No. 00-1471

In the Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL., PETITIONERS

v.

JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

PAUL D. CLEMENT
Acting Solicitor General
Counsel of Record

EDWIN S. KNEEDLER
Deputy Solicitor General

JAMES A. FELDMAN
Assistant to the Solicitor General
Department of Justice
Washington, D.C. 20530-0001
(202) 514–2217

HOWARD M. RADZELY
Acting Solicitor of Labor

ALLEN H. FELDMAN
Associater Solicitor

NATHANIEL I. SPILLER
Deputy Associate Solicitor

GARY K. STEARMAN
Attorney
Department of Labor
Washington, D.C. 20210

QUESTION PRESENTED

Whether Kentucky's "any willing provider" law, which requires each health maintenance organization (HMO) in the State to make available to its subscribers the services of any medical provider in its geographical region that agrees to the terms and conditions offered by the HMO, is saved from pre-emption as a law that "regulates insurance" under ERISA Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A).

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Cases—Continued: Page

Statutes:

In the Supreme Court of the United States

No. 00-1471

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL., PETITIONERS

v.

JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. Kentucky's "any willing provider" (AWP) law provides:

> 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.

Ky. Rev. Stat. Ann. § 304.17A-270 (Michie 2001).[1] Under the AWP law, a "health insurer" must make available to its

[1] When this suit was commenced, the AWP law applied to "health benefit plan[s]," Ky. Rev. Stat. Ann. § 304.17A-110(3) (Banks-Baldwin 1995); but in 1998, the Kentucky legislature revised the law to apply to "health insurer[s]," as quoted above. Pet. App. 5a-6a. The court of appeals addressed the validity of the law in its "present form." Pet. App. 6a.

subscribers the services of any medical provider in its geographical area that agrees to the terms and conditions offered by the HMO to providers. An "insurer" is defined as

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001). Supporters of AWP laws argue that the laws make it easier for patients to have access to providers of their choice, while opponents argue that they lead to increased costs by limiting the ability of insurers to guarantee a high volume of patients to providers in return for lower charges. See Pet. App. 34a n.18.

The issue in this case is whether ERISA preempts the Kentucky AWP law. Three ERISA provisions are relevant. First, ERISA's general preemption provision, Section 514(a), 29 U.S.C. 1144(a), states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Second, ERISA's insurance saving clause, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." Third, ERISA's deemer clause, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), which qualifies the insurance saving clause, provides that "[n]either an employee benefit plan * * * nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer * * * for purposes of any law of any State purporting to regulate insurance companies, [and] insurance contracts."

2. Contending that ERISA preempts Kentucky's AWP law, petitioners—five health maintenance organizations (HMOs) licensed under the laws of Kentucky and a Kentucky-based non-profit association of HMOs—filed suit against the Insurance Commissioner of Kentucky in federal district court to enjoin enforcement of the law. Pet. App. 64a-65a. The district court upheld the law, ruling that, although the AWP law "relate[s] to" ERISA plans, it "regulates insurance" and is therefore saved from preemption under the insurance saving clause. *Id.* at 78a-82a.

3. A divided panel of the Sixth Circuit affirmed. Pet. App. 1a-38a. The court unanimously ruled that Kentucky's AWP law "relate[s] to" employee benefit plans under 29 U.S.C. 1144(a), because it has both a "reference to" and a "connection with" ERISA plans. The panel concluded that, because the AWP law applies to a "self-insured plan * * * *to the extent permitted by ERISA*," Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001) (emphasis added), it refers to ERISA plans. See Pet. App. 10a-11a. The court further held that AWP laws have a "connection with" ERISA plans, because they "affect the benefits available by increasing the potential providers, [and] they directly affect the administration of the plans," *id.* at 19a.

Like the district court, however, the panel majority ruled that the AWP law is saved from preemption as a law that "regulates insurance." Applying the analytical framework, of *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358, 367-368, 373 (1999), the court first found that the AWP law is specifically directed at the insurance industry, thus satisfying the common-sense test for insurance regulation. Pet. App. 22a-24a. The court observed that "[t]he fact that it includes within its reach HMOs as well as traditional insurance companies does not take it out of the realm of insurance regulation," because "[i]n the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he

