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1 P R O C E E D I N G S

2 (11:07 a.m.)

3 CHIEF JUSTICE REHNQUIST: We'll hear argument
4 next in Number 00-1471, The Kentucky Association of Health
5 Plans versus Janie A. Miller.

6 ORAL ARGUMENT OF ROBERT N. ECCLES

7 ON BEHALF OF THE PETITIONERS

8 MR. ECCLES: Mr. Chief Justice, and may it
9 please the Court:

10 When Congress enacted ERISA, it created a
11 Federal regulatory structure for employers and unions to
12 sponsor plans that provide health care benefits for
13 employees and their families. The vast majority of ERISA
14 plans throughout the country have chosen to provide these
15 benefits through HMO's or other managed care entities that
16 use limited provider networks in order to deliver quality
17 health care at a reasonable cost.

18 The Kentucky laws before the Court today
19 preclude that use of limited provider networks and require
20 an HMO, and by using that term I mean to encompass a
21 variety of managed care arrangements, require those
22 arrangements to allow into the network any provider
23 willing to accept the network terms. Because ERISA saves
24 from preemption State laws which regulate insurance, the
25 question here is whether these any willing provider, or

1 AWP laws, regulate insurance.

2 QUESTION: Now, I take it these laws have become
3 fairly common --

4 MR. ECCLES: That's correct, Your Honor.

5 QUESTION: -- around the country, so Kentucky's
6 not alone in having such a law.

7 MR. ECCLES: Kentucky has a relatively broad
8 law, Your Honor. Many of the laws are pharmacy solely,
9 but they -- Kentucky is not alone, that's correct.

10 QUESTION: Yes.

11 QUESTION: Can -- can Kentucky exclude certain
12 specialties, like they say, we will not have
13 chiropractors? In -- in Kentucky, can the plans do that?

14 MR. ECCLES: No.

15 QUESTION: In other words, they have to be open
16 to various subspecialties?

17 MR. ECCLES: There are -- there are different
18 laws about that. The Kentucky law by itself, in the
19 definition of provider, includes a variety of specialties,
20 including chiropractor, and there's a separate
21 chiropractor any willing provider law also, but the
22 question here is whether that law regulates insurance, and
23 last term, in Rush Prudential versus Moran, the Court said
24 that a law regulates insurance when insurers are regulated
25 with respect to insurance practices.

1 AWP laws do not regulate insurance practices.
2 They do not affect the risk of financial loss that's
3 transferred by the HMO policy, they do not change the
4 terms of the policy at all, and they do not change the
5 bargain between the insurer and the insured.

6 QUESTION: But they -- they do have something to
7 say about who's going to be available as a doctor on the
8 plan.

9 MR. ECCLES: They -- they change the network,
10 that's correct, Your Honor. They -- through a -- they
11 potentially change the network. The law itself creates no
12 change. If the provider elects to join the network, and
13 is willing to accept the terms --

14 QUESTION: But isn't that a change in the
15 policy? Doesn't it give the patient a right he otherwise
16 would not have?

17 MR. ECCLES: No, Your Honor. It -- it gives the
18 patient no right he would otherwise not have. If you look
19 at the exemplar policy that's in Exhibit C to the joint
20 appendix, you will see nothing that's changed in the
21 policy terms.

22 QUESTION: Well, there's nothing in the policy
23 term that is changed in -- in the literal sense of a
24 change in language, but it seems to me that it does mean
25 that under a policy subject to a law like Kentucky's, the

1 person who joins the HMO, in effect the person who obtains
2 the insurance, has a far greater choice, in -- in effect,
3 in -- in the expenditure of benefits under that policy
4 than he otherwise has. He's getting something under a
5 policy subject to the Connecticut law -- the Kentucky law,
6 that he does not get under a policy without that law, and
7 that is a breadth of choice about who is going to treat
8 him.

9 MR. ECCLES: Not necessarily, Your Honor. The
10 choice, you know, exists if the provider elects to join
11 the network, and it's entirely --

12 QUESTION: Well -- well, sure, but I mean, the
13 point of the statute and the point of the case is that
14 providers do elect, and to the extent that they elect,
15 the -- the person subject to the policy has a choice that
16 is a -- a breadth of options that otherwise are not going
17 to be available.

18 MR. ECCLES: Potentially. In a --

19 QUESTION: Even -- not potentially. I mean,
20 even -- even if nobody elected -- even if nobody elected
21 to join, what has happened by reason of this law, is it
22 not the case that the term of the policy is changed, that
23 originally the policy said, we will pay for your treatment
24 by a limited number of individuals whom -- whom we -- whom
25 we approve, and that policy is now changed to, by reason

1 of this law, we will pay for your treatment by any
2 individuals who want to join our plan. Isn't -- isn't
3 that a different policy?

4 MR. ECCLES: Not -- the policy does not change
5 in that way, Justice Scalia. What -- what the policy
6 says --

7 QUESTION: It's not rewritten, but doesn't the
8 law have that effect, to -- to effectively change the term
9 of the policy?

10 MR. ECCLES: No -- no, it does not, and the
11 reason is, what the policy provides is, we will pay for
12 care from participating physicians, from network
13 providers, and that is still the policy. The -- before,
14 with or without the AWP law.

15 QUESTION: Well, to use your term, physicians,
16 before the law, is defined as those physicians whom we are
17 willing to accept as part of the plan, and after the law,
18 the definition of participating physician is any physician
19 who wants to join the plan.

20 MR. ECCLES: It -- it has taken away the HMO's
21 ability to select, that's correct --

22 QUESTION: It's --

23 MR. ECCLES: -- but the definition of who -- it
24 is still limited to participating physicians who meet its
25 own --

1 QUESTION: In -- in your opening remarks, you
2 said it doesn't change the bargain. It seems to me the
3 thrust of Justice Scalia and Justice Souter's questions
4 is, it does exactly that.

5 MR. ECCLES: But the -- before or after the AWP
6 law, the participant has no right to choose any particular
7 provider. The participant has the right to use the
8 network physicians under the terms in the policy.

9 QUESTION: Yes.

10 MR. ECCLES: After the AWP law, if a provider
11 joins the network, the participant still has exactly the
12 same right. The network has a different composition.

13 QUESTION: But -- but that -- that really does
14 not seem to make sense to me. The purchaser has the same
15 right, in theory, certainly to go to any physician in the
16 network, but the HMO has been required to expand the
17 network.

18 MR. ECCLES: Under that hypothetical, that's
19 correct, Your Honor, you know, if that's --

20 QUESTION: What's hypothetical about it?

21 MR. ECCLES: Well, we don't know the effect of
22 the law on the networks --

23 QUESTION: Well, for instance, here, if it's
24 chiropractic services, and let's assume the HMO did not
25 previously include chiropractic physicians as providers,

1 after this law, if a chiropractic physician in good
2 standing were willing to come in under the HMO, then the
3 HMO would have to take that physician, and then the -- the
4 patient would have a possibility, at least, of having paid
5 services seeing a chiropractor that formerly would not
6 have been available.

