Understanding ERISA

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Employee Retirement Income Security Act (ERISA): 2003 Rulings and Impact on Chiropractic

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Appendix A

Section I – Introduction to New ERISA Regulations

The information provided in this section is also available in *Employee Retirement Income Security Action (ERISA): Introduction to New Regulations*, also available on the ACA website, and is restated below as a reminder of the basic changes to ERISA regulations with impact on the chiropractic profession.

A. Background Statement

What is ERISA?

The Employee Retirement Income Security Act (ERISA), a law passed by the U.S. Congress in 1974, sets standards for:

- Administering private employee health benefit plans ("plans"),
- Disclosing financial and other information to plan participants ("enrollees/beneficiaries"), and
- Processing of health claims [1].

What is an ERISA Plan?

ERISA regulations only cover plans provided by private employers; therefore, non-private employer-provided plans are not covered under ERISA regulations. ERISA regulations apply to private employer plans that are self- and fully-insured plans. Non-private plans are provided by:

- Government Agencies
- Medicare
- Medicaid
- Public Schools
- Workers' Compensation
- Military
- Churches
- Any other plans that are not covered by a private employer.

Determining whether an enrollee/beneficiary is in an ERISA plan versus a non-ERISA plan is tricky for providers because the same networks can be used by an ERISA and non-ERISA plan. The test to determine whether an enrollee/beneficiary is covered by an ERISA plan or non-ERISA plan is to find out if the plan is provided by a private employer; if so, the plan is an ERISA plan unless the private plan is a church.

Why was ERISA enacted?

ERISA was enacted to:

- Protect the interests of enrollees/beneficiaries and their dependents with private employee benefit plans, and
- Establish one Federal comprehensive law, thereby reducing the conflict of the employer meeting multiple states' laws.

Enrollee/beneficiary interests include:

- Access to financial and other information regarding the plan,
- A standard of conduct requirement for plan fiduciaries [2], and
- Consistency in the administration of plans in multiple states.

B. 2003 Changes to ERISA Plans

What changes occurred recently that affect ERISA Plans?

Certain State Laws may now apply to ERISA Plans. The U.S. Supreme Court ruled in April 2003, in the case of *Kentucky Association of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471 (S Ct., April 2, 2003), deciding that ERISA plans are no longer exempt from certain state insurance laws (in some important areas). Simply stated, ERISA plans that were previously exempt from state law, may no longer be exempt and are subject to applicable insurance laws.

With this ruling, plus other U.S. Supreme Court rulings and several U.S. Courts of Appeals rulings, the legal groundwork has radically changed in the area of preemption [3] of state insurance laws that may individually regulate ERISA health care plans. The new test, to determine whether any state insurance law is shielded from ERISA preemption, requires determination as to whether the law regulates insurance (i.e., assumes financial risk for claims payment). Evaluation of a state law must:

- Show the state law is specifically directed toward these groups engaged in insurance; and
- Substantially affect the financial risk of claims payment between the insurer (i.e., employer) and the enrollee/beneficiary.

In addition, in January 2003, the U.S. Department of Labor established new claim and appeal [4] procedures effective for all ERISA health benefit plans. These can be found at: www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

Generally, the claim appeal procedures hold plans to these requirements:

- Include a specific time frame for filing an appeal,
- Spell out the rights of plan participants and responsibilities of the plans, and
- Require the plan to indicate why and on what basis a claim was denied.

C. Changes Resulting from Recent Regulatory Changes

How has my practice been affected?

Before these 2003 ERISA claim and appeals regulations there was:

- Lack of recourse in filing an appeal.
- Lack of information on whom, in a payer organization, made an adverse benefit or claim review decision.
- No responsibility to determine on what basis or sources the decision was adjudicated.

What do the new ERISA Regulations allow?

The new ERISA regulations:

- Allow access to an appeals process in the case of an adverse benefits or claims-payment decision.
- Require the citing of any reasons (e.g., efficacy research studies) used in the claim decision.
- Require the credentials of the decision-maker be provided to the enrollee/beneficiary upon request free of charge.

D. ACA Actions on ERISA Regulations

What is the ACA doing?

In regard to the new ERISA court determinations the ACA, in order to support the chiropractic profession and state associations, is developing information on how to deal with these recent rulings, including recommendations on state law evaluation. An ongoing analysis to explore other new laws that may develop following these Court decisions is also underway.

