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

REPLY BRIEF FOR PETITIONERS

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Respondent and her amici rest their contention that AWP laws "regulate insurance" principally on the ground that, by preventing HMOs from limiting the number of providers with whom they will contract to provide health services to members, AWP laws confer a valuable insurance benefit on HMO members. AWP laws do no such thing. AWP laws confer rights *solely on providers*, who may elect to join a network if they are willing to accept the terms set by the HMO. Contrary to the suggestions of respondent and her amici, Kentucky's AWP laws do *not* give HMO members the right to obtain care from any provider they choose. Notwithstanding AWP laws, HMO members may only obtain care from providers who have agreed to the terms of the HMO network contract, and the choice whether to do so remains entirely with the provider. As respondent's own amici state, AWP laws "directly and primarily regulate[] the relationship between the insurer and the health care service provider." AMA Br. 25. They do *not* regulate the relationship between the HMO and its members. Because there is no sense in which the rights conferred on providers by AWP laws also reflect a legal alteration in the terms of the insurance relationship between HMOs and their members, there is no sense in which AWP laws "regulate insurance" within the meaning of ERISA's saving clause.

There is therefore also no reason to depart from this Court's holding in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), that an insurer's contracts with health care providers to provide care to its insureds do not constitute an "insurance" practice. Respondent and her amici labor mightily to distinguish *Royal Drug*, but their efforts are unavailing.

Two principal grounds are suggested for escaping the dispositive force of *Royal Drug*. The first is that the question in *Royal Drug* was whether provider contracts are

business decisions that constitute "insurance," whereas here the question is whether *laws* that regulate those decisions are laws that "regulate insurance." Resp. Br. 23; *see* SG Br. 23. That distinction lacks merit: if the provider agreements in *Royal Drug* were not "insurance," then laws that regulate those agreements are not laws that regulate "insurance."

The second is that *Royal Drug* arose under the McCarran-Ferguson Act, and the test for "insurance" mandated under McCarran-Ferguson differs materially from the test required by the ERISA saving clause. Resp. Br. 23-24; SG Br. 24-27. This Court's precedents refute that contention. From their inception, this Court's ERISA saving clause decisions have used *exactly* the test devised in *Royal Drug* to determine whether the practice being regulated by a challenged state law is an "insurance" practice. To be sure, the ERISA test *also* incorporates a "common sense" component, but no case has ever held, or even intimated, that a law regulating a practice that is *not* "insurance" under McCarran-Ferguson can nevertheless be a law that regulates "insurance" under ERISA. In any event, even the additional "common sense" inquiry invoked under ERISA compels the same result. AWP laws do not regulate "insurers" exclusively (they also regulate non-insurer providers) and they do not regulate the "insurance" contract at all (they do not affect insureds' legal rights directly or indirectly).

AWP laws do not "regulate insurance" as a matter of law, as a matter of precedent, or as a matter of common sense. They are therefore preempted by ERISA.

ARGUMENT

The court below unanimously agreed that Kentucky's AWP laws "relate to" ERISA plans. Pet. App. 7a-19a, 24a-25a. Neither party sought review of that holding in this Court, and both parties agree that this threshold question of preemption is satisfied here. Resp. Br. 9; Petrs. Br. 12-13.

The Solicitor General, speaking for the Department of Labor, concurs. SG Br. 9-10.[1]

Accordingly, the parties before this Court agree that Kentucky's AWP laws are preempted unless they fit within ERISA's "saving clause" exemption from preemption that applies to laws that "regulate insurance." This Court's precedents make plain that the ERISA saving clause applies only when insurers "are regulated *with respect to their insurance practices*." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2159 (2002) (emphasis added). The laws at issue here regulate HMOs' practice of entering into agreements with providers to provide the medical care promised in the contract of insurance. Thus the question here – the sole question – is whether that practice is an "insurance practice."

