IN THE SUPREME COURT OF THE UNITED STATES

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KENTUCKY ASSOCIATION OF :

HEALTH PLANS, INC., ET AL., :

Petitioners :

v. : No. 00-1471

JANIE A. MILLER, COMMISSIONER, :

KENTUCKY DEPARTMENT OF :

INSURANCE :

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Washington, D.C.

Tuesday, January 14, 2003

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

APPEARANCES:

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

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

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

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P R O C E E D I N G S

(11:07 a.m.)

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

ORAL ARGUMENT OF ROBERT N. ECCLES

ON BEHALF OF THE PETITIONERS

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

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

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

AWP laws, regulate insurance.

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

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

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

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

QUESTION: Yes.

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

MR. ECCLES: No.

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

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

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

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

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

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

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

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

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

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

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

MR. ECCLES: Potentially. In a --

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

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

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

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

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

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

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

QUESTION: It's --

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

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

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

QUESTION: Yes.

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

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

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

QUESTION: What's hypothetical about it?

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

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

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

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

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

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

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

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

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

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

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

QUESTION: I -- is --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

QUESTION: That would require an act of Congress.

MR. ECCLES: Yes, that's correct.

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

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

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

MR. ECCLES: Right.

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

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

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

MR. ECCLES: The --

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

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

part of our distinction, Justice Ginsberg.

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

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

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

MR. ECCLES: That's right.

QUESTION: -- Ward or --

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

of its Savings Clause decisions, including those two.

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

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

MR. ECCLES: But --

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

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

If the Kentucky statute, the general any willing

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

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

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

MR. ECCLES: But under the Kentucky law, the

patient has no right to choose the family doctor.

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

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

QUESTION: Absolutely -- absolutely right.

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

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

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

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

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

QUESTION: Right.

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

QUESTION: You mean just as a matter of convenience?

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

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

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

QUESTION: It's an antitrust case, then.

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

QUESTION: I would think maybe that makes a difference.

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

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

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

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

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

Kentucky has laws like that on its books.

QUESTION: How would you characterize them?

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

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

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

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

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

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

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

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

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

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

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

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

MR. ECCLES: Well, what --

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

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

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

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

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

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

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

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

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

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

MR. ECCLES: Right.

QUESTION: But I would suppose that the

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

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

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

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

ORAL ARGUMENT OF ELIZABETH A. JOHNSON

ON BEHALF OF THE RESPONDENT

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

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

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

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

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

MS. JOHNSON: That's --

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

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

QUESTION: Well, there would be the equivalent

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

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

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

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

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

MS. JOHNSON: Your Honor, Royal --

QUESTION: How do you distinguish that from this case?

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

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

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

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

MS. JOHNSON: No, Your Honor.

QUESTION: As it is here?

MS. JOHNSON: I believe the --

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

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

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

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

QUESTION: They are relevant but not required?

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

QUESTION: I see.

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

QUESTION: So the very -- the very factor that

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

QUESTION: Vice versa.

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

QUESTION: Vice versa means the same.

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

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

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

(Laughter.)

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

common sense test. Is that your position?

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

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

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

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

MS. JOHNSON: Right.

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

MS. JOHNSON: Yes.

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

MS. JOHNSON: Yes. Yes. Yes.

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

(Laughter.)

QUESTION: For you it's the right answer.

MS. JOHNSON: Yes.

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

(Laughter.)

MS. JOHNSON: Yes.

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

MS. JOHNSON: Yes.

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

(Laughter.)

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

(Laughter.)

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

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

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

The --

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

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

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

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

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

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

QUESTION: Yes, it is.

(Laughter.)

QUESTION: You can continue with your argument.

(Laughter.)

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

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

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

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

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

that box.

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

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

I -- I don't trust common sense.

(Laughter.)

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

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

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

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

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

MS. JOHNSON: Yes.

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

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

Unless there's any more questions, I will

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

Thank you.

QUESTION: Thank you, Ms. Johnson.

Mr. Feldman, we'll hear from you.

ORAL ARGUMENT OF JAMES A. FELDMAN

ON BEHALF OF THE UNITED STATES, AS AMICUS CURIAE, SUPPORTING THE RESPONDENT

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

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

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

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

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

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

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

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

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

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

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

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

QUESTION: But it doesn't spread the risk.

QUESTION: It doesn't.

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

MR. FELDMAN: Right.

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

MR. FELDMAN: That -- that's correct.
QUESTION: Now, if you're going to --
QUESTION: And the risk is a condition, is a health condition of the patient that will be covered.
MR. FELDMAN: Yes, but -- but it's really exactly the same as what this Court faced in Fabe, where --
QUESTION: What's the name of the case?
MR. FELDMAN: Department of Treasury against Fabe. In that case, what was at issue was a priority statute about how to distribute the assets of an insurance company after it has become insolvent, and it had nothing to do with the contract as to what -- what risks the insurer was going to insure, but what the Court said is, it does have to do with the performance of that contract, because if the assets are spread in a certain way, the insurer will actually get paid -- the insured will actually get paid if that risk results, and otherwise not.
QUESTION: What -- what if the risk were tied -- the risk is that the patient becomes ill and needs --
MR. FELDMAN: Yes.
QUESTION: -- medical care, isn't it?
MR. FELDMAN: Yes, and this is a condition on that, but I don't --
QUESTION: So -- so how -- how does this measure

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

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

QUESTION: Well --

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

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

MR. FELDMAN: Right, but the Court --

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

antitrust laws.

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

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

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

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

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

QUESTION: It's just common sense.

QUESTION: -- it's just common sense.

(Laughter.)

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

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

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

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

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

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

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

MR. FELDMAN: No, but I --

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

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

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

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

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

QUESTION: Have we ever --

QUESTION: Have you --

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

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

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

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

QUESTION: No.

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

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

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

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

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

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

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

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

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

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

That concludes my -- Thank you.

QUESTION: Thank you, Mr. Feldman.

Mr. Eccles, you have 2 minutes remaining.

REBUTTAL ARGUMENT OF ROBERT N. ECCLES

ON BEHALF OF THE PETITIONERS

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

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

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

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

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

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

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

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Eccles.

The case is submitted.

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