. Employers offering employer-sponsored plans, however, were treated differently under the Act.

The reason for the emphasis on employers, not just individuals, was that the legislature recognized “that many of the state’s small business owners provide health insurance to their employees through small group policies at a cost that directly affects their profitability,” and that “[o]ther small business owners are prevented from providing health benefits to their employees by the lack of access to affordable health insurance coverage.”<sup>219</sup> As such, the legislature intended that through reform health insurance would be made more available and more affordable to small businesses in Washington.<sup>220</sup>

The 1993 Reform Act required employers with more than five hundred employees to “[o]ffer a choice of the uniform benefits package as provided by at least three available certified health plans before July 1, 1995.”<sup>221</sup> Second, those employers with more than one hundred qualified employees had to “[o]ffer a choice of the uniform benefits package as provided by at least three available certified health plans by July 1, 1997.”<sup>222</sup> Lastly, by July 1, 1997 all employers were required to “[o]ffer a choice of the uniform benefits package as provided by at least three available certified health plans.”<sup>223</sup> In addition, employers could opt out of these requirements by purchasing insurance through the BHP or a health insurance purchasing cooperative.<sup>224</sup>

Essentially, all employers had to offer their employees a choice of insurance through three certified health plans by July 1, 1997. They could also, however, provide any other health insurance option—in addition to the three certified plans—to their employees. Accordingly, there were options available for employers and health carriers under the 1993 Reform Act in that carriers could offer a certified health plan or any other health plan to employers.<sup>225</sup> Therefore, the Reform Act

219. 1993 Wash. Laws ch. 492 § 463(1) (repealed by 1995 Wash. Laws ch. 265 § 27).

220. *Id.*

221. 1993 Wash. Laws ch. 492 § 464(2) (these large employers also had the option of self-insuring which would have exempted them from reform requirements) (repealed by 1995 Wash. Laws ch. 265 § 27).

222. 1993 Wash. Laws ch. 492 § 464(3) (repealed by 1995 Wash. Laws ch. 265 § 27).

223. 1993 Wash. Laws ch. 492 § 464(4) (repealed by 1995 Wash. Laws ch. 265 § 27).

224. 1993 Wash. Laws ch. 492 § 464(2)(3)(4) (repealed by 1995 Wash. Laws ch. 265 § 27); *see also* 1993 Wash. Laws ch. 492 § 425(1) (defining Health Insurance Purchasing Cooperatives as “geographic regions within the state . . . based on population, . . . geographic factors; market conditions; and other factors . . . [there shall be] one health insurance purchasing cooperative per region”) (repealed by 1995 Wash. Laws ch. 265 § 27).

225. Health carriers include: disability insurers, WASH. REV. CODE § 48.44.010(12) (1996); HSCSs § 48.44.010(3) (1996); HMOs § 48.55.010(12) (1996). Under the Reform Act, both disability insurers and HSCSs could provide plans other than those they registered as certified

did not include an absolute mandate that every employer-sponsored health benefit plan provided by a health carrier permit every category of provider in each of those health plans.

Why, if this was the situation, did the 1995 Legislature state that “Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, [be required] to permit every category of provider to provide health services for health services included in the Basic Health Plan?”<sup>226</sup> The answer is simple: they did not intend to. The Legislature inserted the words *health carrier* instead of *certified health plan* because they appear analogous in that they are defined similarly. They are not, however, analogous because every certified health plan did not mean every health plan delivered, issued, or renewed by a health carrier in Washington state.<sup>227</sup> Both employers and carriers had options.<sup>228</sup> What the Legislature did not realize when it changed the language was that in doing so it had mandated “Every Category of Provider” be included in every health plan provided by every health carrier in Washington. Hence, it is the words *every health plan* and *health carrier* that renders the statute preempted by ERISA.

Since the Republican-dominated Legislature intended to completely repeal the laws requiring insurers, health care providers, employers, and consumers to comply with the 1993 Reform Act, it is odd that the Legislature did not pay better attention to the language. A review of the Washington law provides no further insight. Legislative history surrounding the repeal of the Reform Act, however, makes it clear that the lawmakers who voted for the statute intended to make alternative medicine available under the controls of managed care.<sup>229</sup> The Legislature did not mean *every health plan*; what it meant was *certified or managed health plans*.<sup>230</sup> In addition, it arguably did not mean to add the words *health carrier* because of the sweeping impact of that

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health plans. Their respective licenses would have allowed them to market other types of plans such as a point of service plans. See WASH. REV. CODE § 48.44.010(3)(12) (1996). HMOs, however, could only have marketed capitated, prepaid services. See WASH. REV. CODE § 48.44.010(12) (1996). Because of this fact, HMOs would have been more limited under health care reform, because they could only have provided a certified health plan option and a noncertified health plan option with benefits differing from plan to plan rather than differing types of plans.