A. *Royal Drug* Controls This Case

The Court in *Royal Drug* addressed precisely the same question in the context of the McCarran-Ferguson Act, holding that an insurer's contracts with pharmacies to provide prescription drugs are not an "insurance" practice. Respondent and her amici offer no persuasive ground for distinguishing that holding.

1. Respondent's principal argument compares apples to oranges, contending that the provider contracts at issue in *Royal Drug* were "business decisions," whereas this case involves "state laws" enacted as "patient protection" legislation. Resp. Br. 19-21, 23. The Solicitor General makes the

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[1] Some of respondent's own amici reject her position and contend that AWP laws do not relate to ERISA plans. Am. Coll. Legal Med. Br. 3-15; AMA Br. 7-25. This Court generally does not consider arguments raised only by amici. *See United Parcel Service, Inc. v. Mitchell*, 451 U.S. 56, 60 n.2 (1981); *Bell v. Wolfish*, 441 U.S. 520, 531 n.13 (1979); *Knetsch v. United States*, 364 U.S. 361, 370 (1960). Their arguments are incorrect in any event, for the reasons explained by the court below, the parties, and the Solicitor General. *See also infra* at 18-19.

same mistake. SG Br. 23 ("the subject of the legal inquiry in this case is a *state law*, not private agreements"). The issue here is whether the private business practice the "state laws" regulate is an "insurance" practice. And the practice they regulate is the practice of entering into provider contracts – exactly the same "business decisions" held by this Court *not* to be "insurance" practices in *Royal Drug*.

2. The Solicitor General emphasizes that the provider contracts in *Royal Drug* were not part of a limited network. SG Br. 22. That proffered distinction is wrong as a practical matter, and immaterial in any event. In fact, the provider agreements in *Royal Drug were* part of a network limited in practice, because only a few larger pharmacies could afford to provide drugs on the terms required by the provider agreements. *See* 440 U.S. at 209.[2] The insureds in *Royal Drug* had no right to demand that their insurer make drugs available on "network" terms from "non-network" pharmacies, just as HMO members have no right to demand that HMOs provide care on network terms through non-network providers. From the perspective of the insureds, in other words, there is no practical distinction between the two arrangements.

Nor does the HMO practice of limiting the number of network participants to obtain cost and monitoring advantages reflect any material legal distinction between this case and *Royal Drug*. The *Royal Drug* Court held that provider contracts are not "insurance" because they do not spread risk, because they do not affect the terms of the insurance contract itself, and because they involve entities outside the insurance industry. *See* Petrs. Br. 14-20. Nothing in that analysis suggests that the provider contracts in that case

[2] Indeed, the substantive antitrust law allegation in *Royal Drug* was that the terms of the provider contracts were anticompetitive because they effectively precluded insureds from dealing with certain pharmacies. 440 U.S. at 207.

would somehow have become "insurance" had the insurer specifically limited the number of providers with whom it contracted. To the exact contrary, the *Royal Drug* Court explicitly stated that a network that *is* formally limited to just one provider would no more constitute "insurance" than did the formally non-limited network before the Court. 440 U.S. at 215. It follows that a network limited to more than one provider is not an insurance practice.

3. The Solicitor General also suggests that *Royal Drug*'s holding is categorically inapplicable here because of linguistic differences between § 2(b) of the McCarran-Ferguson Act and the ERISA saving clause. As explained in our opening brief, these differences have *never* affected this Court's reliance on *Royal Drug*'s analysis of "insurance" in ERISA saving clause cases, and they certainly should not in this one, which implicates not just *Royal Drug*'s analytical approach, but its square holding. Petrs. Br. 36-38 & n.17.