should need them." *Id.* at 22a-23a. The court similarly held that the law's coverage of certain self-insured government and church plans (which are exempt from ERISA, see 29 U.S.C. 1003(b) (1994 & Supp. V 1999) and thus not protected from state insurance regulation by the "deemer clause," 29 U.S.C. 1144(b)(2)(B)) does not preclude a finding that the law "regulate[s] insurance," because "it is * * * within the authority of a state in enacting laws dealing with insurance to include within such laws entities that act as self-insurers." Pet. App. 24a; see *id.* at 24a-29a. Observing that the AWP law increases benefits by giving the insured more freedom to choose and is part of "a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans," the court concluded that the law "clearly" satisfies the commonsense test. *Id.* at 30a. The court also held that the Kentucky law does not apply to non-insurers engaged solely in plan administration, observing that the Kentucky law "eliminate[s] any ambiguity as to whether administrators under contracts with benefit plans are included within the scope of the statutes. They obviously are not." *Id.* at 28a n.14.

The court also followed *UNUM* in considering the three factors utilized in determining whether a particular practice constitutes the "business of insurance" for purposes of the McCarran-Ferguson Act, 15 U.S.C. 1012(b). See *UNUM*, 526 U.S. at 373-375. First, the court concluded that the AWP law "spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice." Pet. App. 31a. The court also found that the AWP laws "directly impact the insurer-insured relationship because they affect restrictions on the network of providers available for treatment under the plan and they directly affect the administration of the plan * * * by expanding covered treatment from a closed pool of providers to an open pool of providers." *Id.* at 36a. Finally, the court reiterated

that, because the Kentucky law does not apply to entities outside the insurance business, it is directed at insurance and thus satisfies the third factor. *Id.* at 36a-37a.

Judge Kennedy dissented from the court's holding that the AWP law "regulates insurance" and is therefore saved from preemption. Pet. App. 39a-63a. In her view, the AWP law fails the common-sense test and the three McCarran-Ferguson Act factors. With respect to the common-sense test, she stated that the law "clearly target[s] more than just members of the insurance industry," because in her view it "appl[ies] to non-ERISA covered self-insured plans," *id.* at 40a-41a, and to "third parties that a self-insured ERISA plan hires to administer its plan benefits," *id.* at 42a, which she viewed as outside the insurance industry. As to the three McCarran-Ferguson factors, Judge Kennedy concluded that the AWP law does not spread risk because "[t]he risk assumed by the benefit plan under its policy, that the policyholder will require medical treatment, remains unaltered" by the AWP law. *Id.* at 50a. She concluded that the AWP law neither changes the relationship between the insurer and the insured nor is integral to it, because it "center[s] on the insurer-provider relationship," *id.* at 58a, and "leave[s] the contract terms between the insurer and insured, unaltered," *id.* at 59a. Finally, she concluded that the AWP law is not "limited to entities within the insurance industry" because the AWP law "not only regulates entities that fall outside the traditional definition of insurer," but also "extends to include entities in no way involved in underwriting risks," such as HMOs that administer ERISA-exempt self-insured plans. *Id.* at 59a.

DISCUSSION

The court of appeals correctly held that ERISA does not preempt Kentucky's AWP law. The law "relates to" employee benefits plans by indirectly but substantially affecting their content, but is saved from preemption because it is a

law that regulates insurance. Nonetheless, further review is warranted because the case presents an important and recurring issue that has caused substantial confusion and widely varying results in the courts of appeals. The issue in this case is, however, related to the issue pending before the Court in *Rush Prudential HMO* v. *Moran*, No. 00-1021. We therefore suggest that the Court hold the petition in this case and then dispose of it as appropriate in light of its decision in *Rush*.

A. Any Willing Provider Laws "Relate To" ERISA Plans

Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This provision is "clearly expansive." *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322, 1327 (2001). It "yield[s] a two-part inquiry: A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it [1] has a connection with or [2] reference to such a plan.'" *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997) (citation and internal quotation marks omitted).

1. Although the Kentucky AWP law makes a literal reference to the ERISA *statute*, the court of appeals erred in holding that the law makes a forbidden "reference to" ERISA *plans*, as this Court has used that phrase. By its terms the AWP law applies to any "insurer," including any "self-insurer or multiple employer welfare arrangement *not exempt from state regulation by ERISA*." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001) (emphasis added). That reference to the ERISA statute neither singles out ERISA plans for differing treatment, *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988), nor is dependent on such plans for its operation, *District of Columbia* v. *Greater Washington Board of Trade*, 506 U.S. 125, 130-131 (1992). Rather, it simply acknowledges the

limits on the scope of state laws imposed by the "deemer clause" of ERISA, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), which prevents the States from regulating self-insured plans under the guise of regulating insurance. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990). The Kentucky AWP law thus treats all insurers and all plans (ERISA and non-ERISA) alike, to the extent permitted by federal law. If such a citation to ERISA itself were sufficient to warrant preemption, it would create the perverse result that a state law's express recognition of the limits imposed by federal law would render the state law preempted, not only to the extent acknowledged by that reference, but in other areas that the States concededly may regulate consistent with ERISA.

