No. 00-1471

IN THE
Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,

Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

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

BRIEF OF *AMICI CURIAE* AMERICAN ASSOCIATION OF HEALTH PLANS, INC., HEALTH INSURANCE ASSOCIATION OF AMERICA, NATIONAL ASSOCIATION OF MANUFACTURERS AND BLUE CROSS BLUE SHIELD ASSOCIATION IN SUPPORT OF PETITIONERS

DALY D.E. TEMCHINE
Counsel of Record
EPSTEIN BECKER & GREEN, P.C.
1227 25th Street, NW
Suite 700
Washington, D.C. 20037
(202) 861-0900

Attorneys for Amici Curiae

(Additional Counsel Listed On Inside Cover)

STEPHANIE W. KANWIT
General Counsel
AMERICAN ASSOCIATION
OF HEALTH PLANS
1129 Twentieth Street, N.W.
Suite 600
Washington, D.C. 20036-3421
(202) 778-3200

JAN S. AMUNDSON
General Counsel
QUENTIN RIEGEL
Deputy General Counsel
NATIONAL ASSOCIATION
OF MANUFACTURERS
1331 Pennsylvania Ave., N.W.
Washington, D.C. 20004-1790
(202) 637-3000

ANGELA J. FRANKLIN
Legislative Director
and Counsel
HEALTH INSURANCE ASSOCIATION
OF AMERICA
1201 "F" Street, N.W.
Suite 500
Washington, D.C. 20004
(202) 824-1667

ALAN JAY LIPSITZ
Executive Director
BLUE PLAN LEGAL DEPARTMENT
COOPERATIVE
BLUECROSS BLUESHIELD
ASSOCIATION
1310 G Street, N.W.
Washington, D.C. 20005
(202) 942-1278

Attorneys for Amici Curiae

TABLE OF CONTENTS

Contents

TABLE OF CITED AUTHORITIES

Page

FEDERAL CASES

Cited Authorities

Cited Authorities

FEDERAL STATUTES

STATE STATUTES

Cited Authorities

Page

MISCELLANEOUS

Cited Authorities

Cited Authorities

STATEMENT OF INTEREST[1]

The American Association of Health Plans, Inc. ("AAHP") is the national association for the managed care community. Its membership includes health maintenance organizations, preferred provider organizations, third-party health plan administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 managed health care organizations serving nearly 160 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans.

The Health Insurance Association of America ("HIAA") is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. HIAA develops and advocates federal and state policies that build upon the health care system's quality, affordability, accessibility and responsiveness. It is the nation's premier provider of self-study courses on health insurance and managed care.

---

1. The parties have consented to the filing of this brief. Their letters of consent are on file with the Clerk of the Court. This brief has been authored in its entirety by undersigned counsel for the *amici curiae.* No person or entity, other than the named *amici curiae* and their counsel, made any monetary contribution to the preparation and submission of this brief.

The National Association of Manufacturers ("NAM") — 18 million people who make things in America — is the nation's largest industrial trade association. The NAM represents 14,000 members (including 10,000 small and mid-sized companies) and 350 member associations serving manufacturers and employees in every industrial sector and all 50 states.

The Blue Cross Blue Shield Association ("BCBSA") comprises 42 independent, locally operated Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield companies provide, through relationships with employers, employee benefits plans, and direct contracts with subscribers, health insurance to private and public employees and individuals, including fee-for-service programs, health maintenance organizations, preferred provider organizations, and a variety of other offerings. They also provide third-party administrative services to private and public employee benefits plans. Collectively, the Blue Cross and Blue Shield companies furnish health care coverage to 84.5 million — or one in four — Americans, making them (as a group) the largest U.S. entity offering health insurance and benefits.

As members of the health plan, health insurance and business communities, Amici AAHP, HIAA, NAM and BCBSA have vital interests in the federal questions presented by this case under the ERISA statute. The member organizations of amici AAHP, HIAA, NAM and BCBSA fund, provide, arrange for, insure or administer, on behalf of employers with self-funded ERISA health benefit plans, the provision of covered health services to participants and beneficiaries ("Ps&Bs") of employee benefit plans regulated

by the Employee Retirement Income Security act of 1974 ("ERISA"). 29 U.S.C. § 1001, *et seq*. (as amended). The members of amicus NAM, are employers, and "employment is the source of health care coverage for two-thirds (67%) of this country's population." Paul Fronstin, *Number of Americans with Job-Based Health Benefits Increased in 2000 While Uninsured Declined*, EMPLOYEE BENEFIT RESEARCH INSTITUTE NEWSLETTER, Vol. 22, No. 11 (Nov. 2001) pp. 1-2.