7 MR. ECCLES: That -- that would be a
8 significantly different law, Justice O'Connor, and for
9 this reason. In that case, which is generally referred to
10 as a mandatory provider law, it's very much like the
11 mandatory benefit laws that this Court has held to be
12 saved. That changes the legal rights to get -- of the
13 insured to get that type of care, and it changes the risk
14 under the policy.

15 QUESTION: No, well, why -- why is what I said
16 different from what happens here?

17 MR. ECCLES: Because the terms of the -- the
18 network would already provide for chiropractors. The only
19 question is how many would come in. This law would not
20 regulate that. That's regulated through other aspects of
21 Kentucky law.

22 QUESTION: Well, it -- it's -- maybe I'm under a
23 misapprehension as to how the bill -- I -- I thought that
24 the -- one of the examples given in the brief was, a woman
25 is being treated during the term of her pregnancy, she

1 changes her employer, she wants the same doctor to --
2 to treat her, and she is the one that can initiate the
3 request to the HMO, please allow this doctor to treat me,
4 and the doctor then says yes, I'm willing to be bound by
5 the terms of the HMO, and -- and she has that doctor.
6 That seems to me to significantly increase the bargain
7 that she made.

8 MR. ECCLES: But the -- the bargain in that
9 circumstance, if it -- if it works out that way, she --
10 she is able to stay with the doctor, but under -- only if
11 the doctor can get into the network, and is willing to
12 meet the terms of the network. It's entirely up to the
13 doctor to come in.

14 QUESTION: Yes, but before the law, the network
15 could have refused him categorically, even though he were
16 willing to meet the terms.

17 MR. ECCLES: That -- that's correct, Your Honor.

18 QUESTION: I -- is --

19 QUESTION: I hear you, I just don't see that --
20 that you -- you make much headway in saying that isn't a
21 change.

22 MR. ECCLES: Because the -- the change is the
23 legal right of the insured, which was never to any
24 particular provider, and that's still true after the --
25 the law.

1 QUESTION: I don't -- you -- you're really
2 asserting that -- that two insurance policies are exactly
3 the same, their terms haven't changed, or their terms
4 aren't different, where one says you can get your
5 automobile fixed, we will pay to get your automobile fixed
6 by these companies, blah, blah, blah, blah, blah, and the
7 other one says, we will pay to get your automobile fixed
8 by any company that is willing to do the job up to our
9 standards, and -- and you think those two insurance
10 policies are saying exactly the same thing, that there's
11 only a hypothetical difference between the two.

12 MR. ECCLES: I -- I think the difference between
13 that hypothetical and -- and mine is, the -- the standard
14 with or without the law is still, if the provider comes
15 into the network, and you have the right to the network
16 provider, and that's all.

17 QUESTION: The thing I don't understand is, if
18 your view is correct, why are you objecting to the law?

19 MR. ECCLES: We believe that the law
20 interferes --

21 QUESTION: Doesn't have any impact on your
22 business.

23 MR. ECCLES: Yes, it couldn't, Your Honor, it
24 precludes the plans from limited networks, and what that
25 does, and this is the point made by the FTC staff, which

1 has been writing States objecting to these laws, is it
2 creates an uncertainty in the network, because the bargain
3 that's been made, the noninsurance bargain between the HMO
4 and the providers is, it's altered, although the policy is
5 not, and -- and suddenly, the providers who are in the
6 network already, they -- they signed up for a different
7 deal, which was a limited network. They may not want the
8 deal they've got, because they'll have less patient volume
9 than they thought they were getting.

10 It also adds significantly just administrative
11 costs to deal with more providers, and it's also more
12 difficult to monitor quality with a larger network, so it
13 does have -- it's the uncertainty of what the law's effect
14 will be that --

15 QUESTION: But you're complaining about the --
16 the increase in the number of providers, and it's that
17 increase that is what might be desirable from the
18 patient's standpoint.

19 MR. ECCLES: Well, we're really complaining
20 about the uncertainty that's created, that the networks
21 can no longer be selective, which has quality and cost
22 implications, including fee implications.

23 QUESTION: The -- the any willing provider
24 statutes have been around now for sometime. I understand
25 the case that you're making in its most dramatic is, this

1 spells the end of HMO's, because the whole thing works
2 only if they have few doctors and lots of patients, so the
3 doctors have a guaranteed patient flow. Has that happened
4 in States with any willing provider laws, that there are
5 so many doctors who are coming in that the doctors who
6 were in in the beginning now say, the rates have to go
7 way, way up, because we don't have any guaranteed patient
8 flow any more?

9 MR. ECCLES: I -- I can't tell you about the
10 number of doctors, Justice Ginsburg. The studies that are
11 in -- cited in, particularly in the amicus briefs, suggest
12 that there's been about a 15 percent increase in cost
13 arising out of --

14 QUESTION: If that's so, I mean, since -- I'm
15 not sure of the relevance of this, but I mean, if it
16 turned out that this law or others like it drove up costs
17 for no advantages, couldn't the Federal Government stop
18 them by -- under Medicare and Medicaid, wouldn't they have
19 enough power, or would they, to simply write regulations
20 such that they won't reimburse States for -- if these
21 circumstances were quite bad?

22 MR. ECCLES: I -- I'm not sure they could do it
23 in -- in that avenue, through Medicare or Medicaid. The
24 Federal Government could obviously do it directly with its
25 own law on the books, which would --

1 QUESTION: That would require an act of
2 Congress.

3 MR. ECCLES: Yes, that's correct.

4 QUESTION: I want to -- you think they don't
5 have the authority?

6 MR. ECCLES: I -- I don't think it would do
7 the --

8 QUESTION: But anyway, as far as the harm is
9 concerned, a) we don't know that there's any harm.

10 MR. ECCLES: Right.

11 QUESTION: b) We don't know that the Government
12 could deal with it in some other way, and so it's pretty
13 much irrelevant to our decision, is that right?

14 MR. ECCLES: Right. Right. What is relevant is
15 whether, as the Court said in Moran last term, these are
16 insurance practices, and the Court's --

17 QUESTION: Then we're back at Justice Scalia's
18 question.

19 MR. ECCLES: The --

20 QUESTION: Is the whole distinction that here
21 the direct beneficiary is the provider? That is, the
22 effect of the any willing provider law has opened the door
23 to the provider, whereas in Rush and in Ward, it was the
24 insured himself or herself?

25 MR. ECCLES: That -- that's certainly a major

1 part of our distinction, Justice Ginsberg.

2 QUESTION: Is -- is there anything more than
3 that that -- here, the patient is the indirect beneficiary
4 of opening the door to the provider. In those two cases,
5 it was the insured. There -- there was no third party
6 involved. It was just the insurer and the insured.