2. The court of appeals was correct, however, in holding that the AWP law falls within the scope of ERISA's express preemption provision because it has a "connection with" ERISA plans. A state law has such a connection if it "mandate[s] employee benefit structures or their administration." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 658 (1995); see *Dillingham*, 519 U.S. at 328. The AWP law requires that insurers offer to all who purchase their policies, including ERISA plans and their participants and beneficiaries, open-panel provider networks (*i.e.*, those in which the insurer may not limit the universe of available providers) rather than closed, exclusive networks. Participants and beneficiaries of ERISA plans therefore have a wider choice of providers than they would have without the law. Accordingly, the AWP law "relates to" ERISA plans for the same reasons that other mandated-benefits laws do. See *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985) (assuming that law requiring minimum mental health benefits relates to ERISA plans); *Travelers*, 514 U.S. at 663-664 (discussing *Metropolitan Life*); *Shaw* v. *Delta Air Lines*,

Inc., 463 U.S. 85, 97 (1983) (law requiring pregnancy benefits relates to ERISA plans).[2]

B. AWP Laws Are Saved By ERISA's Insurance Saving Clause

The court of appeals correctly held that Kentucky's AWP law is saved from preemption as a law that "regulates insurance" under 29 U.S.C. 1144(b)(2)(A). In deciding whether a state law is saved under that clause, the Court first asks "whether, from a 'common-sense view of the matter,' the contested prescription regulates insurance." *UNUM*, 526 U.S. at 367-368. To satisfy the common-sense test, a "law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 50 (1987); see *UNUM*, 526 U.S. at 368. Thus, a general state tort or contract law that includes the insurance industry within its reach, but is not specifically directed at it, does not "regulate insurance" and therefore is not within the saving clause. *Pilot Life*, 481 U.S. at 50, 57. Here, as the court below concluded, the AWP law makes clear on its face that it is targeted at the insurance industry. In reviewing that determination, this Court does not "normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law." *UNUM*, 526 U.S. at 368.

1. The court below correctly ruled that the AWP law satisfies the common-sense test because it is specifically directed at insurance. By its terms, the AWP law applies to "health insurer[s]." Pet. App. 89a. It defines health insurers

---

[2] The direct impact of the AWP law's mandatory open-panel provider networks on plans' benefit structures and the ability of plans to operate uniformly across state lines contrasts with the incidental economic impact of state laws of general applicability that are not sufficiently connected to ERISA plans to meet the "relates to" requirement. See *Travelers*, 514 U.S. at 668; see also *De Buono* v. *NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806, 815-816 (1997); *Dillingham*, 519 U.S. at 334; *Mackey*, 486 U.S. at 831-836.

to include not only traditional health insurers, but also entities that take more innovative approaches to insurance and the provision of health care, such as a "health maintenance organization" or a provider-sponsored "health service corporation." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001). HMOs may play several roles in relation to a health benefit plan, but one role—and the one covered by the Kentucky law—is that of insurer. As this Court has recognized, such organizations are "risk-bearing organizations," because they generally "assume[] the financial risk of providing the benefits promised." *Pegram* v. *Herdrich*, 530 U.S. 211, 218-219 (2000); see also Pet. App. 22a-23a; U.S. Amicus Br. at 13-16, *Rush Prudential*, No. 00-1021.[3] Indeed, millions of employees in the United States are offered the choice between indemnity health insurance plans and HMO membership as similar ways to obtain health insurance coverage. Accordingly, the application of the Kentucky law to HMOs as well as traditional insurers does not detract