Amici have joined together to file this brief in support of Petitioners' Brief on the Merits because the Sixth Circuit Court of Appeals' decision in *Kentucky Association of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000) is unsupported by ERISA and by decisions of this Court that are directly on point, and because of the extraordinarily destabilizing effects of the holding upon both: (a) providers of health care benefit coverages and benefit administration services; and (b) the purchasers and payors of such services.

The Sixth Circuit's decision which holds that Kentucky's "Any Willing Provider" statutes ("AWP") are saved from preemption under ERISA will have a significantly adverse effect on the ability of both managed care organizations ("MCOs"), such as the members of AAHP, HIAA and BCBSA, and employers, such as the members of NAM, to control the increasing rate of inflation in the cost of health care and health care coverage. As the lower court recognized, its decision allows states to interfere with ERISA benefit plan design and administration. *Id*. at 358-63, 372-73. Critically, the decision rests on the wholly mistaken premise that AWP laws benefit Ps&Bs of either insured or self-funded ERISA plans. To the contrary, the only persons and entities whose interests are advanced and protected by AWP statutes are health care providers, not their patients.

SUMMARY OF THE ARGUMENT IN SUPPORT OF PETITIONERS' BRIEF ON THE MERITS

The holding of the Sixth Circuit Court of Appeals threatens the financial ability of the Nation's employers to provide comprehensive health benefits to their employees who depend upon their employment for health care coverage for themselves and their dependents. That holding, if allowed to stand, eliminates long-standing and effective means of cost control utilized by HMOs and other MCOs. It effectively nullifies the determination of Congress, when it enacted the Federal Health Maintenance Organization Act of 1973, Pub. L. 93-222 (as amended), 42 U.S.C. §§ 300e, *et seq.*, that entities with controlled and limited provider networks constitute an effective and beneficial approach to the containment of health care costs.

The lower court's decision rests on two indefensible assumptions. The first is that AWP laws constitute a benefit to plan participants. That assumption might be valid if AWP laws granted to MCO members any capacity to compel providers to participate in the provider network created by their MCO, on the terms offered by the MCO. Neither Kentucky's AWP law nor those of any other state, grant any such ability to MCO members. In sum, the decision whether or not to participate in a network is left solely to the discretion of providers. KY. REV. STAT. § 304.17A-270.

AWP statutes, therefore, cannot reasonably be understood to confer an insurance benefit, indeed a benefit of any kind, to insureds, including MCO members, the risk of which is borne by MCOs. This fact alone precludes any possibility that the insurance Savings Clause[2] (the "Savings Clause")

2. 29 U.S.C. § 1144(b)(2)(A).

exception to ERISA's preemption provisions can apply to Kentucky's AWP law. The only risk to which Kentucky's AWP statute exposes MCOs is the risk that a provider may choose to participate in their network when the financial calculus works in the provider's favor. Providers, however, are not insureds. The risk that a provider may find it economically advantageous to force its entry into a network cannot be characterized as an insurance risk under any reasonable meaning of that term.

The second untenable assumption is that the provision of Kentucky's AWP statute which states that any provider who elects to join the network must accept the terms of participation offered by the network actually can operate to prevent the MCOs' costs of providing care from increasing. KY. REV. STAT. § 304.17A-270. As a simple matter of economic common sense and reality, however, it is plain that the inability of MCOs to control the number of providers in their network deprives them of the ability to negotiate rates on the basis of volume discounts. Under an AWP statute regime, an MCO cannot tender an assurance of any kind to providers that their direct competitors will be excluded from the MCO's network and from having access to the MCO's members. Consequently, providers have little, or no, incentive to agree to charge the MCO materially discounted rates for their services to the MCO's members.

There are other forms of adverse economic effects caused by AWP statutes that the Sixth Circuit's decision permits, none of which confer additional benefits to MCO members or transfer risk to MCOs. The addition of providers to a network is not a cost free exercise for the MCO. For example, there are the provider applications to be processed. This includes provider credentialing, the costs of educating the provider, or

its billing staff, on how to submit claims in compliance with the MCO's criteria, and supervising the compliance of additional providers with the MCO's quality and utilization criteria. All of these costs are passed to MCO members and employers, and not a penny's worth of those costs is spent on the provision of additional health care to MCO members.