7 MR. ECCLES: The -- the patient, I would say, is
8 a potential beneficiary, but without rehashing that, those
9 two cases, a legal right was created for the insured. In
10 Ward, the Court said that was a mandatory contract term
11 that had been added by using the notice-prejudice rule,
12 and Rush added the option of seeking external review and
13 those -- and described it as a legal right enforceable
14 against the HMO. Here, there is no such legal right, and
15 we believe that in order to be an insurance practice under
16 this Court's precedents, the practice must either affect
17 the spreading of risk, which any willing provider laws do
18 not do --

19 QUESTION: But that was not true, that was not
20 true in either --

21 MR. ECCLES: That's right.

22 QUESTION: -- Ward or --

23 MR. ECCLES: Or, as in Ward and Rush Prudential,
24 must affect the legal rights of the insured. The -- the
25 Court has used a formulation of that phrase in -- in many

1 of its Savings Clause decisions, including those two.

2 We -- we also think the Court has approached
3 this through a common sense inquiry. That's how it begins
4 the Savings Clause inquiry, and on a common sense basis,
5 nobody contends that the provider contracts themselves are
6 insurance contracts, and nobody contends that the
7 providers are part of the business of insurance.

8 Instead --

9 QUESTION: Yes, but nobody -- nobody can
10 seriously deny, on the common sense criterion, that a
11 person who gets HMO coverage -- whether it's subject to a
12 law like Kentucky's, is getting a far greater choice,
13 potentially and, I presume, actually, since you're here,
14 than a person who signs up for an HMO without the choice
15 guaranteed.

16 MR. ECCLES: But --

17 QUESTION: In a common sense way, someone is
18 getting a different kind of coverage, i.e., a breadth of
19 choice under the medical coverage, that otherwise wouldn't
20 be available.

21 MR. ECCLES: I -- I think the common sense
22 approach can be viewed by looking at this Court's decision
23 in Royal Drug, and particularly if you look at the factual
24 parallels with this case.

25 If the Kentucky statute, the general any willing

1 provider statute can be disaggregated into a bunch of
2 separate statutes, each about a different provider, that
3 the term, provider, includes podiatrists, physicians,
4 optometrists, and pharmacists, so we have here effectively
5 one part of the statute is an any willing pharmacy
6 statute, that's functionally indistinguishable from the
7 statute that was before the case in Royal Drug.

8 QUESTION: Well, considered by itself, if -- if
9 you simply narrow to the provider subcategory of
10 pharmacists, I -- I assume you're right, but if you look
11 at the -- at the broad category that is covered by this
12 statute, there is one, I think, significant difference
13 between this and the -- and the limited to pharmacy
14 coverage in Royal Drug. I think the difference is this.
15 Pharmacy coverage basically is -- is coverage for -- for
16 benefits that are fungible regardless of where you get
17 them.

18 The super-aspirin, the industrial strength
19 Motrin is going to be the same no matter what drug store
20 you get it from. Medical coverage, however, is not. It
21 is really important to patients to -- to choose a doctor
22 because of the personal relationship, and therefore, I
23 don't see the -- the precedential force of Royal Drug
24 in -- in a physician coverage; a -- a physician option
25 kind of case like this.

1 MR. ECCLES: But under the Kentucky law, the
2 patient has no right to choose the family doctor.

3 QUESTION: Well, the -- the patient, in fact,
4 is -- is given in practical terms a breadth of option.
5 It's true the patient can't force a doctor to sign up with
6 the HMO or force the HMO to take on a particular doctor,
7 but in practical terms, there are going to be more doctors
8 available under a Kentucky kind of regime, and in that
9 sense, the patient is given a breadth of options that
10 otherwise wouldn't be available. That seems to me to be
11 important when one is selecting physician coverage in a
12 way that is not important when one is selecting drug store
13 coverage.

14 MR. ECCLES: I -- I understand the point,
15 Justice Souter, although the -- the option and the -- the
16 preference don't match up perfectly. Even if there is a
17 broader range of options, they don't necessarily include a
18 doctor with whom the patient has a prior relationship.

19 QUESTION: Absolutely -- absolutely right.

20 MR. ECCLES: But returning to the pharmacy, it's
21 true that the aspirin is all the same wherever you go, but
22 the -- the agreements at issue in Royal Drug, besides
23 giving the benefits of pure convenience, the ability to
24 get the drug at the corner drug store, which is not
25 nothing, also gave a very important financial advantage if

1 you -- if your pharmacy were participating, and --

2 QUESTION: Yes, but another difference is,
3 there -- there is an any willing provider law here.

4 There's no any willing provider law in Royal Drug. There
5 was a private arrangement among the --

6 MR. ECCLES: That's correct, Your Honor.

7 QUESTION: -- with the -- the Blue Cross.

8 MR. ECCLES: That's correct, Your Honor, but the
9 effect that the agreements that were being regulated in
10 Blue -- with Blue Shield and Royal Drug, the Court held
11 were not part of insurance.

12 QUESTION: Right.

13 MR. ECCLES: And we have functionally the same
14 type of agreements here, an agreement between the HMO and
15 the pharmacy or other provider, and they also should not
16 be part of insurance. They're -- they're outside the
17 insurance relationship, and -- but it was important --
18 I want to make this point, important potentially to the
19 patients, the insureds in Royal Drug, that -- that their
20 pharmacy became a -- a participating pharmacy. It was not
21 inconsequential.

22 QUESTION: You mean just as a matter of
23 convenience?

24 MR. ECCLES: Besides convenience, Mr. Chief
25 Justice. The example in the Court's opinion was taken

1 from the brief of the United States as amicus. They
2 posited a 10-dollar drug at retail, and if you got it at a
3 participating pharmacy it cost \$2, if you got it at a
4 nonparticipating pharmacy it cost 100 percent more, or \$4.

5 Presumably those numbers are indexed since 1979
6 now, and -- and greater, but it was of great interest to
7 the insured whether the pharmacy was participating or not.
8 It made a large cost difference, and yet the Court said it
9 is not insurance in part because it was not affecting, was
10 not integral to, was not changing the legal rights of the
11 insured-insurer relationship.

12 QUESTION: It's an antitrust case, then.

13 MR. ECCLES: That's correct, Justice Breyer.

14 QUESTION: I would think maybe that makes a
15 difference.

16 MR. ECCLES: That's argued in the briefs that
17 it -- that it makes a difference, and we understand it's
18 an antitrust case. We -- we still think besides the
19 direct, factual parallel with the fact that Kentucky has
20 an any willing pharmacy statute, that Royal Drug is still
21 the correct analysis for -- it gives the correct analysis
22 as to the McCarran-Ferguson factors really for two
23 reasons. One is, that's what this Court has applied
24 consistently in its Savings Clause case -- cases.

25 It -- it -- this Court said in the first Savings

1 Clause case, Metropolitan Life versus Massachusetts, that
2 the Royal Drug analysis was directly relevant to the ERISA
3 Savings Clause, so it has the virtue of familiarity and
4 precedent, and the -- the standards, the McCarran factors
5 make sense here. They're objective factors that give some
6 content to the subjective test, the common sense test.

