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 *AMICI CURIAE* OF COMMUNITY HEALTH PARTNERS AND RESERVOIR PARK HEALTH SERVICES, INC. D/B/A CENTER CARE

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## QUESTION PRESENTED

Whether state Any Willing Provider statutes regulate "insurance" and are therefore saved from preemption by ERISA?

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## BRIEF *AMICI CURIAE*

## INTEREST OF THE *AMICI*[1]

*Amici curiae* Community Health Partners and Reservoir Park Health Services, Inc. d/b/a Center Care are the plaintiffs in a parallel challenge to Kentucky's Any Willing Provider ("AWP") statute. *Amici* assemble panels of selected health care providers, including hospitals, and physicians of various specialties, to provide services on a preferred or exclusive basis for managed care entities and traditional insurance companies, as well as for employers that provide health plans but do not carry any form of insurance (so-called "self-insured" or "self-funded" plans). *Amici* brought suit against respondent alleging that the Kentucky AWP statute was preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). The district court granted respondent summary judgment and the Sixth Circuit affirmed on the basis of its ruling in this case, which it decided the same day. The petition for certiorari filed by *amici* from the Sixth Circuit's decision is pending as 00-1295, *Community Health Partners* v. *Kentucky*.

## SUMMARY OF ARGUMENT

I. Any Willing Provider laws have been adopted to protect the interests of politically powerful health care providers that face a loss of their market share under managed care. A major component of the shift from traditional indemnity insurance to managed care has been the increased emphasis on "limited provider networks" – *viz.* discrete groups of providers who offer discounted rates in exchange for guaranteed volumes of patients. The consequence of this trend has been to reduce provider incomes and to exclude less efficient (and

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[1] Petitioners and respondent have filed global consents to the filing of all *amicus* briefs in this case. No counsel for a party authored this brief in whole or in part. No persons or entities other than the *amici* made a monetary contribution to the preparation or submission of this brief.

hence more expensive) providers from a substantial portion of the marketplace. AWP statutes make limited provider networks illegal so as to prevent managed care organizations from securing the economic advantage that comes with the size of their base of policyholders.

II. AWP statutes have neither the form, nor the purpose, nor the effect of regulating "insurance." AWP laws take the form of regulation of the insurer-provider relationship. Their purpose is not to correct any defect in the insurance relationship but instead to preserve market share for certain providers. And they have no effect whatsoever on the insurer-insured relationship, which remains entirely unaffected. AWP statutes are accordingly not saved from preemption by ERISA.

## ARGUMENT

### I. State Any Willing Provider Statutes Are A Response To The Economic Leverage That Managed Care Organizations Exercise Over Health Care Providers On Behalf Of Their Subscribers.

1. The principal role of traditional indemnity health insurers, like insurers generally, has always been to spread risk. Individuals facing the possibility of needing substantial medical care which could result in crushing expenses turned to a risk pool, which eliminated that prospect in exchange for a fee. The cumulated fees provided the insurers with sufficient revenue to pay their subscribers' medical expenses while covering their own administrative costs and earning a profit.

As health insurance spread widely after World War II (in large part as a result of tax incentives for employers), a substantial diseconomy emerged. For reasons of cost, an uninsured or underinsured individual would avoid unnecessary visits to a medical provider, and the provider would avoid ordering unnecessary procedures. But for individuals with traditional fee-for-service insurance – where the insurer essentially just dispensed money to providers from the pool of

premiums – that important constraint on rising health-care costs was largely missing. Provider fees rose greatly because insurance contracts not only guaranteed providers a certain amount of revenue for each visit and each procedure, but also created little incentive for patients to avoid incurring unnecessary medical expenses. Rather, insured patients had every incentive to seek as much medical care as possible, and doctors had every incentive to provide it. Insurance premiums rose as a result.