[3] Like the dissent below, some courts of appeals have suggested that HMOs are not engaged in insurance for purposes of ERISA's insurance saving clause. Pet. App. 41a n.3. See also *Prudential Ins. Co. of Am.* v. *National Park Med. Ctr., Inc.*, 154 F.3d 812, 829 (8th Cir. 1998); *Texas Pharmacy Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1038-1039 (5th Cir.), cert. denied, 522 U.S. 820 (1997). The continued validity of those decisions, however, was undermined by this Court's discussion in *Pegram*. More recent decisions from those same courts recognize that HMOs may be classified as insurers for ERISA purposes. See *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 538 (5th Cir. 2000) ("A statute may regulate insurance if it applies to insurers, health care service contractors, and HMOs."), petition for cert. pending, No. 00-665; *Express Scripts, Inc.* v. *Wenzel*, 262 F.3d 829, 836 (8th Cir. 2001) ("The language of the statutes was specifically directed at HMOs and we conclude that the provisions regulate insurance under the common sense test."); see also 29 U.S.C. 1144(b)(2)(B) (protecting self-insured plans from application of state insurance laws saved by 29 U.S.C. 1144(b)(2)(A) by barring plans from being deemed to be "an insurance company *or other insurer*" for purposes of such state laws) (emphasis added).

from the law's basic character as one that regulates "insurance."[4]

Nor does the inclusion of self-insured plans, including governmental or church plans, take the AWP law outside the insurance saving clause. Governmental and church plans are exempt from ERISA, 29 U.S.C. 1003(b) (1994 & Supp. V 1999), regardless of whether they are self-insured. Moreover, a State may reasonably conclude that "a party who has not purchased insurance, effectively act[s] as its own insurer," and States may therefore regulate self-insuring entities as part of their regulation of insurance. Pet. App. 24a; see *General Elec. Co.* v. *Gilbert*, 429 U.S. 125, 138 n.16 (1976) ("That General Electric self-insures does not change the fact that it is, in effect, acting as an insurer."). Indeed, ERISA's deemer clause, 29 U.S.C. 1144(b)(2)(B), necessarily presumes that self-insured entities are subject to state insurance regulations. The precise function of the clause is to exempt self-insured plans from state laws that would otherwise apply to them through operation of ERISA's insurance saving clause. See *FMC*, 498 U.S. at 61 ("We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause."). *UNUM*, 526 U.S. at 367 n.2 (deemer clause is a "limitation on state regulatory authority"). That exemption would be unnecessary—and the deemer clause

---

[4] Judge Kennedy observed that such entities may in some instances merely "handle paperwork and plan administration for a self-funded [*i.e.*, self-insured] ERISA plan." Pet. App. 43a. She noted that in such cases, "[t]he only risk underwritten is that accepted by the ERISA self-insured plan, which under the 'deemer clause' of ERISA * * * cannot be treated as an insurance company for the purposes of state regulation." *Id.* at 44a. The majority, however, expressly addressed whether HMOs and similar entities acting solely as plan administrators for self-insured plans "are included within the scope of the" AWP law and concluded that they "obviously are not." *Id.* at 28a n.14. Cf. *Corporate Health Ins., Inc.*, 215 F.3d at 538 (administrators function as insurers in making benefit determinations).

superfluous—if the fact that a state law regulates self-insurance meant that the state law does not "regulate[] insurance."

This Court recognized as much in *Metropolitan Life*. There, the Court held that the state mandated-benefits law was a law that regulated "insurance" within the meaning of the saving clause, even though it included self-insured plans among the insurers within its scope. See 471 U.S. at 735-736 n.14, 740-747. Notwithstanding that intended scope, the Court simply held that, because of the "deemer clause," the mandated-benefits law did not *apply* to self-insured plans covered by ERISA. See *id.* at 735-736 n.14. The Court did not hold that the inclusion of self-insured plans made the law one that does not regulate insurance.

2. Consideration of the three McCarran-Ferguson factors, insofar as they bear on the ERISA analysis, confirms the conclusion that the Kentucky AWP law "regulates insurance." At least the last two of those factors are satisfied here. As the court below correctly concluded (Pet. App. 35a-36a), the AWP law "serves as 'an integral part of the policy relationship between the insurer and the insured.'" *UNUM*, 526 U.S. at 374; *Stuart Circle Hosp. Corp.* v. *Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.) (regulations governing treatment and cost are integral parts of insurer-insured relationship), cert. denied, 510 U.S. 1003 (1993). Like other mandated-benefit provisions, the AWP law's mandate of open networks fundamentally changes the underlying insurance promise between the insurer and insured. See *Metropolitan Life*, 471 U.S. at 744 (state regulation affecting "*the type of policy which could be issued*" is part of "the core of the 'business of insurance'"); see also *UNUM*, 526 U.S. at 374 (notice-prejudice rule integral to relationship by changing bargain between insurer and insured); *Texas Pharmacy*, 105 F.3d at 1041. The AWP law, although not mandating coverage of specific conditions like the mandated coverage of mental illnesses in *Metropolitan Life* nevertheless defines

the scope of the benefits provided and mandates the type of policy that may be issued.