Remarkably, the lower court ignores the complete absence of any evidence in the record that the AWP law addresses or rectifies any alleged or documented coverage or health care quality gaps that adversely affect Kentucky's MCO members. Nothing in the record documents that either the quality or the quantity of the care received by MCO members was deficient, much less deficient in any manner that is addressed or ameliorated by the provisions of the AWP statute.

Indeed, AWP laws may have the effect of diminishing the average quality and competence of the providers in an MCO's network, particularly with respect to certain specialties. As amici hereafter demonstrate, AWP statutes impair the capacity of MCOs to: (a) control the quality of the providers they allow in their networks; and (b) periodically evaluate the quality and efficiency of the care network providers deliver to their patients who are MCO members. In addition to the public health implications of these impairments, the forcible inclusion of providers in an MCO's network has adverse liability implications for MCOs which, under a number of legal theories, have been held accountable for the negligent acts of the providers in their networks. AWP statutes such as Kentucky's law here at issue create quality control and liability burdens and exposures for MCOs, without improving the quality of care available to or received by their members. They also fail to provide MCOs with any means with which to manage those additional burdens other

than, of course, incurring additional costs that will increase the current double digit rate of inflation for health care coverage.[3]

ARGUMENT

A. AWP Statutes Confer No Benefits Upon MCO Members.

1. Only Providers Have Rights Under AWP Statutes.

There is no advantage to the Court for the amici to present what would be a redundant demonstration of the clear errors of law in the Sixth Circuit's ERISA Insurance Savings Clause (the "Savings Clause"), 29 U.S.C. § 1144(b)(2)(A), analysis. The Petitioners Opening Brief addresses that issue comprehensively. Amici will focus upon a critical misunderstanding by the lower court of the purpose and effects of AWP laws.

Amici submit that the Sixth Circuit Court of Appeals, as well as the Fourth Circuit Court of Appeals in its decision in *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), erred because they failed to acknowledge a fundamental characteristic of AWP statutes. AWP statutes provide no rights, benefits, entitlements or

3. According to the Kaiser Family Foundation annual national survey of employer health benefit plans, "Between Spring of 2001 and Spring of 2002, monthly premiums for employer-sponsored health insurance rose 12.7%. . . ." Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2002 Summary of Findings" 2002, www.kff.org. *See also, Health Insurance Prognosis is Poor*, THE WASHINGTON POST, September 6, 2002, Section E at pp. 1 and 4.

privileges to MCO members. This is so even if such members' coverage is through insurance rather than through a self-funded ERISA plan administered by an MCO. Under an AWP statute, an MCO member has no individual capacity to either: (a) compel an MCO plan to include a provider in its network or; (b) to compel a provider to participate in such a network. If that provider does not choose to seek admission to the network, the MCO member is utterly powerless under AWP statutes to do anything about that circumstance.

There is no provision under the AWP statutes of either Kentucky or Virginia (Virginia Code 38.2-3407) which enable MCO members to compel a provider to agree to the compensation terms of an MCO. If, as a hypothetical matter, AWP statutes empowered MCO members to compel providers to participate in an MCO's network upon terms generally offered to similarly situated providers by the MCO, there arguably would exist some benefit that was conferred upon the MCO member. That circumstance would justify an argument whether the benefit involved a transfer of risk that qualified as the "business of insurance" under the Savings Clause. Amici submit that, in any event, even this "benefit" would not qualify as a transfer of risk within the meaning of the term "business of insurance." The ability of an MCO member to compel a provider to join an MCO's network can have no impact on the actuarial or statistical probability that the member will experience a covered health event. It can only impact upon the identity of the vendor who will be paid by the MCO. This result fits squarely within the Court's ruling in *Group Life & Health Ins. Co. v Royal Drug Co.*, 440 U.S. 205, 231 (1979), that the relationship between an insurer and its vendors is not a part of the "business of insurance."

That circumstance, however, is purely a hypothetical one and does not exist. There was no objective basis for either the Sixth Circuit or the Fourth Circuit Courts of Appeal to even venture into an analysis of whether AWP laws could be saved from preemption under the Savings Clause because those laws do not confer any benefit of any kind on insureds.