Managed care developed largely in response to this phenomenon of health care "overutilization" and the skyrocketing costs of medical care, especially for employer-sponsored health insurance plans. The fundamental premise of managed care is that traditional indemnity insurance, under which the provider was simply reimbursed by the insurer for services rendered, was not economically sustainable because the provider had no incentive to control expenditures. See Matthew K. Wynia, *The Oregon Capitation Initiative*, 276 J.A.M.A. 1441, 1441 (1996) ("[M]any health economists believe that fee-for-service payment of physicians has been a major contributor to the rapid growth in health care costs in the United States."). Among the most common approaches to managed care are reduced-fee-for-service systems and "capitation." "Reduced-fee-for-service" means just what it says – the insurer secures a discounted rate (often substantial) for each visit or procedure. "Capitation" is a per-patient (*i.e.*, per-capita) mechanism: for a set fee, a provider agrees to furnish the insured whatever services are necessary and offered under the plan.[2]

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[2] Paying primary care physicians on a capitated basis achieves the goal of managed care organizations, since "capitation puts the provider at some level of risk or incentive for medical expenses and utilization." Peter R. Kongstvedt, *Compensation of Primary Care Physicians in Managed Health Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE 103, 118 (Peter Kongstvedt ed., 4th ed. 2001). Be-

A principal feature of managed care has been the recognition that insurers can reduce the diseconomy of overutilization by leveraging the purchasing power of their policyholders to obtain better deals from providers, both in terms of lower prices and stricter utilization controls. After all, a large number of patients can have a material effect on a provider's income. Traditional insurance companies nonetheless failed to leverage this economic power because they did not combine the purchasing power of their subscribers. Although policyholders were part of a single risk pool, individuals covered by those policies could spend their insurance benefits with virtually any provider. No particular group of physicians, for example, would know *ex ante* that it would receive the benefit of a large number of patients from any particular insurer. Those physicians accordingly had very little incentive to agree to a reduced fee schedule.

A managed care organization ("MCO") leverages its insurance pool by creating a "limited provider network." Insureds receive services only from this discrete group of providers (unless they pay a higher fee or secure an appropriate referral to go "out of network") and therefore form what is, in effect, a purchasing cartel, through the MCO. The providers in the limited network are guaranteed a certain number (or at least a certain proportion) of the insurer's patient base, accepting lower unit prices in return for higher volume. The providers are accordingly willing to enter into agreements that contrib-

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cause the provider receives a fixed amount per member per month whether she treats the member once or ten times, capitation eliminates the incentive to "overutilize" or over-treat patients that exists in a fee-for-service payment arrangement. Moreover, under capitation, a managed care organization's costs are more predictable, because it knows roughly how much it will have to pay for each member's health care. Capitation is also easier and less costly to administer because there are fewer claims to keep track of and adjudicate than under fee-for-service.

ute to a substantial reduction in health care costs. As reflected in the sworn deposition testimony of a manager of an unrelated MCO in the parallel challenge brought by *amici* against Kentucky's AWP statute:

> [The] bottom line is [that] it's just a very basic business princip[le]. An HMO has contracts and covered lives. They can come to us as a provider network and give us that volume and we take care of them. In exchange for that volume, we provide services for less.

Deposition Testimony of Ronald Derstadt, No. 1:96-CV-202-M, *Community Health Partners, Inc.* v. *Commonwealth of Kentucky* 4 (Sept. 15, 1997). The Kentucky AWP statute is "like a dagger to the heart" of that effort. *Id.* 8.

2. Many providers, particularly those that are less competitive, are understandably hostile as an economic matter to the lower revenues they receive when MCOs create limited provider networks. The economic clout of medical providers is dispersed, and they are accordingly unable to exercise much negotiating leverage to maximize their profits vis-à-vis MCOs. Physicians, for example, generally practice in small groups that serve only a portion of the local population. But unlike insureds, medical providers lack a vehicle through which they can join together to exert a corresponding pressure on MCOs to raise their subscribers' premiums and pay out higher fees. Formal attempts at collective bargaining by providers who lack substantial financial integration would be suspect under the antitrust laws. *See, e.g.*, *Arizona* v. *Maricopa County Med. Soc'y*, 457 U.S. 332 (1982). And any *informal* effort to discourage participation in limited networks is doomed to failure through defections by providers willing to accept the guaranteed revenues offered by MCOs.

