

1                   IN THE SUPREME COURT OF THE UNITED STATES

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3   KENTUCKY ASSOCIATION OF                 :  
4   HEALTH PLANS, INC., ET AL.,            :  
5                   Petitioners                 :

6           v.   :   No. 00-1471

7   JANIE A. MILLER, COMMISSIONER,         :  
8   KENTUCKY DEPARTMENT OF                 :  
9   INSURANCE                                     :

10   - - - - -X

11   Washington, D. C.

12   Tuesday, January 14, 2003

13                   The above-entitled matter came on for oral  
14   argument before the Supreme Court of the United States at  
15   11:07 a.m.

16   APPEARANCES:

17   ROBERT N. ECCLES, ESQ., Washington, D. C.; on behalf of the  
18                   Petitioners.

19   ELIZABETH A. JOHNSON, ESQ., Frankfort, Kentucky; on behalf  
20                   of the Respondent.

21   JAMES A. FELDMAN, ESQ., Assistant to the Solicitor  
22                   General, Department of Justice, Washington, D. C.; on  
23                   behalf of the United States, as amicus curiae,  
24                   supporting the Respondent.

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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 pharmacy coverage  
14 in Royal Drug. I think the difference is this. Pharmacy  
15 coverage basically is -- is coverage for -- for benefits  
16 that are fungible regardless of where you get them.

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

25           MR. ECCLES: But under the Kentucky law, the

1 patient has no right to choose the family doctor.

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

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

18 QUESTION: Absolutely -- absolutely right.

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

1           QUESTION: Yes, but another difference is,  
2 there -- there is an any willing provider law here.  
3 There's no any willing provider law in Royal Drug. There  
4 was a private arrangement among the --

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

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

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

11          QUESTION: Right.

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

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

23          MR. ECCLES: Besides convenience, Mr. Chief  
24 Justice. The example in the Court's opinion was taken  
25 from the brief of the United States as amicus. They

1    posited a 10-dollar drug at retail, and if you got it at a  
2    participating pharmacy it cost \$2, if you got it at a  
3    nonparticipating pharmacy it cost 100 percent more, or \$4.

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

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

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

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

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

24           It -- it -- this Court said in the first Savings  
25   Clause case, Metropolitan Life versus Massachusetts, that

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

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

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

1 Kentucky has laws like that on its books.

2 QUESTION: How would you characterize them?

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

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

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

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

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

1 for medical, surgical, or hospital care, or benefits in  
2 the event of sickness. That's the risk.

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

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

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

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

24 MR. ECCLES: That's absolutely regulation of the  
25 business of insurance, and that's --

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

4           MR. ECCLES: Well, what --

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

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

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

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

25           QUESTION: So you say it's purely financial. As



1 long as you pay the bills, that's the only thing the  
2 insurance was intended to cover.

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

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

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

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

24 MR. ECCLES: Right.

25 QUESTION: But I would suppose that the

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

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

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

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

16 ORAL ARGUMENT OF ELIZABETH A. JOHNSON  
17 ON BEHALF OF THE RESPONDENT

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

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

1 plans that they offer are exclusively regulated by the  
2 Commissioner of Insurance.

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

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

9           MS. JOHNSON: That's --

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

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

25           QUESTION: Well, there would be the equivalent

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

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

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

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

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

9 MS. JOHNSON: Your Honor, Royal --

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

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

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

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

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

1 MS. JOHNSON: No, Your Honor.

2 QUESTION: As it is here?

3 MS. JOHNSON: I believe the --

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

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

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

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

17 QUESTION: They are relevant but not required?

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

22 QUESTION: I see.

23 MS. JOHNSON: -- but they are not required.  
24 They are relevant. They're guidelines.

25 QUESTION: So the very -- the very factor that

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

7 QUESTION: Vice versa.

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

10 QUESTION: Vice versa means the same.

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

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

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

19 (Laughter.)