2. AWP Laws Are Not Akin to State Mandated Benefit Laws.

AWP laws cannot be analogized to state laws that mandate insurers and MCOs to cover certain diseases, mental illness for example, or to include certain categories of providers in their networks, such as osteopaths. *See Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985) (Massachusetts statute requiring insurers to cover mental health benefits saved from preemption under Savings Clause.); *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986) (State law mandating that insurers cover services by podiatrists and dentists among other specialties was not preempted). In those instances, there is a transfer of risk from insured MCO members to their MCOs, as such laws compelled the MCOs to pay for categories and types of medical services they did not previously cover, i.e., to assume new risks. *Cf. Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 127 (1982). Kentucky's AWP law is not comparable to the State law at issue in *Washington Physicians' Service Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998). There, the statute at issue required that the services of every type of licensed health care provider be covered. *Id.* at 1042-43. It did not, as is the case with Kentucky's AWP law, empower providers to force MCOs to accept their participation in the MCO's

networks. *Id*. Under the statute at issue in *Gregoire*, an MCO might be obligated to include at least one acupuncturist in its network, but could not be compelled to admit all acupuncturists who desired to participate. *Id*.

In contrast, AWP laws such as Kentucky's do not shift or transfer any new risks, nor do they allow MCOs to limit the number of providers in their network. AWP laws do nothing more than dictate to ERISA plans which choose to have their benefits administered or provided by MCOs the identity of the providers entitled to be paid for services to plan participants. The Sixth Circuit erred in failing to recognize that state AWP laws, such as Kentucky's, that dictate to ERISA plan claim administrators who they must pay for covered benefits are preempted by ERISA. *See, e.g., Blue Cross Blue Shield of Alabama v. Nielsen*, 917 F. Supp. 1532 (N.D. Ala. 1996); *Delta Dental Plan of California v. Mendoza,* 1996 U.S. Dist. Lexis 2106 (N.D. Cal. 1996).

3. AWP Laws Offer No Quality of Care Advantages to MCO Members.

Theoretically, the argument might be advanced that AWP laws somehow improve the quality of the care available to MCO members. However, nothing in the record of this case offers any factual support for that argument. There is no evidence that the care provided to MCO members who only have access to limited provider networks compares unfavorably in any respect or degree to the care received by persons whose coverage permits them to receive care from

any provider of their choice. Indeed, a compelling argument can be made for the proposition that AWP laws adversely affect the ability of MCOs to take steps to develop networks populated by superior providers.

"[A]ny-willing-provider laws greatly hinder quality assurance." Karen A. Jordan, *Managed Competition And Limited Choice Of Providers: Countering Negative Perceptions Through A Responsibility To Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875, 918 (1995) (hereafter referred to as "*Jordan*"). This is so because a proper network should have the right mix of providers and the right providers. *Id.* at 919. For example, it has been suggested that heart surgeons should perform some 200 heart surgeries a year to "develop and maintain the skills necessary to do high-quality work." Mark A. Kadjielski, *et al.*, *Peer Review Potpourri: New Developments In Credentialing And Privileging*, 15 WHITTIER L. REV. 51, 53 (1994).[4] MCOs, therefore, in order to best serve their members, should have the ability to exercise selectivity in order to provide network physicians, specialists in particular, an adequate patient base so that their expertise and level of competence will not be diluted. *Jordan*, at 919.

---

4. The American College of Cardiology also has identified and recommended minimum numbers of procedures which should be performed on an annual basis in order to maintain competency. These standards apply to both cardiologists and institutions that provide cardiology services. *See* http://www.acc.org/clinical/competence/coronary/jac5492Fla1b.htm.

It may be argued that because AWP laws require a provider to accept an MCO's network participation criteria, a provider who does not satisfy the MCO's credentialing criteria does not have to be allowed into the network. That simplistic argument overlooks, actually evades, a number of objective realities. For example, MCOs' credentialing criteria typically set qualification standards such as licensure, acceptable medical malpractice history, medical malpractice coverage at specified levels, possession of staff privileges in accessible network hospitals, board certification or board eligibility. These criteria, however, have to be flexible in application. MCOs' service areas may include medically underserved areas that have shortages of specialists, tertiary hospitals, and even primary care physicians. MCOs must be able to include in their networks for their members located in such underserved areas accessible providers whose qualifications are not on a par with those of network providers in medically better served regions of the MCOs' service area.[5] That circumstantial need, however, should not prevent MCOs from being more selective, both in terms of cost and quality, in those parts of their service area where there is a plentiful supply of providers in competition with each other. AWP laws prevent MCOs from exercising any such judgments and