a. Providers have accordingly turned to state governments to break up the purchasing power of managed care organizations. Their approach is modeled on the "any willing phar-

macist" legislation enacted in response to the leverage exercised by insurers with respect to prescription drugs. In the 1970s, faced with rising drug costs but seeking to take advantage of the efficiency of larger pharmacies and pharmacy chains, insurers sought to impose caps on pharmacists' profits. Thus, in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), this Court considered a Blue Shield plan under which participating pharmacies accepted a maximum margin of $2 per prescription. Small pharmacies that faced the prospect of losing market share because they could not operate on such thin margins filed suit, alleging that the provider agreement was an unlawful price-fixing agreement and group boycott. This Court rejected the insurer's argument that the agreements were regulated by state law as the "business of insurance" and thus were immune from antitrust scrutiny under the McCarran-Ferguson Act (59 Stat. 34, *as amended*, 61 Stat. 448, 15 U.S.C. 1012(b)).

Insurers faced a substantial difficulty in sustaining the prescription drug purchasing plans of the type at issue in *Royal Drug*. They needed to promise pharmacists a large number of patients to secure, in effect, volume discounts. Not only would high volume justify smaller margins on a per-transaction basis, but those volumes were essential to induce the pharmacies to assume the costs of the plan's administrative requirements (including substantial paperwork). Insurers accordingly created limited pharmacy networks through which plan participants were required to purchase drugs (unless they were willing to pay a higher price).

Smaller, yet politically powerful, pharmacists responded to this expanding threat to their market share by encouraging the adoption of "any willing pharmacy" legislation, which now exists in at least eleven states. See Bureau of National Affairs, Health Law Reporter, *Managed Care: Any Willing Provider Bills Proliferate at the State Level*, Dec. 1, 1994, at 2; Lynn Holladay Avery, *Debate about "Any Willing Provider" Laws Continues in 1995*, 61 Aorn J. 594, 594 (1995)

("Pharmacists traditionally have led efforts to enact any willing provider laws."). These statutes confer two rights: (i) a *pharmacy* has the right to participate in any health insurance network; and (ii) a plan *participant* has the right to use the insurance at any pharmacy he or she chooses. In either event, the pharmacy must be willing to abide by the plan's terms and conditions. See, *e.g.*, 18 Del. Code 7303.

On their face, these "any willing pharmacy" statutes render insurance companies' efforts to create limited networks for pharmacy benefits illegal. The statutes are not, however, intended to expand the number of pharmacists actually participating in limited provider networks. They expressly require each pharmacy to abide by the plans' terms, including reimbursement rates, however low. And, as the *Royal Drug* case illustrated, smaller pharmacies cannot afford to operate at such low margins, particularly when they are not guaranteed large numbers of customers. Rather, the point of the statutes is to break up the purchasing power of insurance companies by depriving any pharmacy of the knowledge *ex ante* that it is guaranteed to receive the high volume that justifies participating and accepting a discounted rate in the first place.

b. The enactment of these statutory schemes was not limited to pharmacies. Politically powerful doctors and other health care providers sought similar legislation – known as "any willing provider" ("AWP") statutes – in resisting the leverage created by the expansion of limited provider networks. Indeed, "[v]irtually every legal scholar who has addressed the issue" regards AWP statutes "as an attempt by politically powerful interest groups in the medical community to protect their current income levels and jobs at the risk of substantially increasing the cost of health care and completely unraveling the optimal combination of cost control and quality that managed care has achieved." James W. Childs, Jr., *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 CUMB. L. REV.

199, 200 (1996-97). The historical record thus demonstrates that AWP statutes represent health care reform "hijacked to serve the economic interests of health care providers who were losing market share, autonomy and income to managed care." David A. Hyman, *Consumer Protection in the Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 412 (1998).