7 But the -- the second piece of -- of the many
8 attacks that have been made on the -- the relevance of
9 Royal Drugs in the brief is, it -- it's argued in the
10 brief that this Court in Fabe took a broader view, looked
11 to a different clause of McCarran-Ferguson and said it's
12 broader, that insurance regulation can be a little
13 broader, and it's geared to protect the performance of the
14 contract, and we don't shy away from that. The any
15 willing provider laws have nothing to do with the
16 performance of the HMO policy here. They just do not add
17 to that policy at all.

18 It's argued in the briefs through hypothetical
19 examples that they are effectively Kentucky's regulation
20 of HMO's, the adequacy of the networks and so on, and we
21 are accused of wanting to undo all regulation of HMO's.
22 That's not our position here. The line we would draw
23 would preserve most of the State's regulation of HMO's,
24 but these laws are not laws that are substantive
25 regulation of insurance, the AWP laws. They are not

1 adequacy laws. They are not continuity of care laws.
2 Kentucky has laws like that on its books.

3 QUESTION: How would you characterize them?

4 MR. ECCLES: I would characterize them as a law
5 that gives a right to a provider and makes it difficult
6 for HMO's and ERISA plans, but gives nothing of
7 enforceable right to the insurers.

8 QUESTION: Well, you -- you don't like the
9 label, insurance. Would you call it a health care law?
10 You said it's not an -- an insurance law --

11 MR. ECCLES: It -- it might be considered a
12 health care law, Justice Ginsburg, that's correct, and in
13 that case, it would not come within the Savings Clause,
14 but it's a law that regulates the contracts between the
15 providers and the HMO's.

16 Now, just to go back slightly over what I just
17 said, we are not here challenging the basic concept of
18 State regulation of HMO's. Where we think the Court has
19 drawn the line, and where we would urge that it continue
20 to draw the line, is to say that a law regulates insurance
21 if it affects risk-spreading, which this does not.

22 The risk here is the risk of financial loss from
23 needing medical care. ERISA actually has a helpful
24 definition that makes that clear. The definition of an
25 employee welfare benefit plan, which is the kind of plan

1 we're dealing with here, is a plan that provides benefits
2 for medical, surgical, or hospital care, or benefits in
3 the event of sickness. That's the risk.

4 QUESTION: I -- I recognize that we have the
5 risk-spreading and the factors, and then we have the
6 common sense test -- we can all have tests floating around
7 here. It -- it seems to me that this just does regulate
8 insurance.

9 MR. ECCLES: But it regulates only the
10 noninsurance relationships, Justice Kennedy. It -- it's
11 exactly what the Court held was not insurance in Royal
12 Drug. They're external to the insurance relationship, and
13 they don't change the insurance relationship at all.

14 QUESTION: How do you -- what about Metropolitan
15 Life? What about -- you have a -- you have a contract the
16 State says -- I would have thought the harder thing, which
17 I don't think any more, is, is -- is an HMO an insurer.
18 We went over that in that other case, Rush, and it's quite
19 clear that 40 States regulate them as insurers, so we know
20 they're insurers.

21 Now, if any State tells an insurer,
22 Mr. Insurance Company, when you write that contract, you
23 have to put in it mental health benefits, isn't that --
24 that's part of the business of insurance, or not?

25 MR. ECCLES: That's absolutely regulation of the

1 business of insurance, and that's --

2 QUESTION: All right. Now, here what they're
3 saying is, you have to put in, use any physician benefits.
4 I mean, it's the same question.

5 MR. ECCLES: Well, what --

6 QUESTION: How do we -- how do you get out of
7 that?

8 MR. ECCLES: Sure. The distinction is, our test
9 is, effect the transfer of the risk, and in that case,
10 there is suddenly a new covered risk, the risk of needing
11 mental health care is covered by the policy and, if that's
12 not at issue, and the Court has had recent decisions where
13 it has not analyzed risk-spreading, found it unnecessary,
14 it's always looked at the second McCarran factor. It's
15 always considered, you know, whether the legal rights of
16 the insured are being regulated here, are being protected
17 by the State regulation in the insurer-insured
18 relationship, and in that mandated benefit case, they're
19 clearly getting a new legal right which they do not have
20 under any willing provider.

21 QUESTION: But you would not consider the -- the
22 benefit of having the selection among physicians as a
23 benefit?

24 MR. ECCLES: That's -- in a colloquial sense, of
25 course, if all these things fall into play.

1 QUESTION: So you say it's purely financial. As
2 long as you pay the bills, that's the only thing the
3 insurance was intended to cover.

4 MR. ECCLES: If all these eventualities fall
5 into place and you do have a broader choice, that's
6 obviously, in a colloquial sense, of some benefit, but
7 it's not what benefit means under, and insurance means
8 under the Court's Savings Clause process.

9 QUESTION: Well, of course, the -- the criteria,
10 the way we refer to that criterion under the McCarran-
11 Walter trio is -- is not in terms strictly of legal right,
12 though that will satisfy it. We ask whether it's integral
13 to the policy relationship, and I suppose something can be
14 integral -- integral to the policy relationship even
15 though it is not expressed literally in terms of policy
16 language which grounds a conventional right.

17 MR. ECCLES: That -- that's correct, Justice
18 Souter, it is phrased in terms of, integral to the
19 relationship. However, when the Court has described that
20 factor in Pilot Life, in UNUM versus Ward, and Rush
21 Prudential, it's used terms, Rush Prudential, a legal
22 right to the insured enforceable against the HMO.

23 QUESTION: No -- no question that that certainly
24 is a -- an example of something that is integral.

25 MR. ECCLES: Right.

1 QUESTION: But I would suppose that the
2 difference in -- in the kind of policy choices that we've
3 been talking about would be regarded as a -- by a
4 potential HMO subscriber as -- as integral to what he is
5 purchasing when he signs up with -- with one HMO rather
6 than another.

7 MR. ECCLES: Our point -- in Pilot Life, the
8 Court described the second factor as not satisfied because
9 the, you know, the cause of action does not define the
10 terms of the relationship, and we would say, you know,
11 that has not -- does not occur, either, under any willing
12 provider.

13 If there are no further questions, I'd reserve
14 the balance of my time.

15 QUESTION: Very well, Mr. Eccles. Mr. --
16 Ms. Johnson, we'll hear from you.

17 ORAL ARGUMENT OF ELIZABETH A. JOHNSON

18 ON BEHALF OF THE RESPONDENT

19 MS. JOHNSON: Mr. Chief Justice, and may it
20 please the Court:

21 As a matter of common sense, Kentucky's any
22 willing provider statutes regulate insurance because they
23 are solely directed at the insurance industry. These
24 statutes apply only to Kentucky insurers issuing Kentucky
25 health benefit plans. Petitioners are insurers regulated

1 by the Commissioner of Insurance. The health benefit
2 plans that they offer are exclusively regulated by the
3 Commissioner of Insurance.