The ERISA saving clause saves state laws that "regulate insurance." Section 2(b) of McCarran-Ferguson includes two clauses pertinent here. The first saves state laws "enacted . . . for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b). The second exempts "the business of insurance" from federal antitrust law to the extent such business is "regulated by State law." *Id.*

a. The Solicitor General first tries to distinguish *Royal Drug* on the ground that while "the ERISA clause broadly saves laws that regulate 'insurance,' the McCarran-Ferguson Act applies in accordance with the more limited term 'business of insurance.'" SG Br. 25-26. In construing the latter term, the Solicitor General claims, this Court has distinguished the "business of insurance" from the "business of insurance companies," holding that "not everything an insurance company does is within the 'business of insurance.'" SG Br. 26. By contrast, the Solicitor General asserts, "the

ERISA saving clause saves the regulation of 'insurance' more generally." *Id.*

That argument is without merit. It is true that this Court has, in several McCarran-Ferguson cases, emphasized that not everything an insurance company does is within the business of insurance. But what is also true – and what the Solicitor General ignores – is that this Court has made precisely the same point in the ERISA saving clause context as well. *See, e.g.*, *Rush Prudential*, 122 S. Ct. at 2159. Indeed, the Court's seminal ERISA saving clause precedent described the fact that a law "fall[s] within the terms of the definition of insurance in the McCarran-Ferguson Act" as "directly relevant" to the saving clause inquiry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 n.21 (1985). Not one of this Court's subsequent saving clause opinions has suggested that the "*business of* insurance" language in § 2(b) constitutes a material limitation that diminishes the relevance of the McCarran-Ferguson/*Royal Drug* analysis of insurance to ERISA saving clause cases.

b. The Solicitor General also seeks to distinguish *Royal Drug* on the ground that that case was based on the "second clause" of § 2(b), which exempts the business of insurance from federal antitrust laws to the extent such business is not regulated by state law. The Solicitor General mistakenly reads *Royal Drug* to be based fundamentally on a "policy favoring a narrow construction of antitrust exemptions." SG Br. 27. While it is true that the *Royal Drug* Court *mentioned* the principle "that exemptions from the antitrust laws are to be narrowly construed," 440 U.S. at 231, the Court did so only at the very end of its opinion, after a full twenty pages analyzing provider contracts under basic insurance principles. The Court plainly did not *rely* on that canon for any aspect of its analysis of what constitutes "insurance." The Court did not suggest, in other words, that it would – or even could – define "insurance" differently or more broadly if the

canon did not apply. To the contrary, the Court's analysis focused specifically on characteristics fundamental to any conception of insurance. Certainly no subsequent ERISA saving clause case has denigrated the relevance of the *Royal Drug* factors on the theory that they are premised on a narrowing interpretive canon inapplicable in the ERISA context.

c. The Solicitor General similarly errs in arguing that only the *first* clause of § 2(b) – not the second clause discussed in *Royal Drug* – is properly relevant to the ERISA saving clause analysis. SG Br. 26-27. The first clause of § 2(b) saves state laws "enacted *for the purpose of* regulating the business of insurance." As the Court explained in *United States Department of Treasury v. Fabe*, 508 U.S. 491 (1993), laws "enacted for the purpose of regulating insurance" necessarily describes more laws than just those that actually do regulate insurance, *id.* at 504. But ERISA does *not* save laws "enacted for the purpose of regulating insurance." Rather, like the *second* clause of § 2(b) construed in *Royal Drug*, ERISA saves only those laws that do, in fact, "regulate insurance." It is thus the second clause of § 2(b) that is the more analogous to the ERISA saving clause.

It is for that reason this Court's ERISA saving clause precedents have always followed *Royal Drug*'s analysis, and have inquired into whether the law at issue actually regulates "insurers *with respect to their insurance practices*." *Rush Prudential*, 122 S. Ct. at 2159 (emphasis added). The Court has never determined that a practice being regulated was *not* "insurance" under any of the *Royal Drug* factors, but then held a law regulating that practice to be within the compass of the ERISA saving clause on the ground that it was enacted "for the purpose" of regulating insurance.[3]

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[3] The Solicitor General's interpretation of footnote 18 in *Royal Drug* confirms his misunderstanding of the relationship between the McCarran-Ferguson Act and the ERISA saving clause. He reads that footnote as "strongly suggesting" that even though provider contracts are not the