Likewise, for essentially the same reasons that the AWP law regulates insurance as a matter of common-sense, see pp. 8-11, *supra*, the court of appeals correctly held that the law satisfies the third McCarran-Ferguson factor in this context because the law is properly construed as limited to regulating insurers and entities acting as insurers.[5] This Court does not "normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law," *UNUM*, 526 U.S. at 368. As in *UNUM*, the Court "lack[s] cause" to do so here, because the court of appeals' construction is reasonable. See Pet. App. 23a-29a.[6]

---

[5] Neither petitioners, the court of appeals, nor any of the appellate decisions cited by petitioners, see Pet. 15-16, have asserted that AWP laws fail to satisfy the third factor because those laws regulate relations between insurers and other entities (health care providers) that are not insurers. See *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 231 (1979). In applying the ERISA saving clause, that point is more appropriately considered here under the second factor, as discussed in the text, because the fact that the AWP law regulates the relationship between the insurer and providers does not detract from the fact that it *also* regulates the relationship between the insurer and the insured, and therefore "regulates insurance." That does not mean, however, that the relationship between an insurer and a provider is itself the "business of insurance" for purposes of the McCarran-Ferguson Act's exemption from the antitrust laws. See pp. 15-16 & n.8, *infra*.

[6] The application of the third factor to laws that regulate self-insurers in the ERISA context may also differ from the application of that factor to the practice of self-insurers in the antitrust context. See note 8, *infra*. The ultimate statutory test for whether a state law is saved under ERISA is whether it "regulates insurance." 29 U.S.C. 1144(b)(2)(A). The ultimate statutory test in the antitrust context is different. There, the McCarran-Ferguson Act exempts a practice from the federal antitrust laws if it constitutes "*the business of* insurance." 15 U.S.C. 1012(b) (emphasis added). A self-insurer may reasonably be viewed as engaged in "insurance," and therefore a law regulating self-insurers "regulates insurance" under the ERISA saving clause. But a self-insurer would not appear to be involved in "the business of insurance" within the meaning of the McCarran-Ferguson Act.

Thus, at least two of the three McCarran-Ferguson Act factors, plus the common-sense test, are satisfied. That is sufficient to support the court of appeals' holding that Kentucky's AWP law is not preempted. See *UNUM*, 526 U.S. at 374. The court of appeals ruled that the AWP law also satisfies the first, risk-spreading factor because it has the effect of spreading the insureds' risk by providing them with more physicians to choose from and thereby reducing the likelihood that they will receive medical care outside the network and personally shoulder the cost of treatment. Pet. App. 31a; accord *Stuart Circle*, 995 F.2d at 503; see also *Express Scripts*, 262 F.3d at 838 (law preventing HMOs from making mail-order pharmacies exclusive providers transferred risk by enabling insured to avoid paying higher price at retail pharmacy when mail-order pharmacy delays filling prescription); *Texas Pharmacy*, 105 F.3d at 1041-1042; *Blue Cross & Blue Shield* v. *Bell*, 798 F.2d 1331, 1334-1335 (10th Cir. 1986).[7] But even if that conclusion is based on too broad a view of the risk-spreading factor, the McCarran-Ferguson factors are not necessary conditions for determining whether a law regulates insurance under ERISA's insurance saving clause. See *UNUM*, 526 U.S. at 373-374; see p. 16, *infra*. Thus, the court of appeals' ultimate conclusion that the

---

[7] Petitioners correctly note (Pet. 17-19) that the courts of appeals on occasion have narrowly interpreted the McCarran-Ferguson "risk-spreading" criterion as "refer[ring] to the risk of injury for which the insurance company contractually agreed to compensate the insured." *Cisneros* v. *UNUM Life Ins. Co. of Am.*, 134 F.3d 939, 945-946 (9th Cir. 1998), cert. denied, 526 U.S. 1086 (1999); see Pet. App. 48a-57a (Kennedy, J., dissenting). That narrow view of risk-spreading under ERISA is incorrect. See *UNUM*, 526 U.S. at 374 (describing criterion as "whether the rule at issue 'has the effect of transferring or spreading a *policyholder's* risk'") (quoting *Metropolitan Life*, 471 U.S. at 743) (emphasis added); cf *Department of Treasury* v. *Fabe*, 508 U.S. 491, 502-504 (1993) (under first clause of § 2(b) of McCarran-Ferguson Act, Ohio creditor-priority scheme met risk-transfer criterion by ensuring payment of policyholders' claims and performance of insurance contract).