Note these rulings now provide a new opportunity for states to revisit the issue of indirect regulation of ERISA plans - a real opportunity for doctors of chiropractic (DCs) to ensure ERISA plans are administering chiropractic benefits fairly. While the rulings do not mandate

chiropractic benefits, it does allow opportunity to explore the extent to which states may indirectly regulate ERISA plans.

Section II – ERISA Regulations Affecting Providers, Enrollees/Beneficiaries, and Plan Administrators

This section provides detailed information in a question/answer format on the following major categories:

A. Claim Submission Requirements for the Doctor of Chiropractic
B. Plan Administrator Requirements
C. Denied Claim Appeal Process

A. Claim Submission Requirements for the Doctor of Chiropractic

What does ERISA require for claims submission and the filing of an appeal?

It is important for the provider to review and understand the health benefits Summary Plan Description (SPD) [5]. Section 502(a)(1)(A) indicates the Plan Administrator [6] has thirty (30) days to provide the SPD to the enrollee/beneficiary. The purpose of the SPD is to:

- Explain to enrollees/beneficiaries the way the plan is managed, and
- Answer all questions about the plan and the enrollee/beneficiary health benefits.

The SPD contains coverage information and procedures for the following:

- Filing claim forms including claim filing deadlines,
- Providing notification of benefit determinations,
- Reviewing denied claims,
- Obtaining preauthorizations, and
- Utilization review decisions.

ERISA plans are required to provide enrollees/beneficiaries with their health benefits SPD. An enrollee/beneficiary may file suit against a Plan Administrator who fails to comply with the enrollee's/beneficiary's request for a copy of the latest SPD. The Plan Administrator may be held liable for up to $110.00 per day for each day he/she fails to provide the SPD to the enrollee/beneficiary.

Failure to follow claim submission and appeal procedures could result in a denial of a claim.

B. Plan Administrator Requirements

Is the Plan required to provide notice?

Section 502 of the ERISA regulations requires every ERISA plan to provide "adequate notice in writing" to the enrollee/beneficiary and the provider when an initial claim has been denied. This denial notice must:

- Provide the specific reason(s) for the denial, and
- Include the plan provision that is the basis for the denial.

In addition, the enrollee/beneficiary must be given "a reasonable opportunity" for a "full and fair review by the appropriate named fiduciary" of any denied claim.

The fiduciary exercises management or control of the plan and is held accountable in ensuring the provisions of the health benefit plan are administered fairly and without bias.

- **Claim Processing**

How are claims defined?

- Pre-service claim - A request for benefit approval in advance of treatment.
- Post-service claim - A claim for a benefit, after the services were provided.
- Urgent care claim - A claim for medical care or treatment that considers the period or promptness in the delivery of the care. Urgent care claims are characterized by:
  - If the lack of care could seriously jeopardize the life or health of the enrollee/beneficiary or the ability of the enrollee/beneficiary to regain maximum function, or
  - In the opinion of a physician, with knowledge of the enrollee/beneficiary's medical condition, lack of care would subject the enrollee/beneficiary to severe pain that cannot be adequately managed without the care or treatment.

Do the new ERISA Regulations include requirements for claim processing and denial of an appeal?

Under new ERISA regulation 29 CFR §2560.503.1, a Plan Administrator has a set number of days:

- To process the claim and
- To respond to an appeal of a denied claim.

What are the claim processing and appeal response timelines?

Plans must meet claim-processing timelines and provide adequate notice to the employee if more information is needed. The U.S. Department of Labor outlines the timeline the Plan Administrator has to request additional information and the time that the enrollee/beneficiary has to respond. The Plan Administrator must inform the enrollee/beneficiary of the information required to continue processing the claim and the plan's procedures for filing a claim.

The plan must provide a notice for any claims submitted incorrectly, or that lack information, and indicate the plan's claim filing procedures were not followed. Because the filed claim did not include all of the necessary information, it is not considered a claim under the terms of the plan. The notice may be provided orally to the enrollee/beneficiary or the provider (as appropriate), unless requested that the notice be a written notice.

It must be decided within 72 hours of receipt of an urgent care claim whether to reimburse for the services rendered.