4. The Solicitor General's final reason for ignoring *Royal Drug* is that the Court's use of the common sense test in ERISA saving clause cases renders the analysis of "insurance" under ERISA meaningfully different from that in *Royal Drug*. That contention is baseless. In fact, the common sense test does not appear to be any different from the third *Royal Drug* factor, as this Court's precedents reveal, *see* Petrs. Br. 35 n.15 (citing cases), and as the submissions of both the Solicitor General and respondent confirm, SG Br. 21 (AWP law satisfies third factor "for essentially the same reasons that the AWP law regulates insurance as a matter of common sense"); Resp. Br. 21. If the common sense test in this respect simply reflects a subset of the *Royal Drug* analysis, the results of the two tests are likely to be the same in

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"business of insurance" under the second clause, they could be regulated by state law under the first clause, which the Solicitor General takes to mean that the first clause is more like the ERISA saving clause. SG Br. 27. What the footnote actually says is that the "primary purpose" of the McCarran-Ferguson Act was to "assure that the States are free to regulate insurance companies without fear of Commerce Clause attack." 440 U.S. at 218 n.18. That goal was accomplished *not* by the first clause of § 2(b), on which the Solicitor General relies, but by § 2(a), which provides: "The business of insurance . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a); *see Metropolitan Life*, 471 U.S. at 744 n.21. In addition to finding the definition of the "business of insurance" set forth in *Royal Drug* "directly relevant" to the ERISA saving clause, the leading ERISA saving clause precedent equates the saving clause not with the broader, subjective "enacted for the purpose of" language in the first clause of § 2(b), but with the objective language of § 2(a), which parallels the objective second clause of § 2(b). *See Metropolitan Life*, 471 U.S. at 744 n.21. The Solicitor General also ignores the remainder of footnote 18 in *Royal Drug*, which goes on to observe that the second clause of § 2(b) does not address "the business of insurance companies," but the much narrower "business of insurance." *Id.* (internal quotation marks omitted). Likewise, this Court's ERISA saving clause jurisprudence recognizes that the saving clause does *not* save laws that regulate "insurance companies," it only saves laws that regulate "insurance." *See Rush Prudential*, 122 S. Ct. at 2159.

most cases (unless examination of the other *Royal Drug* factors casts sufficient doubt on the results of the common sense test).

The Solicitor General's related argument that the *Royal Drug* factors can *never* be dispositive, SG Br. 24, is equally incorrect. On that view, the common sense test would *always* be dispositive, and the *Royal Drug* factors would serve no purpose whatsoever. That cannot be true. In fact, it is possible for either prong of the saving clause inquiry to be dispositive in the right circumstances. As the Court's precedents describe the *Royal Drug* factors, they are to serve as an objective legal "check" or "test" of the results of the more subjective, intuitional common sense inquiry. As just discussed, in the run of cases the inquiries will be the same, and the *Royal Drug* analysis will only appear secondary or subordinate. But the common sense test can also be "primary" in the more substantive sense that even if one of the *Royal Drug* factors is missing in a given case – such that a practice might not fit the *Royal Drug* definition of "insurance" standing alone – a common sense impression of the practice as "insurance" could prevail, so long as one or two of the other *Royal Drug* factors confirms that intuition to some extent. If the *Royal Drug* factors are to serve as any true "check" or "test" of the common sense inquiry, however, they must prevail when they *all* establish that a given practice is not "insurance." So it is here: this Court has already applied the factors to hold specifically that an insurer's contracts with care providers are not an "insurance" practice. That holding should control.