5. AWP laws also create a bias towards increasing provider incomes and the cost of health care services by skewing the law of supply and demand. In a medically underserved area, the scarcity of supply, i.e., of available providers, will drive the price, or cost, of the suppliers' services upwards. Where the supply of providers is plentiful, the price of their services should move to lower levels. AWP laws interfere with that dynamic. They empower providers in a high supply market to demand inclusion in an MCO's market at the prices paid by the MCO to providers in the low supply areas on the argument that such higher prices are the "terms and conditions" of participation in their network offered by MCOs. KY. REV. STAT. § 304.17A-270.

choices. There is no sensible argument to be made for the proposition that this inability benefits MCO members in any manner.

B. The Sole Effects of AWP Laws Are To Empower Providers to Resist Price Competition and to Impair the Growth of MCOs.

The only beneficiaries of AWP laws are providers who are opposed to managed health care and seek to eliminate the ability of MCOs to negotiate discounted payments through their ability to deliver patient volumes and through the achievement of economies of scale. Jensen & Morrissey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, THE MILBANK QUARTERLY, Vol. 77, No.4, 425, 436 (1999); Marsteller, Bovbjerg, *et al.*; *The Resurgence of Selective Contracting Restrictions*, THE JOURNAL OF HEALTH POLITICS, POLICY AND LAW, 22:1133-89 (1997). A study by the University of Alabama funded by the Robert Wood Johnson Foundation ("RWJF Study") concluded that AWP laws "are not necessarily designed to protect quality, but instead are often conceived as efforts to protect providers from the effects of competition." The Robert Wood Johnson Foundation, National Program Reports, *Research on the Effects of Any-Willing-Provider Laws*, available at http://www.rwjf.org/reports/grr/029014.htm (updated January 2001). It is not coincidence that "The proponents of any-willing-provider laws are . . . often groups of health care specialists or allied health professionals who are suddenly finding it difficult to market themselves." *Jordan*, 27 ARIZ. ST. L. J. at 919.

The Federal Trade Commission ("FTC") was requested by the Attorney General of Montana and the Senates of the

States of California and New Hampshire to provide them with its opinion on the issue whether AWP laws impair competition.[6] In every instance, the FTC concluded that impairment of competition was the inevitable result of those statutes, as their effect was to empower providers to compel MCOs to pay providers more for their services than if providers were forced to compete for the business of MCOs. John Miles, HEALTH CARE & ANTITRUST LAW: PRINCIPLES AND PRACTICE (Vol. 3, 2002) ("Miles") at App. D36-7; App. D33-8; and App. D32-7.

In each of the cited letters, the FTC emphasizes that AWP laws have anti-competitive effects that increase costs, specifically citing to economic studies which demonstrate that selective contracting practices by MCOs moderate health care cost increases. *Id.* at App. D36-4. In an important conclusion, the FTC emphasizes that:

> To the extent that opening programs to all providers reduces the portion of subscribers' business that each provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all providers can 'free ride'

6. FTC Staff Letter to the Attorney General of Montana Regarding "Any Willing Provider" Laws, February 4, 1993 (all providers); FTC Letter to the California State Senate Regarding "Any Willing Provider" Laws; June 26, 1992 (pharmacy providers); FTC Letter to the New Hampshire Senate Regarding "Any Willing Provider" Laws, March 17, 1992 (pharmacy providers).

> on a successful formulation, innovative providers may be unwilling to bear the cost of developing a proposal. Thus 'any willing provider' requirements may substantially reduce provider competition for this segment of their business.

Id. at D36-6. In an observation relevant to the always pertinent question, "Cui bono?" (who benefits?), the FTC points out that AWP laws limit consumer choice in the marketplace. *Id.* at D36-7. *See* note 5, *supra*. They have that effect because they deprive consumers of access to the less costly coverage option of a limited provider panel or network, with its lower costs of administration and greater ability to obtain volume discounts on fees and rates from providers. *Id.* MCOs certainly do not benefit from the impairment of their ability to contain costs. That leaves only the providers who gain anything from AWP laws. The protection of the income and financial well-being of health care providers by sheltering them from marketplace competition is not, and never has been, an aspect of the states' regulation of the business of insurance.