4 These statutes are located in subtitle 17A of
5 the Kentucky Insurance Code.

6 QUESTION: But that's -- they could just as well
7 have been in something labeled, Health Code. This is not
8 like -- I mean, things that regulate risk, you'd say, oh
9 yeah, I'm going to find that in the Insurance Code --

10 MS. JOHNSON: That's --

11 QUESTION: -- but here, wouldn't it have been --
12 suppose the law had been written to say that no doctor can
13 join a closed plan. It would be the same thing, wouldn't
14 it?

15 MS. JOHNSON: If that law was not in the
16 Insurance Code, first of all it would not be enforceable
17 by Commissioner Miller. Second of all, insurers are the
18 only entity that builds networks for the benefit of their
19 insured. When an insurer decides to offer a managed care
20 plan, they tie in the network of providers to the benefit.
21 Thus, the terms in-network benefit, out-of-network
22 benefit. Therefore, if that law was on the books and was
23 not enforceable against the insurer, the insurer would
24 create closed panels, and they wouldn't be able to have
25 any doctors --

1 QUESTION: Well, there would be the equivalent
2 of disbarment. A doctor, a rule, a regulation of the
3 medical profession is, doctor, you cannot join a closed
4 plan. It seems to me that would accomplish the very same
5 thing, but it would be in their Health Code. Unlike some
6 things -- it can't be that everything that the Insurance
7 Commissioner does is therefore regulating insurance within
8 the meaning of this legislation.

9 MS. JOHNSON: That's correct, Justice Ginsburg,
10 but this Court has found that relevant to the inquiry, and
11 the fact that this is a insurance law that is only
12 directed toward those insurers regulated by the
13 Commissioner of Insurance is very important, and it is
14 relevant, and the fact that these statutes are in subtitle
15 17A of the Kentucky Insurance Code, which dictates the
16 benefits to be included in a Kentucky health benefit, and
17 the requirements for those insurers offering those plans.

18 The common sense test is also met because these
19 statutes regulate an insurance practice, and that practice
20 is the practice of insurers offering managed care plans to
21 contract with providers for the benefit of their insureds.

22 QUESTION: I -- I would -- I would be
23 sympathetic to your case -- I -- I keep bumping up against
24 the Royal Drug case, where it seems to me all of the
25 practical things you say about this case could have been

1 said there. The -- the contract really is -- is altered,
2 the contract of the insured. Under one situation, he has
3 to go to a certain drugstore, under another situation he
4 has his choice of drugstores which may provide lower cost.
5 Even if it doesn't provide lower cost, it's a great
6 convenience to be able to go around the -- around the
7 corner, and yet we said that, you know, limiting the
8 number of drugstores with whom the insured could deal did
9 not affect the business of insurance.

10 MS. JOHNSON: Your Honor, Royal --

11 QUESTION: How do you distinguish that from this
12 case?

13 MS. JOHNSON: Your Honor, Royal Drug is both
14 factually and legally distinguishable from the present
15 case. First of all --

16 QUESTION: I know it is factually. I don't care
17 about factually. Tell me why it's legally
18 distinguishable.

19 MS. JOHNSON: Well, legally distinguishable is
20 that you're -- in Royal Drug you were looking at one
21 Federal statute. In the present case, you're looking at
22 another. In Royal Drug --

23 QUESTION: Well, now, wait. You -- you want us
24 to abandon the -- the proposition that what constitutes
25 the business of insurance is the same under -- under the

1 antitrust laws as it is --

2 MS. JOHNSON: No, Your Honor.

3 QUESTION: As it is here?

4 MS. JOHNSON: I believe the --

5 QUESTION: Unless you want us to abandon that,
6 then -- then what you've just said doesn't make any sense.

7 MS. JOHNSON: No, Your Honor. I believe the
8 analysis in Royal Drug was -- was appropriate and -- and
9 accurate for an antitrust analysis as opposed to analysis
10 under the Savings Clause, which this Court has said --

11 QUESTION: So you say the same analysis does not
12 apply. You're saying that the McCarran-Ferguson criteria
13 do not necessarily apply to ERISA. I mean, maybe they
14 shouldn't, but that's certainly new for --

15 MS. JOHNSON: No, Your Honor, they are relevant,
16 as this Court has said, but they are not required, and in
17 this Court --

18 QUESTION: They are relevant but not required?

19 MS. JOHNSON: In this, in Metropolitan Life this
20 Court came up with a -- a broader test than the common
21 sense test, and that test is tested by the McCarran-
22 Ferguson factors that were developed in Royal Drug --

23 QUESTION: I see.

24 MS. JOHNSON: -- but they are not required.
25 They are relevant. They're guideposts.

1 QUESTION: So the very -- the very factor that
2 qualifies as -- the very same factor. Let's assume that
3 they were factually the same. The very same factor that
4 qualifies as part of the business of insurance in our
5 antitrust analysis could nonetheless qualify as not
6 business of insurance under ERISA, is that -- is that
7 right?

8 QUESTION: Vice versa.

9 MS. JOHNSON: In an ERISA case, this Court
10 starts with --

11 QUESTION: Vice versa means the same.

12 MS. JOHNSON: -- the common sense test, and
13 under the common sense test this Court looks at whether or
14 not --

15 QUESTION: No, but just answer yes or no to what
16 I just said. I think you got -- I think you -- I think
17 you want to say yes.

18 MS. JOHNSON: Would you please restate your
19 question? Thank you.

20 (Laughter.)

21 QUESTION: Let's take the very same factor, like
22 the exclusion of certain pharmacies, which -- which was
23 the case in Royal Drug. That very same factor could
24 constitute the business of insurance under ERISA, and yet
25 not constitute the business of insurance under the

1 antitrust laws, because we're applying a different test, a
2 common sense test. Is that your position?

3 MS. JOHNSON: The common sense test controls in
4 ERISA preemption analysis.

5 QUESTION: So your answer to my question is yes
6 or no?

7 MS. JOHNSON: In your analysis is there a State
8 law that requires, or is it the Royal Drug --

9 QUESTION: Well, in the ERISA case there is, in
10 the antitrust case there isn't. I mean, that's what makes
11 antitrust different from ERISA, I think.

12 MS. JOHNSON: Right.

13 QUESTION: But -- but they both focus on the
14 very same factor, the provision of -- the ability of the
15 insured to select pharmacists. Now, you say that that
16 could be the business of insurance for ERISA, and yet
17 could not be the business of insurance in antitrust cases.
18 Yes or no?

19 MS. JOHNSON: Yes.

20 QUESTION: Okay. I think that's the right --

21 MS. JOHNSON: Yes. Yes. Yes.

22 QUESTION: That's the right answer. I mean,
23 for --

24 (Laughter.)

25 QUESTION: For you it's the right answer.

1 MS. JOHNSON: Yes.

2 QUESTION: But I'm not sure it's the right
3 answer for me.

4 (Laughter.)