Our point, of course, is not that *Royal Drug* leads to a conclusion about an HMO's provider contracts that differs from the results of the common sense inquiry. Our point is that *even if* provider contracts appeared to be an insurance practice as a matter of common sense, that impression would be refuted once "tested" or "checked" by *Royal Drug*. That

is why the holding of *Royal Drug* fully suffices, on its own terms, to answer the dispositive legal question in this case. Unless *Royal Drug* is overruled – and no party here contends that it should be – its analytical premise compels the conclusion that an HMO's contracts with providers are not the practice of "insurance," and thus that laws regulating that practice are not laws that regulate "insurance."

B. The ERISA Saving Clause Inquiry Confirms That AWP Laws Do Not Regulate A Practice That Is "Insurance"

In any event, AWP laws do not "regulate insurance" as a matter of common sense. The factors set forth in *Royal Drug* confirm that conclusion, not just in light of *Royal Drug*'s own holding, but also in light of the way the factors have been applied in the Court's ERISA saving clause cases.

1. AWP laws do not "regulate insurance" from a common sense viewpoint. The contracts they directly regulate are contracts between insurers and non-insurers. As respondent's amici the American Medical Association et al. explain: "The Kentucky statute *directly* and *primarily* regulates the relationship between the insurer and the health care service provider." AMA Br. 25 (emphasis added). Neither respondent nor any of her amici contend that the insurer-provider contract itself involves any risk-spreading – the "primary element[] of an insurance contract," *Rush Prudential*, 122 S. Ct. at 2159 – or in any other way constitutes an insurance contract. AWP laws thus do not "home in" on insurance contracts or the insurance industry, *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 368 (1999), but on non-insurance contracts involving non-insurers.

The Solicitor General denies this, arguing that "the specific obligation of the AWP law falls only upon health insurers." SG Br. 13 (internal quotation marks omitted). But that is to acknowledge only half of the necessary legal effect of the law: by imposing an explicit regulatory prohibition upon

insurers, an AWP law creates a formal legal right *in providers* – i.e., the right to join any network whose terms they are willing to accept.[4]

In any event, the fact that the state acts explicitly only on the insurer half of the transaction is merely a coincidence of the state's choice to codify the regulation in the state's insurance code. The state could just as easily have elected to directly bar providers from entering into limited network contracts with insurers, and codified that prohibition in the statutory provisions regulating health-care providers. Indeed, respondent herself refers to the laws repeatedly as "patient protection" legislation. Resp. Br. 3, 15, 19. Under this Court's precedents, the mere fact that the state elected to *label* its AWP laws "insurance laws" (Resp. Br. 13-14; SG Br. 14) simply does not determine their character as laws that regulate an "insurance *practice*," especially where the laws directly regulate a practice that necessarily includes non-insurer entities.[5] *See Rush Prudential*, 122 S. Ct. at 2162 n.5. In this respect AWP laws cannot be accurately described as targeted at entities and transactions solely, or even primarily, within the insurance industry.[6]

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[4] By contrast, such laws create no legal rights in insureds. *See infra* at 12-14.

[5] Respondent's amici Council of State Governments et al. suggest that AWP laws are "grounded in policy concerns specific to the insurance industry." Council State Gov. Br. 13. That is incorrect. Respondent herself describes them specifically as a form of health care legislation. In fact, AWP laws historically have been motivated more by concerns about provider market share than by concerns about *either* patient care *or* the adequacy or extent of insurance coverage. Comm. Health Ptnrs. Br. 2-9; American Ass'n Health Plans et al. Br. 13-16.

[6] The Solicitor General argues that if the fact that AWP laws regulate HMOs' contracts with providers "were sufficient to remove a state law from the scope of ERISA's saving clause," then a number of state laws purportedly regulating insurers' arrangements with providers "would be in danger of preemption." SG Br. 13-14; *see* Resp. Br. 15 n.12. But the

Respondent and her amici also contend that AWP laws regulate insurance as a matter of common sense because they "specifically regulate the terms of the insurance contract." Resp. Br. 17; *see* SG Br. 15 (AWP laws "directly affect the terms of the relationship between insurer and insured"). That contention is demonstrably incorrect. Even the majority below found it "admittedly true that the AWP laws do not change the substantive terms of the insurance coverage." Pet. App. 36a. The terms of the kind of insurance contract at issue here can be found in the exemplary Certificate of Coverage set forth in the Joint Appendix. In support of their contentions that AWP laws "specifically" and "directly" alter the terms of HMO policies, neither respondent nor the So-