AWP statutes have now been adopted in at least thirteen states; Kentucky's is representative. It prohibits any "health insurer" from excluding "any provider * * * who is willing to meet the terms and conditions for participation established by the health insurer." Ky. Rev. Stat. Ann. 304.17A-270. The statute does not limit the term "health insurers" to traditional insurance companies, but rather includes every conceivable entity that could possibly exercise leverage in health care purchasing (other than an ERISA plan): "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." *Id.* § 304-17A-005(23). And "provider" includes every kind of health care practitioner and pharmacist (including dentists and optometrists). *Id.* § -17A-005(19).

AWP statutes, like "any willing pharmacy" statutes, seek to eliminate the leverage MCOs exercise through limited provider networks. The statutes reduce the purchasing power of the MCOs, and hence their ability to secure reduced fee agreements.[3] The adverse consequences of AWP laws can be

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[3] Indeed, AWP statutes make capitation (see *supra* at 3-4 n.2) an economic impossibility for both providers and plans. Without a limited network, providers face the prospect that they will treat too few patients to make the capitation agreement worthwhile. More-

particularly profound for larger insurers that operate in multiple states. These statutes require plans to establish multiple administrative schemes – for example, one for capitated subscribers outside Kentucky and another for subscribers in that state – and thereby create substantial practical difficulties in the plans' operations. As the Federal Trade Commission has observed, AWP laws "discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs, without any substantial public benefit." 00-1295 Pet. App. 101a-02a.

## II. Because AWP Statutes Do Not Regulate "Insurance," They Are Not Saved From Preemption By ERISA.

ERISA preempts state laws that "relate to any [covered] employee benefit plan" (29 U.S.C. 1144(a)) but saves from preemption those measures that "regulate[] insurance" (*id.* § 1144(b)(2)(B)). This Court has taken a "common-sense" view of what constitutes insurance (*Rush Prudential HMO, Inc.* v. *Moran*, 122 S. Ct. 2151 (2002)), distinguishing that term from the "business of insurance" and the "business of insurers" (*Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 210 (1979)). Thus, an otherwise preempted statute is saved only when "insurers are regulated

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over, a physician who treats only a few patients on a capitated basis runs a higher risk of treating a disproportionate number of insureds who have serious medical problems, the costs of which are not covered by the capitated fee. A larger patient base from the insurance pool ensures that the provider also has a number of clients for whom the cost of care is less than the capitation fee, offsetting the potential costs of insureds needing substantial care. For their part, insurers *require* limited networks to engage in capitation – it is not possible to agree to pay a specialist $50 per patient per year when five, ten, or twenty other specialists may demand to enter the network. The insurer would then be required to pay for the same care many times over.

*with respect to their insurance practices*." *Rush Prudential*, 122 S. Ct. at 2159 (emphasis added). The indispensable characteristic of insurance, in turn, is the "spreading and underwriting of a policyholder's risk." *Id.* (quoting *Royal Drug*, 440 U.S. at 211). It is this feature "distinctive to insurance" (*id.* at 2160) that delimits the field that Congress intended to leave to state regulation notwithstanding the consequences to ERISA plans.

1. The focus of this Court's inquiry under the saving clause is the insurer-insured relationship. The statutes that this Court has found encompassed by the clause have not only regulated the insurer-insured relationship (or at least the insurer's management of the assets it receives from policyholder premiums), but have also had the purpose and effect of regulating that relationship.

Most recently, *Rush Prudential* sustained a statute granting plan subscribers the right to an "independent review" of adverse benefits determinations. Previously, *UNUM Life Insurance Co.* v. *Ward* held that California's notice-prejudice rule – under which an insurer must prove prejudice before denying an insured's claim as untimely – constitutes the regulation of insurance, explaining that the test under the saving clause is whether the statute "govern[s] the *insurance relationship* distinctively." 526 U.S. 358, 373 (1999) (emphasis added). Similarly, *FMC Corp.* v. *Holliday* held that Pennsylvania's subrogation rule – which prohibits insurance contracts from providing that payments to insureds will be recouped from tort recoveries – falls within the savings clause because it "controls the terms of insurance contracts." 498 U.S. 52, 61 (1990). And *Metropolitan Life Insurance Co.* v. *Massachusetts* sustained a state law requiring that insurance policies include mental health benefits, explaining that the statute directly "regulates the terms of certain insurance contracts." 471 U.S. 724, 740 (1985).