The claim-processing clock begins when a claim is filed, even if some information necessary to process the claim is not provided. Each calendar day is counted, including weekends/holidays. If an incomplete claim delays the claim processing, the days used to obtain the missing information are counted in the processing timeline.

Claim Processing and Appeal Timelines

	Pre-service Claim	Post-service Claim	Urgent Care Claim
Processing Timeline	15 days from receipt of claim	30 days from receipt of claim	72 hours from receipt of claim
Extension for the Plan	15 days	15 days	None
Request Missing Information from Enrollee/Beneficiary	5 days	30 days	24 hours
Enrollee/Beneficiary to Provide Missing Information	45 days	45 days	48 hours
Enrollee/Beneficiary's Request for an Appeal	180 days	180 days	180 days
Appeal Determination Timeline	30 days from receipt of request, or 15 days for each appeal if the plan provides two levels of appeal.	60 days from receipt of request, or 30 days for each appeal if the plan provides two levels of appeal.	The decision must be made within the initial 72 hours.

Notice of the extension must be given by the plan to the enrollee/beneficiary within the initial decision period. If the extension is required because the enrollee/beneficiary failed to submit sufficient information to process the claim, the enrollee/beneficiary must be allowed enough time, from receipt of the notice of the extension, to submit the missing information.

The regulations do not provide for any extensions of these periods by plans under any circumstances, although they do not prohibit consensual agreements between enrollees/beneficiaries and plans on the timing of decisions.

- **Claim Reviewer Credentials**

Does ERISA mandate the credentials of the Plan Administrator's claim reviewer?

The regulations require that if the denial involves questions of medical necessity, the plan must consult a health care professional with the appropriate experience in the health care field involved with the claim. This means a DC should be consulted for a professional opinion on treatment provided by a DC. Refer to ACA's policy on consultant selection criteria by reviewing the Payer Medical Review Accountability policy at: www.acatoday.com/about/policies.shtml for additional information.

Does ERISA mandate the information requirements for an enrollee/beneficiary?

Under the regulations, enrollee/beneficiary must have reasonable access to "relevant information" upon request and free of charge. "Relevant information" includes:

- Information that was relied on in making the benefit determination,
- Information submitted, considered, or generated while making the benefit determination, and
- Statements of policy or guidance concerning denied treatment or benefits, even if the plan did not rely on it.

C. Denied Claim Appeal Process

- **Claim Denial**

How are denials and appeals handled?

Health claim denial based on a **health plan rule, guideline, or protocol**:

- If a claim denial is based on a plan's internal rule, guideline, or protocol, then the rule, guideline, or protocol must be referenced in the denial notice, and

- The enrollee/beneficiary either must be given a copy of the information or be told that he/she has the right to receive a copy of the information upon written request, free of charge.

Health claim denial based on **medical necessity or medical judgment**:

- If a claim denial is based on medical necessity or medical judgment, the enrollee/beneficiary must be provided with the clinical basis upon which the decision was made, or
- Be told that he/she has the right to receive this explanation upon request, free of charge.
- In addition, the enrollee/beneficiary has the right to receive the name and qualifications of any health care professional consulted in connection with the claim denial.

- **Claim Appeal**

Group health plans [7] may not require more than two levels of mandatory appeal and both must be completed within the relevant time frame described in the regulation. In addition, the plan cannot require mandatory binding arbitration.[8] However, nonbinding voluntary arbitration and voluntary appeals are permitted, but the process should be completed within the applicable time frame specified in the regulation or at the time the dispute arises.

An appeal is a formal notice, submitted by the enrollee/beneficiary to the plan, requesting a reconsideration of the initial denied claim.

- **Enrollee/Beneficiary Rights**

Can a DC act as the authorized representative for an enrollee/beneficiary when filing an appeal?

A DC may act as the authorized representative for the enrollee/beneficiary in the claim appeal process. Regulations provide that:

> *"A plan's claims procedures may not preclude an authorized representative (including a health care provider) from acting on behalf of a Claimant* [9] *and further provides that a plan may establish reasonable procedures for verifying that an individual has been authorized to act on behalf of a Claimant. However, subparagraph (b) (4) requires a group health plan to recognize a health care professional with knowledge of a Claimant's medical condition as the Claimant's representative in connection with an urgent care claim."*

For the DC to act as the authorized representative, the patient must complete an Authorization Form, which is available on page 15 of this document.