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fact that AWP laws regulate the insurer-provider contract is not, in and of itself, necessarily "sufficient" to establish that the law is outside the saving clause. If the regulation of the insurer-provider contract has a material effect on the legal rights of insureds under their insurance policies, then the regulation would be tantamount to laws that mandate benefits or otherwise alter the terms of the insurance contract itself. *See, e.g.*, *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) (law affecting insurers' rights to deny claims not preempted); *Metropolitan Life, supra* (law requiring minimum mental health benefits not preempted). Many of the provisions cited by the Solicitor General and the respondent arguably constitute regulations that materially alter the legal rights of insureds. By contrast, as we have explained, AWP laws do *not* materially alter the legal rights of HMO members under their HMO policies. Other laws cited by the Solicitor General and the respondent – including claim forms regulations and ministerial notification and disclosure requirements – have only a *de minimis* effect on ERISA plans and therefore do not "relate to" such plans at all. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983) ("Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."). Finally, to the extent that there are other provisions with more direct impacts on ERISA plans but *not* on the benefits such plans provide – such as laws governing the submission of claims by providers – such provisions likely are *not* laws that regulate insurance and would thus be preempted. Neither the Solicitor General nor respondent identifies any problematic policy implications that would result from the routine application of saving clause principles to such laws.

licitor General identifies a single item in that Certificate that is "specifically" or "directly" altered by the AWP laws.

Instead respondent and her amici argue more generally that AWP laws allow "greater access to care and, thus, provide a richer benefit for the insured." Resp. Br. 17. As the Solicitor General puts the point, AWP laws require HMOs to provide coverage for services from any provider willing to comply with the terms of the network contract, which is coverage they would not otherwise be required to provide. SG Br. 16. Those arguments fundamentally misconceive the nature of the coverage and benefits HMO policies provide.

To begin with, it is flatly incorrect to argue that AWP laws give an HMO member "a right to select a provider" outside the HMO's network. Council State Gov. Br. 24. They do not. AWP laws do not affect *in any way* the right of HMOs to require that members seek care only from providers who are part of the HMO network. Nor do AWP laws affect *in any way* the right of HMOs to set the terms of the provider networks. What AWP laws do is to create a right in providers – entities wholly outside the insurer-insured relationship, *see supra* at 10-11 – to join a network if they so decide. The only "right" or "benefit" AWP laws confer on an HMO member is the opportunity to try to "convince" his or her provider to join a network. SG Br. 15. The decision whether to do so remains entirely in the hands of the provider. Thus, under no construction do AWP laws provide "a legal right to the insured, enforceable against the HMO." *Rush Prudential*, 122 S. Ct. at 2164. And neither respondent nor the Solicitor General point to any evidence demonstrating that, in fact, providers often do join networks at the behest of individual patients.

Absent AWP laws, HMO members already have the opportunity the try to persuade their own providers to try to join a network. The provider will not even try to do so if the terms of the network contract are unacceptable. AWP laws

do not affect that decision at all, because AWP laws do not require HMOs to alter the substantive terms of their network contracts. AWP laws only require HMOs to accept providers who want to join but who would be excluded by a network size limitation. From the perspective of the HMO member, then, AWP laws mean only that a member has a somewhat increased likelihood of successfully persuading his or her provider to join a network.[7] That the HMO member may applaud whatever marginal increase AWP laws have on the likelihood of getting his or her provider of choice into a given network simply does not mean the member has any different legal rights or benefits under the contractual insurance relationship than he or she did absent the AWP laws. With or without AWP laws, a subscriber has rights under a typical HMO policy to necessary and appropriate care for covered medical needs from network providers. AWP laws do not alter any of those rights in the slightest.