5 MS. JOHNSON: Yes.

6 QUESTION: And may I ask a follow-up question,
7 then? If the whole difference, then, is this, quote,
8 common sense test --

9 MS. JOHNSON: Yes.

10 QUESTION: -- I'll tell you frankly what my
11 problem is. I read the Sixth Circuit opinion, I said,
12 yes, that makes common sense, and I read Judge Kennedy's
13 dissenting opinion and said, yes, that's common sense,
14 too, so what --

15 (Laughter.)

16 QUESTION: These -- these are rational judges on
17 both sides, they both made good arguments, and they both
18 conformed to some sense of what goes on in the real world,
19 so what is the common sense test?

20 (Laughter.)

21 MS. JOHNSON: Well, Justice Ginsburg, it's a
22 very broad test, and I -- I think it -- it's looking at
23 the whole picture, and the fact that this law is focused
24 on regulated insurers, risk-bearing entities that are
25 under the control of Commissioner Miller, and it regulates

1 their insurance practices.

2 20 years ago you might not have had the issue
3 where providers -- that insurers were contracting with
4 providers for the benefit of insurers, but that is a -- a
5 very prevalent practice in the insurance industry today,
6 and the State Departments of Insurance regulate that
7 practice, and in Kentucky it's heavily regulated.

8 On page 15 of my brief, I -- I set forth many
9 Kentucky statutes that regulate the insurer's relationship
10 with the health care provider for the benefit of the
11 insured. These statutes were also set forth on page 2 of
12 the Solicitor General's brief. That is a common practice
13 in -- in the insurance industry today, and it's a heavily
14 regulated practice.

15 The --

16 QUESTION: Also, I guess if you were taking the
17 view that the language business of insurance could mean
18 different things for purposes of section 2(B) of McCarran-
19 Ferguson in here, you'd find support for that in Royal
20 Drug itself, isn't it, which said that maybe the meaning
21 of those words in 2(A) and 2(B), although they're the same
22 words, is different.

23 MS. JOHNSON: It is different, and -- Your
24 Honor, and in Royal Drug was -- this Court made it clear
25 that they were trying to decide whether an insurer's

1 practice of entering into provider agreements was --
2 constituted the, quote, business of insurance for the
3 purpose of meeting a very narrow exemption from the
4 antitrust liability.

5 QUESTION: Well, it isn't only that. I think
6 the statutory language refers to the regulation of the
7 business of insurance, and in the insurance case in Royal
8 Drug there was no official regulation, only private
9 regulation of the agreement, whereas in this case you have
10 public regulation, so it's conceivable that here you have
11 regulation of insurance, and there you don't count a
12 private agreement as the kind of regulation that the
13 statute's speaking about.

14 MS. JOHNSON: That's true, Justice Stevens, and
15 in --

16 QUESTION: That isn't what the Court said
17 though, is it?

18 QUESTION: Yes, it is.

19 (Laughter.)

20 QUESTION: You can continue with your argument.

21 (Laughter.)

22 MS. JOHNSON: The McCarran-Ferguson factors are
23 also met. As the Sixth Circuit noted, the second factor
24 is clearly met. These statutes regulate an integral part
25 of the policy relationship between the insurer and the

1 insured.

2 In managed care plans, provider agreements are
3 essential. In managed care plans, and under Kentucky law,
4 certificates of coverage cannot exist independently from
5 the provider directory. These statutes simply prohibit
6 insurers from arbitrarily limiting the number of providers
7 that they contract with for the benefit of their insureds.

8 These statutes allow insureds greater access to
9 the health care provider of their choice, and I think this
10 is -- is clearly seen in KRS 304-17A-505(1)(k), which
11 requires the insurer to disclose that they are willing to
12 contract with any willing provider. This simply puts more
13 control to the insured in their relationship with their
14 health care provider, which is a very personal and unique
15 relationship.

16 QUESTION: Royal Drug says that the spreading of
17 risk is an indispensable characteristic of insurance. It
18 then holds that the pharmacy agreements do not involve any
19 underwriting or spreading of risk. Now, why aren't those
20 two propositions as -- as true here as they were in Royal
21 Drug, that the spreading of risk is the essence of -- of
22 insurance, and that an agreement between the provider of
23 the goods or services and the insurance company is not
24 part of the spreading of risk?

25 I mean, maybe Royal Drug is wrong, but I -- I

1 don't see -- I don't see how you -- how you get out of
2 that box.

3 MS. JOHNSON: Well, again, Justice Scalia --

4 QUESTION: And I don't like the, you know,
5 common sense test, I know it when I see it. What I worry
6 about, the -- the common sense test is that we will
7 approve those things that we like, and disapprove those
8 things that we don't like. I mean, who likes a private
9 antitrust arrangement that -- that limits choice, so you
10 just say, common sense, that's not the business of
11 insurance, and who doesn't like something that enables --
12 enables the insureds to -- to have a greater selection
13 in -- in doctors, so we say, common sense says, that is
14 the business of insurance.

15 I -- I don't trust common sense.

16 (Laughter.)

17 QUESTION: I -- I want some rule of law that --
18 that I can adhere to. I thought we had one in Royal Drug,
19 and I -- I'm just not persuaded about why insurance is one
20 thing there, and it's something else here. I mean, if --
21 if, indeed, the spreading of risk is what insurance is
22 about, then --

23 MS. JOHNSON: Your Honor, the Sixth Circuit did
24 find that Kentucky's any willing providers transfer or
25 spread policyholder risk. As the Sixth Circuit noted,

1 these statutes open --

2 QUESTION: But how does it spread the risk,
3 actually? It's hard for me to see that it does that.

4 MS. JOHNSON: Justice O'Connor, when a -- when
5 an insurer sets up a managed care plan and structures
6 their benefits to be in a managed care plan, they have
7 tied in the network of providers to that benefit, and when
8 you have a statute on the books that allows the insured
9 and the health care provider greater control to continue a
10 relationship, and common sense tells us that an -- an
11 insured will seek an out-of-network provider in order to
12 ensure continuity of care and that unique relationship,
13 what these statutes do is, they --

14 QUESTION: I -- I don't see how that spreads the
15 risk. I understand you think there's a practical benefit
16 to the insureds --

17 MS. JOHNSON: Yes.

18 QUESTION: -- but how does it spread the risk,
19 please?

20 MS. JOHNSON: It -- Your Honor, it increases the
21 risk for the insurer that the insured will not have to
22 seek treatment from the out-of-network provider. However,
23 as this Court has noted, all three McCarran-Ferguson
24 factors are not required to be met. This Court reiterated
25 that last term in *Rush Prudential versus Moran*.

1 Unless there's any more questions, I will
2 conclude by saying that Kentucky's any willing provider
3 statutes are laws that regulate insurance, and therefore
4 are saved from ERISA preemption.

5 Thank you.

6 QUESTION: Thank you, Ms. Johnson.

7 Mr. Feldman, we'll hear from you.

8 ORAL ARGUMENT OF JAMES A. FELDMAN

9 ON BEHALF OF THE UNITED STATES, AS AMICUS CURIAE,

10 SUPPORTING THE RESPONDENT

11 MR. FELDMAN: Mr. Chief Justice, and may it
12 please the Court:

13 QUESTION: Mr. Feldman, what would be an example
14 of a measure which did spread the risk, as that term was
15 referred to in Royal Drug?