What are the enrollee's/beneficiary's rights?

An enrollee/beneficiary can request, in writing, copies of:

- Guidelines,
- Protocols, and
- Explanations of any clinical or scientific judgments that were applied in denied claims.

An enrollee/beneficiary can learn the identity and qualifications of any health care professional consultant used in the review of the claim. An individual who made the initial denial of the claim cannot conduct the appeal. The appeal must be handled as a new situation without deferring to any past denials that were used in making the initial decision. A subordinate of the individual who made the initial denial of the claim cannot be the person who makes the decision on the appeal.

The fiduciary shall consult with a health care professional with appropriate training and experience in the health care field, when reviewing a denied claim appeal where the denial was based on a:

- Medical judgment, or
- Treatment, drug, or other item considered experimental, investigational, or not medically necessary or appropriate.

In the case of a claim involving *urgent care*, the following guidelines apply in order to expedite the review process:

- An enrollee/beneficiary can make the appeal orally, or in writing.
- All necessary information, including the claim payment decision, may be transmitted between the plan and the enrollee/beneficiary by telephone, facsimile, or other available similarly expeditious method.

- **Appeal Process and Response Time**

What is the ERISA process when filing an appeal of a denied claim?

The fiduciary has the responsibility of complying with ERISA regulations and the SPD. Prior to submitting an appeal:

- Contact the Plan Administrator to determine if there is a form to use when filing an appeal.
- Obtain the name and address of the fiduciary. This information is located in the SPD.

Summary of the Appeals Process

Generally, the denied claim appeal should:

- State clearly that an appeal is being filed.
- State it is an appeal, not an inquiry (there should be no question).
- Provide a copy of a signed document (i.e., Authorization Form) that you have been authorized by the enrollee or beneficiary to file the appeal.
- Include the provider's name, address, phone number, and license number.
- Include the enrollee's/beneficiary's name, address, phone number, date of birth, Social Security or plan identification number, and group policy number.
- Include relevant explanations and clarify any information that may have been in question in the initial claim denial.
- Provide all relevant documentation and history of the denied claim.
- Include a copy of the claim and the Explanation of Benefits.
- Sign and date the appeal.
- Address the letter to the fiduciary.
- Forward the appeal to the Plan Administrator via Certified Mail/Return Receipt Requested.
- The enrollee, beneficiary, or enrollee/beneficiary has the right to attend the appeal hearing and can question the Appeals Coordinator or Appeals Committee and any witnesses.

If a plan fails to provide a process that meets the regulatory minimum standards (as outlined above), the enrollee/beneficiary is deemed to have exhausted the available administrative remedies and is free to pursue a claim in U.S. Federal Court.

- **Arbitration and Mediation**

Are arbitration and mediation allowed under ERISA regulations?

Arbitration

Arbitration and mediation [10] are allowed under ERISA regulations and may be viable avenues to resolve disputes, as they are less costly and less time consuming than going to Court. Arbitration follows strict guidelines as to what can be negotiated. However, in mediation, all matters can be negotiated. Mediation is grounded on what the parties can agree to. Furthermore, all matters pertaining to the claim can be negotiated in mediation.

Some plans contain mandatory requirements for Arbitration in the review process. ERISA regulations indicate a plan may require Arbitration as one, or both, of the permitted levels of review of a denied claim, provided that:

- Arbitration is conducted in accordance with the ERISA regulations applicable to such appeals and
- The enrollee/beneficiary is not precluded from challenging the arbitrator's decision, including pursuing the claim in Court.

Additional levels of voluntary appeal, including voluntary binding arbitration or other methods of dispute resolution, may be offered by a plan only after the appeal has been filed. In addition, the plan must provide the enrollee/beneficiary with sufficient information about the voluntary process to allow the enrollee/beneficiary to make an informed judgment about whether to submit the dispute to the voluntary process. This requirement includes:

- Information about the applicable rules,
- The process for selecting the decision maker, and
- The circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result, or any past or present relationship with any party to the review process.

The plan must also make clear to the enrollee/beneficiary that the decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the enrollee/beneficiary's rights to any other benefits, under the plan.

In arbitration, the enrollee/beneficiary must be allowed an opportunity to have legal counsel.