Kentucky AWP law comes within the insurance saving clause is correct.

3. Contrary to petitioners' contention (Pet. 19-23), the decision of the court of appeals does not conflict with this Court's decision in *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), which held that an arrangement between insurers and pharmacists was not exempt from the federal antitrust laws under Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b). The insurer in *Royal Drug* entered into agreements with participating pharmacies, whereby policyholders could purchase drugs from the pharmacy for two dollars and the insurer would reimburse the pharmacy for the actual costs of the drugs purchased. Although the insurer offered that arrangement to all pharmacies, not all pharmacies chose to participate on those terms. 440 U.S. at 209. The Court held that the agreements satisfied none of the McCarran-Ferguson Act factors, and that they therefore were not exempt from the federal antitrust laws. The Court reasoned that the insurer's policyholders were "basically unconcerned with arrangements made between [the insurer] and participating pharmacies." *Id.* at 214. Characterizing the agreements as "merely arrangements for the purchase of goods and services by [the insurer]," *ibid.*, the Court held that they did not spread risk, were not central to the insurer-insured relationship, and extended to entities outside the insurance industry, *id.* at 214, 216, 231-233.

In contrast to the private agreements at issue in *Royal Drug*, state AWP laws do not merely set the rate at which an insurer will reimburse a provider who already is part of the provider network—a matter with which the policyholders in *Royal Drug* were "basically unconcerned." See also *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 132 (1982) (policyholder's "only concern is *whether* his claim is paid") (emphasis added). AWP laws regulate who may be included in that network to begin with. Pet. App. 32a. Thus,

although such laws affect persons other than the insurer and the insured, they do so by inviting them into the provider network that the insurer makes available to the insured. In that respect, AWP and similar laws affect the nature of the insurer's underlying promise to the insured by changing the network of providers available to the insured from a limited, closed one to an open one. See *UNUM*, 526 U.S. at 374; see also Pet. App. 31a; *Express Scripts*, 262 F.3d at 837-838; *Texas Pharmacy*, 105 F.3d at 1041. Although policyholders are likely not to be directly concerned with the insurer's costs of providing benefits (as in *Royal Drug*), they are likely to be very concerned with the range of providers available to them under the plan (and therefore the likelihood that the "family doctor" is covered by the plan). Access to health care is a key element of the relationship between insurer and insured. AWP laws therefore "regulate insurance" within the meaning of ERISA's insurance saving clause. Pet. App. 33a-34a; *Texas Pharmacy*, 105 F.3d at 1041.[8]

More generally, although *Royal Drug* is informative in the ERISA context, it was not itself an ERISA case and does not control the ERISA analysis. *Royal Drug* involved the application of the second clause of Section 2(b) of the McCarran Ferguson Act, which is an exemption to the federal antitrust laws and, as such, must be construed narrowly. See *Pireno*, 458 U.S. at 126; *Royal Drug*, 440 U.S. at 231. ERISA's saving clause, by contrast, is not an exemption subject to a narrow construction, but a preservation of state authority. Cf. *Metropolitan Life*, 471 U.S. at 741 ("[t]he

---

[8] Although the Kentucky AWP law's effect on the insurer-insured relationship is sufficient to bring that law within the scope of ERISA's insurance saving clause, which is designed to preserve the *broad* authority of the States over insurance, it does not follow that private conduct by an insurer affecting a provider's ability to participate in the insurer's provider network would be protected by the McCarran-Ferguson Act's *narrow* exemption from the antitrust laws simply because that conduct might also have an effect on the insurer-insured relationship.

presumption is against pre-emption"). In that regard, the saving clause bears a greater resemblance to the first clause of Section 2(b), which preserves state laws "enacted * * * for the purpose of regulating the business of insurance," 15 U.S.C. 1012(b), and "was intended to further Congress's primary directive of granting the States broad regulatory authority over the business of insurance." *Department of Treasury* v. *Fabe*, 508 U.S. 491, 505 (1993). The ERISA saving clause thus has a broader scope than the narrow exemption from the antitrust laws at issue in *Royal Drug*. See *ibid.*