Other than HMOs and the ERISA plans that use them, the only parties whose legal rights are altered by AWP laws are providers. The fact that AWP laws regulate the latter non-insurance entities, and their non-insurance contracts with HMOs, with no material impact on insurance contracts or the rights of insureds, demonstrates that AWP laws do not regulate "insurance" as a matter of common sense.

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[7] Contrary to the Solicitor General's assertion, SG Br. 20, we do not contend that AWP laws pose a risk to HMOs because provider networks will necessarily expand significantly as a result. The larger problem is uncertainty: absent foreknowledge of the size of the network, a provider considering whether to join will not be able to predict reliably the volume of patient business membership would provide, and thus will be less likely to agree to a discounted fee for services, eviscerating one of the fundamental purposes of managed care arrangements. *See* Comm. Health Ptnrs. Br. 7, 8 & n.3; Soc'y for Human Res. Br. 8.

2. The same result obtains when HMO provider contracts are analyzed under the *Royal Drug* factors – as *Royal Drug* itself held.

a. *Royal Drug* held that provider contracts do not spread risk. Respondent and her amici do not contend otherwise. Instead they argue that by directly regulating non-insurance provider contracts, AWP laws *indirectly* alter the risk transferred by HMO policies. AWP laws affect risk-spreading, the argument goes, by allowing subscribers who think they will want to see a non-network provider in the event of medical need to avoid assuming the risk of having to pay for care from such a provider. Resp. Br. 18-19; SG Br. 19.

As explained in our opening brief and discussed further above, that analysis mischaracterizes the risk HMO policies address. Insurance of any kind is not typically purchased to guarantee that one will be able to receive care from a particular provider. Insurance, including HMO-style coverage, exists to transfer the risk of needing to pay for care at all. Petrs. Br. 22-26. HMOs thus do not transfer the risk of needing to pay for care only from a limited number of network providers; the limitation on providers simply results from the HMO's business decision about how to satisfy its general obligation to provide care. Respondent's analysis confuses that business decision with the fundamental risk an HMO assumes. The fact that a member may care how an HMO decides to fulfill its policy obligations simply does not determine or affect the nature of the risk transfer those obligations reflect.[8]

What is more, even if it made sense to imagine that insurance exists to shift the risk that an insured will want to

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[8] For the same reasons, the Solicitor General is mistaken when he describes the "covered risk" as the risk of needing care *from network providers*. SG Br. 19. The only risk "covered" is the risk of needing care at all.

seek care from a particular provider in the event of medical need, AWP laws do not force a transfer of that risk to the HMO. As we have explained, AWP laws do not confer on an HMO member the right to seek care from any particular provider and then demand satisfaction from the HMO. At best they give the member a marginally improved chance of convincing his or her provider of choice to join the network on the HMO's terms. Even under respondent's conception, the limited risk assumed by the HMO – the risk of needing care from the particular providers who decide to become members of the HMO's network – remains the same. The only difference is the price the HMO must pay to provide that care.[9]

b. *Royal Drug* also held that provider contracts are not integral to the insurer-insured bargain. More recently, this Court has characterized a law as affecting a practice "integral" to this bargain when the law provides "a legal right to the insured, enforceable against the HMO." *Rush Prudential*, 122 S. Ct. at 2164. That simply is not true of AWP laws, as we have demonstrated. *See supra* at 12-14.

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[9] Similarly, AWP laws plainly do not remove the "condition" that treatment must be provided only by a provider who is part of the HMO's network. SG Br. 19. AWP laws may, or may not, have the effect of expanding the number of providers in the network, but they in no way confer a right on the member to demand payment for treatment from any provider not already in the HMO's network. It is equally incorrect to say that AWP laws "regulate the performance of the insurance contract . . . by specifying which providers' services may be furnished in kind in fulfillment of the HMO's insurance obligation." SG Br. 19 n.3. AWP laws do *not* specify which providers' services may be furnished to satisfy the care obligation; the *only* services that may be used are those of providers who have decided to accept the terms of membership in the HMO's network. A member may not seek care from any provider of his or her choosing, and then present the bill for payment with a representation that the provider is willing to join the network. Rather, the provider must first agree to abide by all the contractual terms of the network, a decision that can be made only by the provider.