2. Unlike the statutes previously sustained by this Court under the saving clause, AWP laws have nothing to do with

the insurer-insured relationship, whether in form, purpose *or* effect.

a. As this Court explained in *Rush Prudential*, the "dominant feature" distinguishing managed care organizations from traditional insurers is that MCOs act as a "combination of insurer and provider." 122 S. Ct. at 2161. MCOs thus have not only insurer-insured relationships with their policyholders, but also insurer-provider relationships with those persons and entities from whom policyholders receive services. This combinatorial role does not preclude characterizing MCOs as "insurers" for purposes of the saving clause, for they still spread policyholders' risk. *Id.* at 2162. But neither does it expand the scope of regulation saved to the states under ERISA to encompass, for the first time, state regulation of providers. Instead, this Court must examine at the threshold which of the two MCO roles – insurer or provider – the state is attempting to regulate. If only the latter (as is true of AWP statutes), the state's resort to the saving clause to avoid preemption should fail.

The form of AWP statutes relates not to the insurer-insured relationship, but instead to the insurer-*provider* relationship. The Sixth Circuit frankly conceded that "AWP laws do not change the substantive terms of the insurance coverage." 00-1295 Pet. App. 60a. Indeed, the form of AWP laws is most notable for what the statutes do *not* do. Unlike "any willing pharmacy" statutes (see *supra*), AWP measures do not confer on policyholders a right to visit their personal physicians (or any other provider). Indeed, AWP laws confer no right – whether procedural or substantive – on policyholders at all.

Not only are the limited provider networks regulated by AWP statutes not an "*integral* part of the policy relationship" (*Rush Prudential*, 122 S. Ct. at 2163 (emphasis added)), they are not a part of the policy relationship at all. The Sixth Circuit thus profoundly confused the widespread requirement that managed care participants visit only providers within the

network (unless they receive a referral or pay a surcharge) with the concept of limited provider networks. The former exists whether or not a state has an AWP law. The latter is the method by which MCOs determine the size of their network. Subscribers are generally unaware that their insurer employs a limited provider network.

To be sure, subscribers are aware that their plan permits them to visit only a discrete list of providers and they are similarly aware whether that list includes a physician who previously treated them. But the number and identity of providers are not necessarily or exclusively a function of limited provider networks. Kentucky's AWP law forbids an MCO in that state from formally limiting the size of its network, but the law does not prohibit reimbursement rates that have an identical effect on the number of providers. A Kentucky plan may thus have a very small network because it offers low reimbursement rates that few providers will accept. (Indeed, unable to benefit from the cost savings of limited networks, the plan is quite likely to offer poor reimbursement.)

Thus, MCO participants in Kentucky (which has an AWP law) and Pennsylvania (which does not), may have identical health plans and have access to provider networks that are indistinguishable in size. In both states, it may be equally as likely that a particular individual's doctor participates in the insurer's network. And, in either state, the policyholder is restricted to visiting providers in the network.

It is no answer that, as a formal matter, the AWP statute appears in the Kentucky Insurance Code. Contra 00-1295 Pet. App. 23a. States easily could have taken the alternative approach of forbidding providers from joining limited provider networks rather than forbidding insurers from forming such networks. But that alternative approach would plainly be preempted on the ground that such a restriction on provider participation "relates to" ERISA health benefit plans. In an effort to take advantage of ERISA's saving clause, states accordingly imposed the regulation on the insurer and codified

the AWP restriction in their insurance codes. But the inescapable fact remains that regulation of insurer-provider relationships is *not* a traditional subject of insurance regulation that Congress can be said to have intended to reserve to the states in the saving clause. The Kentucky Department of Insurance thus candidly acknowledged in its official response to an inquiry by the Kentucky Optometric Association regarding the effect of the state's AWP statute: "In the past, the Department has had very little involvement in the relationship between a provider and the insurer/HMO."[4]