Furthermore, the language of the ERISA insurance saving clause, which saves "any law of any State which *regulates insurance*," 29 U.S.C. 1144(b)(2)(A) (emphasis added), is broader than the language of the first clause of Section 2(b) of the McCarran-Ferguson Act, which applies to state laws enacted for the purpose of regulating "*the business of* insurance." 15 U.S.C. 1012(b) (emphasis added). Although the Court simply applies the three McCarran-Ferguson Act factors in determining the scope of the second clause (the antitrust exemption) in Section 2(b) of that Act, see *Pireno*, 458 U.S. at 129-134, and likewise applies those same factors (albeit perhaps more flexibly) under the first clause of Section 2(b) (the preservation of state authority) at issue in *Fabe*, see 508 U.S. at 502-504, the Court has adopted a different analysis under the ERISA insurance saving clause. In the ERISA analysis, the Court first and foremost applies a "common-sense view of the matter," *UNUM*, 526 U.S. at 367, and only then considers the McCarran-Ferguson factors, which in any event are merely "relevant" but not "required" in assessing whether a state law "regulates insurance" under ERISA. *Id.* at 373. See also *id.* at 374 (factors are "guideposts"); *FMC*, 498 U.S. at 60-61 (finding that a law "regulates insurance" under ERISA without mention of McCarran-Ferguson factors). See also note 6, *supra*. Thus, even if the Kentucky AWP law would fail *Royal Drug* scrutiny under

the McCarran-Ferguson Act, the court of appeals' decision that the AWP law satisfies the ERISA insurance saving clause would remain sound.

C. The Issue Of Whether ERISA Preempts AWP Laws Merits Further Review, Although The Court May Wish To Hold This Case Pending Its Decision In *Rush Prudential HMO* v. *Moran*

1. The decision in this case appears to conflict with decisions of two other courts of appeals holding similar state AWP statutes to be preempted. The Eighth and Fifth Circuits have held that AWP-type laws are not preempted if they apply only to traditional insurance companies, see *Texas Pharmacy*, 105 F.3d at 1040 (ruling on pre-1995 state law), and HMOs, see *Express Scripts*, 262 F.3d at 836-837, but that such laws are preempted if their definitions of covered entities also include self-insured plans (and, perhaps, third-party administrators for such plans, though that is unclear from the decisions). See *Prudential*, 154 F.3d at 829; *Texas Pharmacy Ass'n*, 105 F.3d at 1038-1040 (ruling on state law enacted in 1995); *CIGNA Healthplan of La., Inc.* v. *Louisiana*, 82 F.3d 642, 650 (5th Cir.), cert. denied, 519 U.S. 964 (1996). Although the Fifth Circuit's decisions holding such laws to be preempted have rested at least in part on misconceptions of the law that have since been clarified, the Fifth Circuit appears to adhere to those decisions.[9] See

---

[9] For instance, in *Texas Pharmacy*, the Fifth Circuit rested its decision in part on the proposition that HMOs and similar entities are not part of the insurance industry, 105 F.3d at 1038-1039, but this Court has determined otherwise. *Pegram*, 530 U.S. at 218-223. Following *Pegram*, the Fifth Circuit broadened its view. See note 3, *supra*. Furthermore, in *Texas Pharmacy* and *CIGNA Healthplan*, 82 F.3d at 650, the Fifth Circuit required the laws to satisfy both the common-sense test and all three McCarran-Ferguson factors to be saved as an insurance regulation. 105 F.3d 1038. This Court, however, has expressly rejected that requirement, holding that the McCarran-Ferguson factors are merely "guideposts" in the analysis and that a law may "regulate insurance" under ERISA without satisfying all three factors. *UNUM*, 526 U.S. at 373-374. In

generally *Corporate Health.*, 215 F.3d at 538 (attempting to harmonize Fifth Circuit case law).