Mediation

Mediation is a voluntary alternative dispute resolution process. An agreement for mediation would need to be agreed to by the fiduciary and the enrollee/beneficiary. Contact the local U.S. Department of Labor Office and/or the state insurance regulatory agency, which can provide assistance with mediation.

Any voluntary dispute resolution must follow the guidelines below:

- The plan can only offer mediation after a dispute has arisen.
- The plan must provide the enrollee/beneficiary with sufficient information about the voluntary process to permit the enrollee/beneficiary to make an informed judgment about whether to submit the dispute to the voluntary process.
- The plan must make clear to the enrollee/beneficiary that the decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the enrollee/beneficiary’s right to any other benefits, under the plan.
- A plan that offers to a claimant the option of a voluntary appeal cannot assert in its defense that the claimant failed to use all possible administrative remedies (i.e., voluntary appeal), if the claimant chose to not use the voluntary appeal procedure.

- The plan must agree that any statute of limitations, or other defense based on timeliness, will count the days the dispute is under submission to the voluntary process.
- The enrollee/beneficiary cannot be charged for arbitration or mediation.

What are the enrollee/beneficiary rights when filing a suit?

Section 502 of the ERISA regulations permits an enrollee/beneficiary to file suit (after filing an appeal) against the plan to:

- Recover health benefits due under the terms of the SPD, including reimbursement of the provider for the claim and
- Clarify his/her rights for future benefits under the terms of the SPD.

Section 502 of the ERISA regulations provides the following for an enrollee/beneficiary who files suit:

- Payment for the claims, and
- Injunction prohibiting the plan from wrongfully denying the payment of future health benefits.

Additional Information

The U.S. Department of Labor Employee Benefits Security Administration provides a question & answer page and other information regarding the Benefit Claims Procedure Regulation at: www.dol.gov/ebsa/ faqs/faq_claims_proc_reg.html

The entire regulation is available at: www.benefitslink.com/erisaregs/claims_health_2000.pdf\2560.50

Further discussion of dispute resolution is described at: www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

Footnotes

[1] **Claim** – The proposal provided that a ‘‘claim’’ is any request for a plan benefit or benefits, made by a claimant or by a representative of a claimant, that complies with a plan’s reasonable procedure for making benefit claims.

[2] **Fiduciary** – A person, as defined under ERISA, that exercises any discretion or control over management of the plan or the management or disposition of its assets. There may be named fiduciaries of a plan, or third-party service providers may be fiduciaries, if they agree to be fiduciaries or if they exercise discretion of control over the management of plan benefits.

[3] **Preemption** – A doctrine of law that allows a federal law to take precedence over, or to displace, a state law.

[4] **Appeal** – A payer process in which a provider or an enrollee/beneficiary can request a reconsideration of a payer decision (e.g., claim payment, benefit determination).

[5] **Summary Plan Description (SPD)** – A statement/contract of the health care services (covered benefits) determined to be reimbursable by the payer on behalf of the insured. An SPD should indicate co-pay amounts, number of chiropractic visits, etc.

[6] **Plan Administrator** – A person or entity, specifically designated as such by the terms of the Summary Plan Description. Plan administrators may also be fiduciaries if they: a) agree to serve as a fiduciary, or b) exercise discretion or control over plan benefits.

[7] **Group health plan** – An employee benefit plan established or maintained by an employer or by an employee organization (e.g., union) or both, that provides medical care for enrollees/beneficiaries directly or through insurance, reimbursement, or otherwise. Generally, group health plans are ERISA plans.

[8] **Arbitration** – A process of resolving a dispute or grievance outside of the court system by presenting it, to an impartial third party or panel, for a decision that may or may not be binding.

[9] **Claimant** – The enrollee/beneficiary or practitioner, in the case where the enrollee/beneficiary has signed an Authorization Form authorizing the practitioner to act as his/her representative, who has filed an appeal.

[10] **Mediation** – A nonbinding process, between two parties, to promote a resolution, reconciliation, settlement, or compromise.

Appendix A

AUTHORIZATION

For good and valuable consideration, I _____, do hereby designate, authorize, and convey to _____ to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee health care benefit plan; and b) the right and ability to act on my behalf to pursue such claim, right or chose in action in connection with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 as provided in 29 CFR §2560.503-1(b)(4)) with respect to any medical or other health care expense incurred as a result of the services I received from the above-named doctor and, to the extent permissible under the law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

_____

Patient's Signature / Date

Note: It is also important to check with the plan to determine if it has its own Authorization form for enrollee/beneficiary use.