Nor is it an answer that the Kentucky AWP statute formally applies to all "insurers" (defined very broadly). Traditional indemnity insurers, long the subject of state insurance regulation, are nominally included within the statute's scope, but are essentially unaffected by it because they lack the direct provider relationships of MCOs. Conversely, entities that have *no* insurer-insured relationship and thus that do not spread risk at all – *e.g.*, MCOs acting merely as administrators for non-ERISA plans – *are* directly regulated and heavily affected by the statute. AWP statutes are thus targeted at every entity that conceivably could, on behalf of its subscribers, exercise economic leverage against providers, without regard to whether those entities are engaging in traditional "insurance practices."

b. AWP laws similarly do not have the *purpose* of regulating the insurer-insured relationship. To the contrary, neither Kentucky nor any of the other states in the litigation over AWP statutes has yet been able to identify a defect in the insurance relationship that states are seeking to correct. In-

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[4] Letter from Commissioner George Nichols III to Darlene W. Eakin, Executive Director, Kentucky Optometric Ass'n 1 (Feb. 7, 1997). This letter is an official record of the State of which this Court may take judicial notice, and was also produced by respondent in discovery in the parallel litigation brought by *amici* challenging the Kentucky AWP statute.

stead, the statutes' transparent purpose is to eliminate the purchasing power of the insurance pool and thereby to preserve the market share and profit margins of those less efficient providers that would lose out under managed care.

But the regulation of insurer-provider relationships, including regulation directed at the competitive consequences of insurers' conduct on providers, is not the regulation of "insurance." That is the holding of *Royal Drug*, which concluded that the "business of insurance" does not encompass agreements between an insurer and its providers. Provider agreements, the Court explained, can be said to involve the "business of insurance *companies*," but they do not involve "insurance," a term of art that describes spreading and underwriting risk. 440 U.S. at 211 (emphasis added). Indeed, the Court made quite clear that its holding extended to exclusive provider agreements indistinguishable from those addressed by AWP statutes, as when "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies *only from stores operated by this chain*." *Id.* at 215 n.12 (emphasis added).

*Royal Drug* explains that provider contracts do not constitute "the spreading and underwriting of a policyholder's risk" through the policy. 440 U.S. at 211. The Court thus distinguished between "the *obligations* of [an insurer] under its insurance policies, which insure against the risk that policyholders will be unable to pay * * * and the *agreements* between the [insurer] and the participating [providers], which serve only to minimize the costs [the insurer] incurs in fulfilling its underwriting obligations." *Id.* at 213 (emphasis added). Provider agreements also are not integral to the insured-insurer relationship or limited to entities in the insurance industry. *Id.* at 216. Instead, they constitute "separate contractual arrangements" between the insurer and providers, the latter of whom are "engaged in the sale and distribution of

goods and services other than insurance." *Id.* That reasoning applies fully to this case.

The Sixth Circuit nonetheless held in this case that state "insurance" regulation includes restrictions on provider contracts. On that view, in states that approve limited provider networks, the McCarran-Ferguson Act protects even the most extraordinary monopolistic and predatory limited provider networks from federal antitrust scrutiny. There is no reason to believe that Congress intended to carve such a substantial hole out of the fabric of federal regulation.

c. Finally, AWP statutes do not have the *effect* of regulating the insurer-insured relationship. It is common ground that AWP statutes do not affect the risk underwritten by the insurer, for the terms and conditions of insurance policies – and thus the risk transferred – remain absolutely identical under AWP laws. The Sixth Circuit nonetheless opined that AWP statutes have the effect of spreading the "risk" that a policyholder will not be able to receive care under the terms of the plan from a participating provider of her choice. 00-1295 Pet. App. 60a. That is simply not correct.

AWP do not confer on policyholders the right to visit their personal physician or even to have their physician admitted to the network. That choice rests with the provider, who may be entirely unwilling to accept the plan's reimbursement rates and other conditions, and who (in the considerable experience of *amici*) will *not* go to the trouble of joining an insurance network in order to be able to treat a particular patient. Nor do AWP laws mandate larger provider networks such that a policyholder's physician will be incrementally more likely to be a member of the network.