Nor can such protection of the economic interests of providers be justified on the basis of the state's interest in the regulation of health care policy. *Cf. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-662 (1995). There is no evidence in either the record of this case, or in documented peer reviewed studies, that the existence of closed panel health care coverage options in the marketplace has caused, or is likely to cause, a shortage of providers of any kind constituting a threat to the public welfare. As the FTC has pointed out:

> Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring

> PPOs (preferred provider organizations constituting MCO selected and limited provider panels) to grant open participation may reduce the number, variety, and *quality* of prepayment programs available to consumers without providing any additional consumer benefit.

Miles at App. D36-7 (emphasis added). The term "PPO" is an acronym for "Preferred Provider Organization," a form of MCO network structure. *See* Weiner & de Lissovy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Politics, 75, 99 (1993). For the past twenty-five years, the FTC has supported the marketplace availability of selective MCO controlled provider panel health care coverage options. *See* Bureau of Economics, Federal Trade Commission, *Staff Report on the Health Maintenance Organization and its Effects on Competition* (1977). The FTC has brought enforcement actions against providers and provider associations when they have attempted to eliminate from the marketplace MCOs that utilize selective contracting and closed provider panels. Miles at App. at D-33-2.[7]

---

7. The FTC hardly stands alone in its position that AWP laws are anti-competitive and anti-consumer. *See generally*, Fred J. Hellinger, *Any-Willing-Provider Laws and Freedom of Choice Laws: An Economic Analysis*, HEALTH AFF., Vol.14, Number 4 (1995); *National Anti-Managed Care Laws Would Raise Health Care Costs, Study Says*, 3 HEALTH CARE POLICY REP., (BNA) No. 26, at D-53 (June 26, 1995); *see* Andrew L. Jiranek & Susan Baker, *Any Willing Provider Laws*, 28 MD. B.J. 27, (1995); Jonathan E. Fielding & Thomas Rice, *Can Managed Competition Solve the Problems of Market Failure*, HEALTH AFF., Supp. 1993, at 216, 221; *Cf.* Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE L.J. on REG. 179, 187-88 (1988).

C. AWP Laws Do Not Benefit the Purchasers of MCO Products and Services.

There is no documentation for the proposition that AWP laws provide any benefit or advantage to the actual recipients of the health care services covered by ERISA plans — i.e. Participants of such plans. AWP laws do not: (a) require coverage of additional benefits; (b) reduce co-payments or deductibles; (c) lower employees' share of premiums, or contributions in the case of self-funded plans, nor; (d) critically, create any authority or capacity the Participants may exercise to compel providers to join an MCO network. It also is the case that AWP laws confer no benefit or advantage upon the entities which bear the primary cost burden of funding ERISA health and welfare plans — employers.

In the context of ERISA plans, the purchasers of coverage (or benefit plan administration services in the case of self-funded plans) from MCOs normally are employers who provide health care coverage benefits to their employees and the employees' eligible dependents as well. *Fronstin*, pp. 1-2. The sole exception consists of the so-called "Taft-Hartley Trust" plans. 29 U.S.C. § 141, *et seq*. These trusts are jointly trusteed by management and labor and sponsor ERISA plans. 29 U.S.C. § 186(c)(5)(B). The funding for such trusts derives from employer contributions required by the terms of collective bargaining agreements between them and labor organizations. 29 U.S.C. §§ 186(c)(4) and (5). Both labor and management are united in their opposition to AWP laws as damaging to the interests of the Participants that they serve as fiduciaries.

In *Prudential Ins. Co. of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998), for example, labor unions (the AFL-CIO of Arkansas and the United Paperworkers International Union) joined with the largest private employer in Arkansas, which sponsored a self-funded ERISA health and welfare plan for its employees (Tyson Foods, Inc.), and MCOs (Prudential entities) to challenge Arkansas' AWP statute. Under Section 404 of ERISA, 29 U.S.C. § 1104, ERISA fiduciaries are subject to a duty to act solely and exclusively in the interests of the Participants of the plans they serve. If AWP laws conferred any benefit upon ERISA plan Participants that was not clearly outweighed by such laws' detrimental effects upon the interests of the Participants, ERISA plan fiduciaries would be obligated to support, not oppose, AWP laws. 29 U.S.C. § 1104(a)(1). There is no case to be found, however, to which an ERISA plan fiduciary is a party, where that fiduciary supported a state's AWP law.