20 QUESTION: Let's take the very same factor, like  
21 the exclusion of certain pharmacies, which -- which was  
22 the case in Royal Drug. That very same factor could  
23 constitute the business of insurance under ERISA, and yet  
24 not constitute the business of insurance under the  
25 antitrust laws, because we're applying a different test, a

1 common sense test. Is that your position?

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

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

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

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

11 MS. JOHNSON: Right.

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

18 MS. JOHNSON: Yes.

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

20 MS. JOHNSON: Yes. Yes. Yes.

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

23 (Laughter.)

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

25 MS. JOHNSON: Yes.



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

3                   (Laughter.)

4                   MS. JOHNSON: Yes.

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

8                   MS. JOHNSON: Yes.

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

14                   (Laughter.)

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

19                   (Laughter.)

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

1           20 years ago you might not have had the issue  
2 where providers -- that insurers were contracting with  
3 providers for the benefit of insurers, but that is a -- a  
4 very prevalent practice in the insurance industry today,  
5 and the State Departments of Insurance regulate that  
6 practice, and in Kentucky it's heavily regulated.

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

14           The --

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

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

1 constituted the, quote, business of insurance for the  
2 purpose of meeting a very narrow exemption from the  
3 antitrust liability.

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

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

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

17 QUESTION: Yes, it is.

18 (Laughter.)

19 QUESTION: You can continue with your argument.

20 (Laughter.)

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

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

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

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

24           I mean, maybe Royal Drug is wrong, but I -- I  
25 don't see -- I don't see how you -- how you get out of

1 that box.

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

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

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

15 (Laughter.)

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

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

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

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

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

16                  MS. JOHNSON: Yes.

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

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

25                  Unless there's any more questions, I will

1 conclude by saying that Kentucky's any willing provider  
2 statutes are laws that regulate insurance, and therefore  
3 are saved from ERISA preemption.

4 Thank you.

5 QUESTION: Thank you, Ms. Johnson.

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

7 ORAL ARGUMENT OF JAMES A. FELDMAN

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

9 SUPPORTING THE RESPONDENT

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

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

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

1 analogous -- it has to do with the performance of the  
2 risk-spreading.

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

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

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

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

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



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

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

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

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

17           QUESTION: It doesn't.

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

23           MR. FELDMAN: Right.

24           QUESTION: It's a regulation of the goods or  
25 services that an insurer provides.

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

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

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

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

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

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

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

21 MR. FELDMAN: Yes.

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

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

25 QUESTION: So -- so how -- how does this measure

1 spread the risk, or why does it not spread the risk?

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

5 QUESTION: Well --

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

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

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

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

1 antitrust laws.

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

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

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

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

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

1 QUESTION: It's just common sense.

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

3 (Laughter.)

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

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

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

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

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

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

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

5           MR. FELDMAN: No, but I --

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

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

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

24                 In ERISA, you're now one step farther away,  
25 because now it just says, regulate insurance, and I think

1 those laws are differently worded, and there's every  
2 reason to give them a somewhat different scope.

3 QUESTION: Have we ever --

4 QUESTION: Have you --

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

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

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

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

14 QUESTION: No.

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

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

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

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

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

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

23          And finally, at the very least, a State law that  
24 affects the contract between the insured and the insurer,  
25 which this one does, has a necessary effect on that



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

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

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

16 That concludes my -- Thank you.

17 QUESTION: Thank you, Mr. Feldman.

18 Mr. Eccles, you have 2 minutes remaining.

19 REBUTTAL ARGUMENT OF ROBERT N. ECCLES

20 ON BEHALF OF THE PETITIONERS

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

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

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

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

17           Third, Royal Drug, it's this Court's precedents  
18 that have said the Royal Drug analysis is directly  
19 relevant to the ERISA Savings Clause. It was the dissent  
20 in Royal Drug who said that pharmacy agreement is integral  
21 to the relationship. You can't have it without -- you  
22 can't have the insurance without the pharmacy agreement,  
23 but that was said in the dissent. The Court rejected that  
24 view, and who is in the participating network is not part  
25 of the benefit of the insured. The insured just has no

1 right to decide what doctor to go to, or any legal right.

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

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

11 The case is submitted.

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

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