226. WASH. REV. CODE § 48.43.045 (1996) (emphasis added).

227. See former WASH. REV. CODE § 43.72.100 (1993); WASH. REV. CODE § 48.43.045 (1996).

228. See *supra* notes 214-25 and accompanying text.

229. See *supra* note 79 and accompanying text (citing former WASH. REV. CODE § 48.43.170(1) & (2) (repealed by 1995 Wash. Laws ch. 265 § 27)).

230. See *supra* note 213 and accompanying text.

language. It inserted those words in the belief that the words most closely matched *certified health plan*, which, as concluded above, means something quite different. Thus, if the statute were to read as intended but not as written, it would say:

*Health plans* delivered, issued for delivery, or renewed on or after January 1, 1996, shall:

- (1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan to the extent that:
  - (a) The provision of such health services or care is within the health care providers' permitted scope of practice; and
  - (b) The providers agree to abide by standards related to:
    - (i) Provision, utilization review and cost containment health services;
    - (ii) Management and administrative procedures; and
    - (iii) Provision of cost-effective and clinically efficacious health services.

The above language is inserted instead of "every health plan delivered, issued for delivery, or renewed by a health carrier."<sup>231</sup> If this language—the intended language—is used, the statute would withstand ERISA preemption because, as per the *Travelers* decision, the statute would have little or no indirect economic impact because plan administrators are not bound to any particular choice.

To reiterate, in *Travelers*, the Court held that any indirect economic effect of a statute is not sufficient to cause preemption; however, preemption still would apply to any state law that attempts to regulate benefit structures or their administration.<sup>232</sup> By changing the language of the "Every Category of Provider" statute to comport with legislative intent, as well as with a more permissive interpretation,<sup>233</sup> the statute no longer attempts to regulate benefits structures or their administration. Plan administrators would have the freedom and discretion of whom to contract with and whom to pay.<sup>234</sup> In this scenario, even if the Bulletin's mandate were still in effect, only the interpretation—not the statute itself—would be preempted.

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231. See WASH. REV. CODE § 48.43.045 (1996).

232. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. at 646; see also *Washington Physicians Service Ass'n*, 967 F. Supp. at 426.

233. See *supra* notes 206-10 and accompanying text.

234. See *supra* notes 124-26 and accompanying text.

Once the statute is written in a way in which it does not regulate benefit structures or their administration, the issue of whether the statute has an indirect economic impact or influence on ERISA plans will have to be decided. Accordingly, the way the statute should have been written and interpreted has little or no indirect economic impact or influence on ERISA plans. First, there is no regulation of rates or exaction of fees or surcharges associated with the statute.<sup>235</sup> Second, with none of the aforementioned items required by the newly-written statute, the only possible economic impact would be on the risk-bearing responsibility of ERISA plans. And, as already illustrated, the statute and its interpretations (mandatory or permissive) do not spread risk.<sup>236</sup> "The choice of health care provider has nothing to do with spreading the risk of coverage. . . . [S]preading the risk entails the amount of coverage that the insurer will bear for the treatment of a particular injury or procedure—not who will perform the treatment."<sup>237</sup> Therefore, as a matter of ERISA policy, the statute as correctly interpreted and newly-written does not "relate to" ERISA plans because it is simply managed care regulation that has no direct, or even indirect, economic impact or influence on them.<sup>238</sup>

#### CONCLUSION

The "Every Category of Provider" statute was public interest legislation passed in order to provide health insurance policyholders the choice of alternative care providers in certain situations proscribed by the statute. The statute was not a blanket mandate forcing insurance carriers to include every category of provider in every one of their health insurance benefit plans.

As such, the statute and its interpretation should be revisited. Because the federal district court decision preempting the statute was rightly decided, the Ninth Circuit should not reach any other conclusion when reviewing the federal district court order: the statute is unambiguous.

Alternatively, it would be in the legislature's best interest to reconsider the language of this statute and rewrite it so that it comports with federal law. Washingtonians have made it clear that they want alternative medicine made available through their health insurance

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235. See *Travelers*, 514 U.S. at 646.

236. See *supra* notes 161-90 and accompanying text.

237. *Washington Physicians Service Ass'n*, 967 F. Supp. at 429 (citing *Blue Cross and Blue Shield of Alabama v. Nielson*, 917 F. Supp. 1532, 1542 (N.D. Ala. 1996)).

238. See *Farrell*, *supra* note 108, at 269.

plans. The statute ensures this process will continue by supporting the insurance industry, the traditional health care industry, and the alternative medicine industry in creating a system that provides—in the most cost-effective, quality-based manner—access to and treatment by all licensed categories of providers.