States That May be Affected by the 2003 ERISA Pre-emption Rulings

"This outline of state statutes is designed to provide general information in regard to the Subject Matter covered. It may also not include all relevant state statutory references. It is provided with the understanding that the American Chiropractic Association is not engaged in rendering legal or other professional service. If legal advice or other expert assistance is required, the services of a competent professional person should be sought."

(Also references to ERISA preemption decisions prior to U.S. Supreme Court decision in *Kentucky Association of Health Plans v. Miller*).

State and Cite	Entities Regulated	Statutory Provisions
ALABAMA Ala. Code §27-1-19 1994	Persons, firms, corporations, associations, HMOs, health insurance service or preferred provider organizations, non-profit health service organizations, and employer-sponsored health benefit companies	The agreement providing coverage to an insured "may not exclude the right of assignment of benefits to any provider at the same benefit rate as paid to a contract provider."
ARKANSAS Ark. Code Ann. §§23-99-201 to 209 1995	Insurers (including HMOs and PPOs)	Benefit differentials are prohibited. Insurers must give qualified health care providers the opportunity to participate in their plan if providers are "willing to accept" the plan's terms and conditions. Does not apply to plans that are self-funded or otherwise exempt from state regulation by virtue of ERISA. *See Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1997) *aff'g* 964 F.Supp. 1285 (E.D. Ark. 1997) (ERISA preempts Arkansas any-willing-provider statute in its entirety).
FLORIDA Fla. Stat. ch.456.055 1985	Preferred provider organizations	Licensed chiropractors or podiatrists "shall not be denied payment" for treatment provided solely on the basis that the chiropractor or podiatrist is not a member of a particular PPO.
GEORGIA Ga. Code Ann.	Health care corporations (defined in §33-20-3 as a	Appropriately licensed providers "shall have the right" to become

§§33-20-16 1976	corporation established to administer one or more health plans)	participating physicians or approved health care providers under terms or conditions imposed on other participating physicians.
Ga. Code Ann. §33-30-25 1988	Insurers	Insurers may impose "reasonable limits" on the number of classes of preferred providers that meet the insurers' standards. However, insurers must not discriminate on the basis of religion, race, color, national origin, age, sex, or marital or corporate status, and must give all licensed and qualified providers within a defined service area the opportunity to become a preferred provider.
Ga. Code Ann. §33-24-54 1992	Persons issuing/administering accident and sickness policies, subscriber contracts, or self-insured health benefit plans	Persons issuing accident and sickness policies, subscriber contracts, or self-insured health benefit plans that provide benefits payable to participating or preferred providers shall be required to pay benefits to licensed non-participating or non-preferred providers who have rendered health care services, have a written assignment of benefits, and have given written notice of such assignment to the person licensed under this title or jointly to such non-participating or non-preferred providers and to the insured, subscriber, or other covered person.
Ga. Code Ann. §31-7-75(27) 1995	Hospital authorities	Any health care provider "shall be eligible to apply to become a participating provider under such a hospital plan or network which provides coverage for health care services . . ., provided that nothing contained in this Code section shall be construed to require any such hospital plan or network to provide coverage for any specific health care service."

IDAHO Idaho Code §41-3927 1994 (1997)	Health maintenance organizations	Organizations issuing benefits must be willing to contract with qualified providers who meet the terms of the organization, practice within the geographic area served by the organization, and wish to become participating providers.
INDIANA Ind. Code §27-8-11-3 1994 (1998)	Insurers	Hospitals, pharmacists, and other providers who agree to comply with established terms and conditions are entitled to enter into contracts with insurers for the provision of health care services. Terms and conditions established by insurers may not "discriminate unreasonably against or among providers."
KENTUCKY Ky. Rev. Stat. Ann. §304.17A-270 1999	Health insurers	"A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky State Medicaid program and Medicaid partnerships." Also requires a "health benefit plan that includes chiropractic benefits [to] . . . [p]ermit any licensed chiropractor who agrees to abide by the terms [and] conditions . . . of the . . . plan to serve as a participating primary chiropractic provider." *See Kentucky Association of Health Plans, Inc. v. Nichols*, 227 F. 3d 352 (6th Cir. 2000) (Kentucky any-willing-provider law is saved from ERISA preemption because it regulates insurance).