The researchers who conducted the RWJF Study cited earlier[8] attempted to determine whether there was a discernable pattern among the states that enacted AWP laws and those states which were unlikely to enact such laws. *See supra*, National Program Reports, *Research on the Effects of Any-Willing Provider Laws.* The researchers "determined that states with greater numbers of health care providers were more likely to enact AWP laws . . . , while states with greater numbers of large employers were less likely to enact the laws." *Id.* at p. 2 of 4. In an intriguing finding, the researchers concluded that AWP laws are more likely to be enacted in states that have not experienced substantial MCO penetration. *Id*. AWP statutes thus are "preemptive" strikes by providers to prevent MCOs from bringing managed care practices into the state that would require providers to engage in price competition. *Id*.

8. *See* p. 14, *supra.*

Consistent with the conclusions of the RWJF Study researchers, the enactment of AWP legislation has been attributed to "state legislators' desires to placate 'a vocal and respected constituency' of health providers." Jordan, 27 ARIZ. L.J. at 916. State executives, however, who are responsible for meeting the healthcare cost burdens of Medicaid programs and benefits for public employees, are not at all enthusiastic about AWP laws. In July 1994, the National Governors' Association unanimously approved a policy to resist AWP legislation. Hellinger, HEALTH AFF., Vol. 14, No. 4 at 299; "*Any Willing Provider Legislation*: *Who's Pro, Who's Con, Who's on the Fence and Why*," HEALTH TECHNOLOGY ASSESSMENT NEWS (September-October 1994): 3.

The alignment of the political and economic interests in favor of and opposed to AWP laws is consistent with the unavoidable conclusion that such laws have nothing at all to do with the business of insurance. Their sole purpose and utility is to permit providers to engage in concerted activities that preclude to MCOs the ability to bargain with providers who have been evaluated and selected for inclusion in their networks for reasons of quality, acceptability to members, and reduced cost. AWP laws promote the very type of activity that the FTC has found to be anti-competitive, and for which it has successfully pursued remedial actions against providers and provider associations. *See Miles,* App. D36-4, 6-7.

D. AWP Laws are Preempted Because They Interfere With The Right and Ability of Employers and Plan Fiduciaries to Design ERISA Plan Benefits, and to Administer ERISA Plans Without Interference by the States.

When Congress enacted ERISA, it clearly intended to provide employers with wide latitude in deciding: (a) which health care coverage benefits they would provide to their employees;[9] and (b) how they would fund those benefits.[10] ERISA also was expressly designed to prevent the states from interfering with the administration of ERISA plans directly, or on a pretense that they constitute "insurance" subject to state supervision. 29 U.S.C. § 1144(b)(2)(B); *see, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 60-65 (1990); *Medical Mutual of Ohio v. DeSoto*, 245 F.3d 561, 572-574 (6th Cir. 2001). The Sixth Circuit's decision disregards the clear intent of Congress in all of these respects.

---

9. *See, e.g.*, 29 U.S.C. § 1001; ERISA leaves to private employers the authority to decide what health care benefits they will cover. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 77-80, (1995) (". . . we are mindful that ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits . . ."); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90-91 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981); *Maez v. Mountain States Tel. and Tel.*, 54 F.3d 1488 (10th Cir. 1995); *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991); *Hlinka v. Bethlehem Steel Corp.*, 863 F.2d 279 (3d Cir. 1988).

10. ERISA preempts state laws that mandate employee benefit structures or their administration. *See, e.g., New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035 (5th Cir. 1997), *cert. denied* 522 U.S. 820 (1997); *Stone & Webster Engineering Corp. v. Ilsley*, 690 F.2d 323, 329 (2d Cir. 1982), *aff'd sub nom; Arcudi v. Stone & Webster Engineering Corp.*, 463 U.S. 1220 (1983).

First, the decision simply ignores the reality that Kentucky's AWP statute is applicable to self-insured ERISA plans that are administered by MCOs. Ky. Rev. Stat. § 304.17A-005(23). The statute is applicable without exception to all the activities and functions of MCOs. It thus sweeps into its scope ERISA self-funded plans whose only connection to an MCO is that they have retained the MCO to administer claims for which the plans alone, not the MCO, bear the risk of payment. As the MCO is not an insurer in that setting, the only basis on which it can be argued that there is a risk-shifting transaction that would constitute the "business of insurance" is if the transaction between the self-funded ERISA plan and its Participants is treated as the insurance transaction. That determination, however, is expressly proscribed to the states by ERISA's "Deemer Clause." 29 U.S.C. § 1144(b)(2)(B).

