When the United States Supreme Court unanimously upheld Kentucky's any willing provider laws on April 2, 2003, physicians, hospitals, and other health care providers in Kentucky and other states with such laws felt a surge of strength for their future dealings with health insurers. No longer can the insurers in those states choose not to allow any clinically qualified provider to furnish (and be paid for) services to the insurers' beneficiaries, as long as the provider satisfies the insurers' reasonable terms and conditions for participation.

The principal Kentucky statute which the court upheld states that "[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."

Time will tell what the "geographic coverage area" of each plan will be deemed to include, and what "terms and conditions" the insurers may now seek to impose. A separate Kentucky statute says they must be "relevant" and "objective" and "reasonably related to the services provided." Procedures for "soliciting and acting upon applications" must be "fair and systematic" with provider enrollment conducted "at least annually."

Kentucky's principal any willing provider law applies explicitly to the Kentucky Medicaid program. But what about Medicare's managed care programs? A federal statute and a federal regulation covering those so-called Medicare + Choice Plans states in so many words that state any willing provider laws will not apply to their provider networks.

What about employers who self-insure their health benefits programs either on a stand alone basis or on a group basis? The U.S. Supreme Court stated in a footnote that self-insured plans are "insurance" for purposes of the rule it announced. It pointed out that Kentucky's insurance code defines "insurer" for purposes of Kentucky's any willing provider laws to include any "self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA."
The health insurance industry initiated the litigation leading ultimately to the Supreme Court's decision. But its "loss" is by no means a devastating development for their business. The marketplace had already rejected many of the managed care products which flourished in the 1990s. The public was never enamored with gatekeepers and pervasive precertification requirements. Insurers had been sued based on their alleged responsibility for the acts and omissions of the limited range of providers they allowed in their panels.

The insurers were already moving toward easier access to providers chosen by the patients, reducing some of their potential liabilities, with the patients more responsible for a share of the costs through higher deductibles, copayments, and coinsurance.

How will this affect physicians as a practical matter? The essential news is, of course, good for those previously denied access. Ethical and competent physicians will now be able to get on virtually any insurance panel (except the Medicare + Choice panels) in the any willing provider states. The news is not so good for the physicians who previously were admitted. Now they will have more competition. Moreover, this important new ruling will not change the fact that physicians will continue to have only marginal power in negotiating payment rates with the insurers, as long as the physicians are splintered into small practice groups.

This column appeared in the June 2003 edition of Medical News.