LOUISIANA La. Rev. Stat. Ann §40:2202(5)(c) 1984 (1999)	Group purchasers (organization or entity that contracts with providers for the purpose of establishing a preferred provider organization)	"No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract, shall be denied the right to become a preferred provider. . . However, nothing in this Part shall be construed to require any hospital to grant any provider or class of providers medical staff membership." *See Cigna Healthplan of La. V. Louisiana*, 82 F. 3d 642 (5th Cir. 1996) (ERISA preempts the Louisiana statute insofar as it relates to third-party administrators and health care plans that provide services to ERISA-covered benefit plans).
MINNESOTA Minn. Stat. §62Q.095 1994 (1999)	Health plan companies, except any health plan company with 50,000 or fewer enrollees and those exempt under subdivision 6. (Subdivision 6 exempts staff-model health plan companies as defined in §295.50, subdivision 12b.)	Health plan company must "establish an expanded network of allied independent health providers, in addition to a preferred network." For acceptance into the expanded network, a provider must (1) satisfy the company's credentialing standards; (2) comply with the terms and requirements of the company's provider agreement; and (3) agree to adhere to the "managed care protocols" of the health plan company. Note: Information from Minnesota Chiropractic Association indicates that this provision has had little if any practical effect.
MONTANA Mont. Code Ann. §33-22-1704 1987 (1993)	Health care insurers entering into preferred provider agreements	A preferred provider agreement must provide all health care providers with the opportunity to participate on the basis of a competitive bid or offer.
RHODE ISLAND R.I. Gen. Laws §23-17.13-3 1996 (1999)	Health plans	(c) Issuance of certification – (7) A health plan shall not exclude a provider of covered services from participation in its provider network based solely on: (a) The provider's

		degree or license as applicable under state law; or (b) The provider of covered services lack of affiliation with, or admitting privileges at a hospital, if such lack of affiliation is due solely to the provider's type of license.
TEXAS Tex. Ins. Code Ann. §20A.14(g), (h) 1987 (1997)	Health maintenance organizations	(g) Licensed providers who comply with terms and conditions set by an HMO may not be denied participation to provide health care services delivered by the HMO "on the sole basis of type of license or authorization." (h) HMOs shall provide a 20-day open enrollment period during which providers or physicians may apply to participate in providing health care services under the HMO's terms. *See Texas Pharmacy Association v. Prudential Ins. Co.*, 105 F.3d (5th Cir. 1997) (Tex. Ins. Code Ann. Art. 21.52B related to employee benefit plans for ERISA preemption purposes because it eliminated a method by which plans could structure benefits).
UTAH Utah Code Ann. §31A-22-617 1994 (2000)	Insurers, third-party administrators	Insurers must allow providers to apply for and be designated as preferred providers if they agree to meet established terms and conditions. Nevertheless, "reasonable limitations" may be placed on the number of designated preferred providers.
VIRGINIA Va. Code Ann. §38.2-3407 1983	Insurers offering preferred provider policies or contracts that limit the providers eligible for payment as preferred providers	Insurers shall establish terms and conditions that must be satisfied in order to receive payment as a preferred provider. The terms and conditions "shall not discriminate unreasonably against or among such health care providers." Insurers must not exclude any hospital, physician, or

		other type of provider listed above willing to meet the terms and conditions. *See Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993) (Va. Code Ann. §38.2-3407 regulates the business of insurance and thus escapes preemption by ERISA).
Va. Code Ann. §38.2-4209 1983 (1999)	Non-stock corporations	Providers who are willing to accept established terms and conditions may qualify for payment under preferred provider subscription contracts.
WYOMING Wyo. Stat. §26-22-503 1993 (1995)	Groups, insurers	Groups or insurers must grant any provider willing to meet the established requirements the right to enter into contracts relating to health care services.
Wyo. Stat. §26-34-134 1995	Health maintenance organizations	Providers willing to meet an HMO's established terms shall not be denied the right to contract with the HMO. ("This subsection shall not be construed to require any health maintenance organization to involuntarily employ any person. . .") An HMO may not discriminate against a provider on the basis of the provider's academic degree.