Second, Kentucky's AWP law effectively prevents self-funded ERISA plans from offering a health care coverage benefit that involves a limited, or selective, provider network, unless the plan itself undertakes to both create and to administer that network. The pragmatic reality, however, is that only the largest and most sophisticated employers and plans could undertake to create such a network, particularly on a multi-state basis. The circumstance that Kentucky's AWP law denies to self-funded ERISA plans the right or ability to access MCO networks, even when the MCO is not an insurer to the plan, without more and irrespective of the plan's ability to create its own provider network, is an interference with the plan's ability to decide how it wants to deliver covered benefits to its Participants. That constitutes proscribed state interference with ERISA plan design and administration. *See* notes 8 and 9, *supra*.

E. Kentucky's AWP Law is Not Saved from Preemption by ERISA'S Insurance Savings Clause.

The Court in its recent decision in *Rush Prudential HMO, Inc. v. Moran*, 536 __, No. 00-1021, slip op. (2002), ("Rush Prudential") affirmed the long-standing principle that ERISA's Insurance Savings Clause, 29 U.S.C. Sec. 1144(b)(2)(a), saves from ERISA's preemptive scope only a limited category of state laws. Such laws must satisfy, as a threshold test, the requirement that, as a "common-sense view of the matter," the state law regulates insurance. *Id*., slip op. at 8 citing *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724, 740 (1985). The Court, citing to its decision in *Group Life & Health Ins. Co. v. Royal Drug Co*., 440 U.S. at 211, confirmed that "the business of insurance" that is saved from ERISA preemption by the Savings Clause is "not coextensive with the 'business of insurers.' "

The first inquiry under the "common-sense" test focuses on "'primary elements of an insurance contract [, which] are the spreading and underwriting of a policyholder's risk'. Id. at 211." Kentucky's AWP statute has absolutely no relationship or connection to any health care risk to which a policyholder may be exposed, which risk has been transferred to an MCO. The ability of a provider to force itself into an MCO's network does not result in creating new health risks to which the MCO's members are exposed, the liability for which has been transferred to the MCO. Thus, the core and indispensable characteristic of a state law that may be saved from preemption under the Savings Clause, that it effectuate the transfer of a risk from an insured to an insurer, simply does not exist in Kentucky's AWP statute.

The relationship affected by Kentucky's AWP statute, and all similar state statutes, is identical in every relevant respect to the relationship between the insurer and its pharmacy vendors in *Royal Drug*. The issues of "who" an insurer compensates for covered goods and, services, and "how much" the insurer may be obligated to compensate such vendors only involves the "business of insurers," and is not "the business of insurance." As a result, Kentucky's AWP statute is not a state law covered by ERISA's Savings Clause, and it is not saved from preemption.

CONCLUSION

For the foregoing reasons, Amici AAHP, HIAA, NAM and BCBSA respectfully submit that the decision of the Sixth Circuit Court of Appeals should be reversed.

Respectfully submitted,

DALY D.E. TEMCHINE
Counsel of Record
EPSTEIN BECKER & GREEN, P.C.
1227 25th Street, NW
Suite 700
Washington, D.C. 20037
(202) 861-0900

STEPHANIE W. KANWIT
General Counsel
AMERICAN ASSOCIATION OF HEALTH PLANS
1129 Twentieth Street, N.W.
Suite 600
Washington, D.C. 20036-3421
(202) 778-3200

JAN S. AMUNDSON
General Counsel
QUENTIN RIEGEL
Deputy General Counsel
NATIONAL ASSOCIATION OF MANUFACTURERS
1331 Pennsylvania Ave., N.W.
Washington, D.C. 20004-1790
(202) 637-3000

ANGELA J. FRANKLIN
Legislative Director and Counsel
HEALTH INSURANCE ASSOCIATION OF AMERICA
1201 "F" Street, N.W.
Suite 500
Washington, D.C. 20004
(202) 824-1667

ALAN JAY LIPSITZ
Executive Director
BLUE PLAN LEGAL DEPARTMENT COOPERATIVE
BLUECROSS BLUESHIELD ASSOCIATION
1310 G Street, N.W.
Washington, D.C. 20005
(202) 942-1278

Attorneys for Amici Curiae