Under the Eighth and Fifth Circuit decisions, the Kentucky law at issue in this case would have been held to be preempted. It has a broad coverage provision that extends to a number of self-insured entities, such as "any self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association or nonprofit hospital, medical-surgical, dental, or health service corporation." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie 2001). To be sure, the Kentucky law excludes self-insured plans that are covered by ERISA and protected from state insurance regulation by ERISA's "deemer clause," because it covers only self-insured plans "not exempt from state regulation by ERISA." But that feature could not save the Kentucky law under the Eighth Circuit's analysis. Although the Arkansas AWP law at issue in *Prudential* similarly excluded such plans, see 154 F.3d at 816 (reciting Arkansas AWP provision stating that AWP law "shall not apply to self-funded or other health benefit plans that are exempt from state regulations by virtue of [ERISA]"), the Eighth Circuit's holding in *Prudential* that the Arkansas law was preempted rested on the premise that the Arkansas AWP law covered some self-insured entities. See *Express Scripts*, 262 F.3d at 836-837 (distinguishing *Prudential*). Because the Kentucky law likewise appears to cover the same self-insured entities—*i.e.*, those, like church and government plans, that are not covered by ERISA—it would thus be preempted under the Eighth Circuit's analysis. It likewise would be preempted under Fifth Cir-

---

Corporate Health, the Fifth Circuit acknowledged that clarification, but reaffirmed the basic holding that AWP laws are preempted to the extent they regulate entities other than traditional insurers and HMOs. 215 F.3d at 537.

cuit precedent. See *Corporate Health*, 215 F.3d at 538 & n.51; compare *Stuart Circle* (holding that Virginia law that apparently applied to self-insured entities is saved by insurance saving clause).

2. The issue that has caused the conflict in the circuits, as well as the accompanying difficulty the courts have had in analyzing AWP laws, is important. The wisdom of AWP legislation can certainly be debated. Pet. App. 34a n.18; see also *Pegram*, 530 U.S. at 221 (structure of HMOs involves "complicated factfinding and such a debatable social judgment" not usually left to courts). But whatever its wisdom, approximately twenty-five States have enacted some form of AWP law. William J. Bahr, Comments, *Although Offering More Freedom to Choose, "Any Willing Provider" Legislation is the Wrong Choice*, 45 U. Kan. L. Rev. 557, 568 n.112 (1997). Managed-care entities subject to the strictures of those laws deliver a substantial portion of health services nationwide. It is important that the permissible scope and limits of state authority in this area be defined. Further review is therefore warranted.

3. The question presented by this case is related to the question in *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021, cert. granted (June 29, 2001). The question there is whether ERISA preempts an Illinois law requiring HMOs to provide independent review by an outside physician in the event of a disagreement regarding whether a particular treatment is medically necessary and therefore included in the insurance coverage provided by the HMO. The court of appeals in *Rush Prudential* held that the state independent review law is saved from preemption by ERISA's insurance saving clause. Citing the Eighth Circuit's decision in *Prudential* and the Fifth Circuit's decision in *Texas Pharmacy*, the petitioner in *Rush Prudential* argues that the Illinois law does not "regulate[] insurance" because it is directed at HMOs, which in the petitioner's view do not necessarily offer insurance products and "do not always bear the risk for the

health plans with which they contract." 00-1021 Pet. Br. at 37, 39-40.[10] If the court addresses that question, its analysis may well affect the issue in this case. If so, this case should then be remanded to the court of appeals for further consideration in light of the Court's decision in *Rush Prudential*. If the decision in *Rush Prudential* does not address the insurance saving clause in a way that sheds light on this case, the Court should grant plenary review in this case at that time.

CONCLUSION

The Court should hold the petition for a writ of certiorari in this case pending its decision in *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021, cert. granted (June 29, 2001), and then dispose of it accordingly.

Respectfully submitted.

PAUL D. CLEMENT
*Acting Solicitor General**

EDWIN S. KNEEDLER
Deputy Solicitor General

JAMES A. FELDMAN
Assistant to the Solicitor General

HOWARD M. RADZELY
Acting Solicitor of Labor

ALLEN H. FELDMAN
Associater Solicitor

NATHANIEL I. SPILLER
Deputy Associate Solicitor

GARY K. STEARMAN
Attorney
Department of Labor

NOVEMBER 2001

---

[10] The petitioner also argues that, under the Court's decision in *Pilot Life*, 481 U.S. at 53-57, the Illinois law conflicts with the provision in Section 502(a) of ERISA for bringing civil actions to recover benefits or enforce the terms of the plan. See 00-1021 Pet. Br. at 19-32, *Rush Prudential*, *supra*.

* The Solicitor General is recused in this case.