In any event, the Sixth Circuit's conception of "risk" is simply another way of saying that AWP statutes can potentially benefit insureds. There is no evidence that AWP statutes actually benefit policyholders, but there is not even a suggestion that they do so in a way that relates to the "risk"

that is "spread" or "underwritten" by the insurance contract as this Court's precedents require. *Royal Drug* thus specifically found with respect to provider networks that while "[s]uch cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums * * * they are *not* the 'business of insurance.'" *Id.* at 214 (emphasis added). It made no difference that policyholders were affected by the provider agreement in *Royal Drug* itself, which, although it may not have directly "restrict[ed] the number of providers in question" (00-1295 Pet. App. 62a), offered such a small reimbursement that numerous pharmacists could not afford to participate (see *Royal Drug*, 440 U.S. at 209 ("only pharmacies that can afford to distribute prescription drugs for less than this $2 markup can profitably participate in the plan")).

As Judge Kennedy explained in her dissent in this case, "any concerns over freedom of choice are beside the point. The critical issue with respect to the risk spreading prong, as well as whether the law regulates insurance as a matter of common sense, is whether or not the law is related to the risks underwritten by the insurer." 00-1295 Pet. App. 84a. AWP laws lack that critical relationship and are accordingly preempted by ERISA.[5]

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[5] There would be no merit to the argument that AWP laws benefit insureds or the employers that finance their coverage. "[M]anaged care has expanded health insurance coverage options available to consumers" by providing them access to coverage at lower costs. Richard I. Smith et al., *Examining Common Assertions About Managed Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra*, 71, 72. Recent studies have found that HMOs, for example, reduce the use of services by 20% compared to traditional health plans, leading to a cost savings ranging from 20% to 40%. Kenneth E. Thorpe, *Health Care Cost Containment: Reflections and Future Directions*, *in* JONAS & KOVNER'S HEALTH CARE DELIVERY IN THE UNITED STATES 439, 452 (Anthony R. Kovner and Steven Jonas, eds., 6th ed. 1999). As a result of this cost savings, managed

care organizations have become more attractive to employers seeking to provide health care coverage for their employees. See Peter D. Fox, *An Overview of Managed Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra*, 3, 3 (as of 1999, HMO enrollment had reached 81.3 million, with preferred provider organization ("PPO") enrollment not far behind). The further movement of workers into managed care plans, in turn, "has generated impressive reductions in private-sector health care spending." *Id.* 466. Spending by employers on health insurance, which increased at an average annual rate of 11.3% between 1985 and 1990, declined to 6.8% during the late 1990s. *Id.* 467.

The effect of AWP laws is to drive more cost-effective managed care organizations from the market. A 1998 Barents Group LLC study commissioned by the American Association of Health Plans found that AWP laws would increase costs for HMOs by thirteen to sixteen percent, and would increase costs for all managed care health plans by between 6.6% and 8.6%. ESSENTIALS OF MANAGED HEALTH CARE, *supra*, at 799. A similar study by Arthur Andersen & Co. commissioned by the Florida legislature concluded that enactment of proposed AWP legislation in Florida would increase per-member, per-month costs of private-sector managed care plans by approximately 15%. *Id.* See Fred J. Hellinger, *The Expanding Scope of State Legislation*, 276 J.A.M.A. 1065 (1996) (citing studies indicating that any willing provider laws "increase the cost of care"); Holladay Avery , *supra*, at 597 (citing studies); Fred Hellinger, *Any-Willing-Provider and Freedom-Of-Choice Laws: An Economic Assessment*, 14 Health Aff. 297, 300 (1995) ("[I]mplementation of an AWP law * * * would increase the administrative costs of the typical managed care organization by 43 percent."). Indeed, both the Federal Trade Commission and the National Governors Association have repeatedly reaffirmed their opposition to AWP laws, on the ground that such laws have the "effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services." *Id.*

## CONCLUSION

*Amici* respectfully suggest that the judgment of the Sixth Circuit should be reversed.

Respectfully submitted,

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