16 MR. FELDMAN: Well, I think one example would in
17 Metropolitan Life against Massachusetts, certainly I think
18 everybody -- I understand everybody here to agree that a
19 law that required an insurance policy to include insurance
20 against a particular risk would spread the risk, but I
21 think what -- in this case also comes right -- it spreads
22 the risk at least for purposes of -- of ERISA for this
23 reason. What this law is, is a condition on the spreading
24 of risk, the insurer is saying, we are going to spread the
25 risk so long as you go to an in-network provider, and the

1 State here is regulating that condition, and really it's
2 analogous -- it has to do with the performance of the
3 risk-spreading.

4 QUESTION: So, you're -- you're saying the first
5 McCarran-Ferguson factor includes a provision that
6 determines the way the insurer manages the risk, even
7 though it may not affect the risk as between the insurer
8 and the insured.

9 MR. FELDMAN: I think it does -- not quite.
10 I think it actually does -- it does affect that risk,
11 but I think it's a condition --

12 QUESTION: No, but I thought that was the
13 argument you were making right then and there.

14 MR. FELDMAN: It's a condition on the spreading
15 of risk, or a condition on the performance of the
16 insurance contract, and in the Fabe case, which was a
17 McCarran-Ferguson Act case, but involved a different
18 provision of the McCarran-Ferguson Act than at issue in
19 Royal Drug and the Pireno case that followed it --

20 QUESTION: Well, how, as a practical matter,
21 does it affect the risk here? Is the -- is the risk
22 increased for the insurance company under this law because
23 it -- under -- under the Kentucky law it has to pay for
24 chiropractic services, where otherwise it would not, so
25 that's an increase in the risk? Is that -- is that your

1 point?

2 MR. FELDMAN: It would -- I guess -- for you --
3 it certainly could be -- I think semantically it could be
4 said to just increase the risk in just that way. I think
5 for me, I'm more -- it's more comfortable to talk about
6 a -- it removes a condition on the spreading of risk. The
7 risk would be spread under -- without this law so long as
8 you go to a provider who the HMO has said we're going to
9 let into our network, whereas here --

10 QUESTION: That's what -- that was going to be
11 my second question. It seems to me that's the risk-
12 spreading.

13 MR. FELDMAN: Right, and here the risk-spreading
14 is so long -- we're going to spread this -- such-and-such
15 a risk, but so long as you go to any willing provider, and
16 that's a different condition.

17 QUESTION: But it doesn't spread the risk.

18 QUESTION: It doesn't.

19 QUESTION: I mean, it just doesn't, does it?
20 I mean, it's simply an ordinary -- it's -- what it's a
21 regulation of is, if the risk eventuates, the insurer has
22 to carry out his side of the bargain in this particular
23 way.

24 MR. FELDMAN: Right.

25 QUESTION: It's a regulation of the goods or

1 services that an insurer provides.

2 MR. FELDMAN: That -- that's correct.

3 QUESTION: Now, if you're going to --

4 QUESTION: And the risk is a condition, is a
5 health condition of the patient that will be covered.

6 MR. FELDMAN: Yes, but -- but it's really
7 exactly the same as what this Court faced in Fabe,
8 where --

9 QUESTION: What's the name of the case?

10 MR. FELDMAN: Department of Treasury against
11 Fabe. In that case, what was at issue was a priority
12 statute about how to distribute the assets of an insurance
13 company after it has become insolvent, and it had nothing
14 to do with the contract as to what -- what risks the
15 insurer was going to insure, but what the Court said is,
16 it does have to do with the performance of that contract,
17 because if the assets are spread in a certain way, the
18 insurer will actually get paid -- the insured will
19 actually get paid if that risk results, and otherwise not.

20 QUESTION: What -- what if the risk were tied --
21 the risk is that the patient becomes ill and needs --

22 MR. FELDMAN: Yes.

23 QUESTION: -- medical care, isn't it?

24 MR. FELDMAN: Yes, and this is a condition on
25 that, but I don't --

1 QUESTION: So -- so how -- how does this measure
2 spread the risk, or why does it not spread the risk?

3 MR. FELDMAN: It -- it operates as a condition
4 on the spreading of risk, because without this law,
5 there --

6 QUESTION: Well --

7 MR. FELDMAN: -- the risk will -- it's -- the
8 insurance policy says we -- you -- we will spread this
9 risk among all our insurers. If you get ill, we're going
10 to pay for it so long as you satisfy a certain condition,
11 and what this law does is, it alters what that condition
12 is.

13 QUESTION: Which is to say, it doesn't spread
14 the risk, so if the other case means you have to have a
15 risk, then you lose.

16 MR. FELDMAN: Right, but the Court --

17 QUESTION: But it doesn't -- I thought that that
18 other case has -- since it involves the provision by an
19 insurer of goods and services, and a regulation of how,
20 when the risk eventuates, it is pretty similar, and so the
21 difference is, what they say in footnote 18, I guess,
22 which is probably what was going on here, which is that
23 we're interpreting not the McCarran Act's effort to allow
24 States to regulate insurance. We are interpreting what
25 they call the secondary purpose, and that purpose was to

1 impose a narrow -- narrower limitation on the reach of the
2 antitrust laws.

3 MR. FELDMAN: Right, and -- that is true, and
4 the Court repeated that in Royal Drug, and in Pireno, and
5 in Fabe, in all of those McCarran-Ferguson Act cases it
6 made exactly that point, and it --

7 QUESTION: But is that the key distinction, or
8 is there another one, too?

9 MR. FELDMAN: Well, I think that's the most
10 important one, but there's a number that are related. In
11 the ERISA context, for example, the Court has added -- the
12 Court said, well, we first look as a matter of common
13 sense at the insurance policies. It didn't just say, we
14 are going to apply the McCarran-Ferguson Act to ERISA, and
15 it shouldn't be surprising that there are therefore some
16 differences between the two, or otherwise it would have
17 been unnecessary for the Court, as the primary test, to
18 look at the policy as a whole.

19 Second, in the ERISA context, the Court has
20 specifically said that not all three factors are necessary
21 to be found in order to find that something regulates
22 insurance.

23 QUESTION: This is all very sophisticated, but
24 I -- it just seems to me that what constitutes the --
25 insurance in one -- in one situation ought to constitute

1 insurance in another, and it --

2 QUESTION: It's just common sense.

3 QUESTION: -- it's just common sense.

4 (Laughter.)

5 QUESTION: And -- and what -- and what we're
6 doing when we -- when we deny it is -- is exercising
7 policy judgments about whether we think the -- the
8 particular thing that's been done is desirable or not
9 desirable.