Respondent's only argument that provider contracts are "integral" to the insurer-insured bargain relies on a recently enacted provision of Kentucky law requiring HMOs to provide the list of network providers along with the Certificate of Coverage. Resp. Br. 20. But obviously Kentucky cannot by this device turn a practice that is otherwise not an insurance practice under federal saving clause law into an insurance practice. And even if it is true as a "function[al]" matter that an HMO must maintain and provide to members a list of network providers, the same could be said of a host of business practices necessary to ensure that the HMO satisfies its policy obligations. As this Court has explained, "in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. . . . Such a result would be plainly contrary to the statutory language, which exempts the 'business of insurance' and not the 'business of insurance companies.'" *Royal Drug*, 440 U.S. at 216-17. Similarly, the ERISA saving clause saves laws that "regulate *insurance*," not laws that "regulate the business of insurers," and certainly not "laws that regulate the business of HMOs."

c. *Royal Drug* finally held that provider contracts are not part of the business of insurance because they directly involve entities outside the insurance industry. This third *Royal Drug* factor does not ask whether a law is one of "broad or general application that happens to include health insurers with in its reach," as the Solicitor General tries to characterize it. SG Br. 21. This Court's ERISA precedents make clear that this factor requires the targets of the law to be "limited to entities within the insurance industry," *Rush Prudential*, 122 S. Ct. at 2164 – "*i.e.*, to insurers and entities acting as insurers," SG Br. 21. Under no conception are AWP laws limited only to "insurers and entities acting as insurers." As discussed above, the only conduct AWP laws directly regulate is the conduct of insurers *and providers*,

and the only contract they directly regulate is the non-insurance contract between those entities.

C. A Finding That AWP Laws Are Outside The Saving Clause Does Not Mean That AWP Laws Do Not "Relate To" ERISA Plans

The Solicitor General concludes his argument by contending that, if AWP laws do not regulate "insurance" under petitioners' theory, then they do not "relate to" ERISA plans at all. According to the Solicitor General:

> Petitioners cannot have it both ways, arguing that the Kentucky AWP law is both so closely connected to an ERISA plan because of its impact on plan benefits that it "relates to" ERISA plans . . . *and* that its operation is so distant from the relationship between an insurer and ERISA plans and their insured members that it does not even constitute a law that "regulates insurance."

SG Br. 29-30.

While the Solicitor General describes with general accuracy our view as to why AWP laws do not "regulate insurance," he misapprehends the reason such laws "relate to" ERISA plans. Our position is clear: AWP laws do *not* have an impact on "plan benefits." They do, however, "bear indirectly but substantially on all insured benefit *plans*," *Rush Prudential*, 122 S. Ct. at 2159 (emphasis added), because they directly affect "employee benefit *structures* or their *administration*," *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) (emphasis added).

To say that a law affects the "structures" or "administration" of ERISA plans is not necessarily to say that the law affects the terms of the plan benefits themselves. By affecting the HMO's ability to control the network of providers who provide health benefits, AWP laws indirectly but substantially affect the way in which ERISA plans that use

HMOs are able to structure and administer the provision of health benefits. Health benefits that previously were provided through "closed panel" structures now must be provided through "open panel" structures. But, for the reasons we have explained, this important change in the structure and administration of ERISA plans that use HMOs does not alter, or even affect, the health insurance benefits the ERISA plans actually provide. In short, AWP laws "relate to" ERISA plans, but they do not regulate the "insurance" such plans provide.

CONCLUSION

For the foregoing reasons, and for the reasons set forth in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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