10 MR. FELDMAN: I -- I don't -- I don't think
11 that's correct, and I -- I don't think it should be
12 surprising that there are some differences between ERISA
13 and the McCarran-Ferguson Act, not only because of the
14 policy differences, but there's a noted difference in
15 language between what -- the statute that the Court was
16 construing in Royal Drug and in Pireno, and with the one
17 it's construing here.

18 QUESTION: So you don't think that the -- that
19 under ERISA it's important that what is regulated is the
20 business of insurance?

21 MR. FELDMAN: Well, ERISA just says, regulate
22 insurance.

23 QUESTION: I understand that, so you think it
24 doesn't have to be the business of insurance. It -- it
25 could be other aspects of the insurance -- of the

1 insurance company?

2 MR. FELDMAN: I think the Court recognized that
3 there can be a difference --

4 QUESTION: Right. Like what buildings the
5 insurance companies have to be in, and other things?

6 MR. FELDMAN: No, but I --

7 QUESTION: I mean, once you depart from the
8 business of -- the business of insurance concept in the
9 McCarran-Ferguson line of cases, it seems to me, was
10 essential to make sense of it, and it's just as essential
11 to make sense of the ERISA prescription, it seems to me.

12 MR. FELDMAN: I think it's because of the
13 difference in language that the Court from Metropolitan
14 Life on has adopted a different analysis in ERISA, and
15 there's actually two differences. One is that in Royal
16 Drug and in Pireno, which involved the antitrust exemption
17 that has to be narrowly construed, you were just talking
18 about a -- a law that is -- that is in -- that is -- the
19 business of insurance.

20 In the Fabe case, which involved the other part
21 of McCarran-Ferguson, which saved State laws in the areas
22 of traditional, in the area of traditional State
23 regulation, it talks about regulating the business of
24 insurance.

25 In ERISA, you're now one step farther away,

1 because now it just says, regulate insurance, and I think
2 those laws are differently worded, and there's every
3 reason to give them a somewhat different scope.

4 QUESTION: Have we ever --

5 QUESTION: Have you --

6 QUESTION: -- analyzed a case that way in
7 solving these problems? Have we ever relied on that
8 difference in language, Mr. Feldman?

9 MR. FELDMAN: Well, in the -- I think the Court
10 in the Pireno case, for -- oh, the difference in language?

11 QUESTION: Of regulation of insurance versus
12 regulating the business of insurance?

13 MR. FELDMAN: I -- I don't think the Court has
14 relied on that specific --

15 QUESTION: No.

16 MR. FELDMAN: -- language in any of its cases so
17 far, because most of the cases everything has lined up and
18 it hasn't had to, but I will say that in the ERISA cases,
19 there's now a couple of them where the Court has made
20 clear that all three of the McCarran-Ferguson actors --
21 factors don't have to be applied in ERISA, and the Court
22 has never reached that conclusion under the antitrust
23 exemption in the McCarran-Ferguson Act.

24 QUESTION: Well, that would be ridiculous to
25 reach it, since the three factors are what the McCarran-

1 Ferguson Act is.

2 MR. FELDMAN: Right, but by recognizing that
3 they -- that they're not all -- specifically holding that
4 they're not all necessary in ERISA, I think the Court
5 again recognized that there can be a divergence in --
6 between the two areas.

7 QUESTION: And one reason, I suppose, is the
8 presumption against preemption which we are trying to
9 maintain in ERISA.

10 MR. FELDMAN: That's right. That's right.

11 And I -- I would like to add one other thing
12 about the -- what's been called the common sense test,
13 which is, I do think the Court has given substantial
14 content to it in its cases. It talks about a regulation
15 that homes in on the insurance industry, or is aimed at
16 the insurance industry. It is relevant how the State
17 codified it because, as the Court said in -- as recently
18 as Rush, I think, the term insurance acquires its
19 coloration and meaning from State law, State practice, and
20 State usage, because what Congress was trying to do was
21 preserve State law in an area of traditional State
22 authority, and therefore, the codification in the
23 Insurance Code is of relevance.

24 And finally, at the very least, a State law that
25 affects the contract between the insured and the insurer,

1 which this one does, has a necessary effect on that
2 contract and, in fact, a substantial one. That, although
3 what is insurance may be broader than that, something that
4 does satisfy that I think clearly is insurance under
5 the -- the common sense --

6 QUESTION: Mr. Feldman, can I ask you a
7 question? Do you suppose, if, in the Royal Drug
8 situation, there had been an insurance regulation that
9 required the insurance company to give the patient an
10 option between generic and nongeneric drugs, that that
11 would have been the regulation of the business of
12 insurance?

13 MR. FELDMAN: I think it probably would have
14 been, and I -- I think that would, of course, have been
15 analyzed under the other half of the McCarran-Ferguson Act
16 if it was a State regulation of that sort.

17 That concludes my -- Thank you.

18 QUESTION: Thank you, Mr. Feldman.

19 Mr. Eccles, you have 2 minutes remaining.

20 REBUTTAL ARGUMENT OF ROBERT N. ECCLES

21 ON BEHALF OF THE PETITIONERS

22 MR. ECCLES: I'll address four points, if I may.

23 First, as to the argument that a condition is
24 removed in the policy by operation of Kentucky law, that's
25 not true. Before and after the Kentucky law, the

1 condition on getting payment from a -- from a
2 participating physician is identical. All that's changed
3 is that outside network. The law, just so I'm clear, does
4 not, by itself, require a network to admit a chiropractor
5 when it has no chiropractic coverage. That's a different
6 law. If it did that, we would say that definitely affects
7 the legal rights of the insured and would be a mandated
8 benefit law such as the Court sustained.

9 Second point, we are not -- a comment was made
10 by counsel for the Commissioner about regulations of
11 providers providing benefits to the insurers. Some do,
12 and those -- the line we would draw, say, if it's a
13 regulation of a provider such as a continuity of care,
14 such as a hold harmless provision that prevents the
15 provider from billing for the balance above the network
16 rate, that clearly affects the legal rights of the
17 insured, and would be saved under our test.

18 Third, Royal Drug, it's this Court's precedents
19 that have said the Royal Drug analysis is directly
20 relevant to the ERISA Savings Clause. It was the dissent
21 in Royal Drug who said that pharmacy agreement is integral
22 to the relationship. You can't have it without -- you
23 can't have the insurance without the pharmacy agreement,
24 but that was said in the dissent. The Court rejected that
25 view, and who is in the participating network is not part

1 of the benefit of the insured. The insured just has no
2 right to decide what doctor to go to, or any legal right.

3 To address -- fourth and finally, to address
4 perhaps more concisely the question of why do we care, if
5 this isn't going to expand the networks, it's -- it hurts
6 us even if the network doesn't expand in the slightest
7 because if nothing changes, if no choices or options are
8 expanded, the uncertainty that has resulted is added to
9 the administrative cost. It's affected the ability to be
10 selective. You have these networks --

11 CHIEF JUSTICE REHNQUIST: Thank you, Mr. Eccles.

12 The case is submitted.

13 (Whereupon, at 12:02 p.m., the case in the
14 above-entitled matter was submitted.)

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