OFFICIAL TRANSCRIPT

PROCEEDINGS BEFORE

THE SUPREME COURT

OF THE

UNITED STATES

CAPTION: NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., Petitioners v. TRAVELERS INSURANCE COMPANY, ET AL.; GEORGE E. PATAKI, GOVERNOR OF NEW YORK, ET AL., Petitioners v. TRAVELERS INSURANCE COMPANY, ET AL.; and HOSPITAL ASSOCIATION OF NEW YORK STATE, Petitioner v. TRAVELERS INSURANCE COMPANY, ET AL.

CASE NO: No. 93-1408, No. 93-1414 and No. 93-1415

PLACE: Washington, D.C.

DATE: Wednesday, January 18, 1995

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IN THE SUPREME COURT OF THE UNITED STATES

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NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL.,
Petitioners
v. : No. 93-1408
TRAVELERS INSURANCE COMPANY, ET AL.;

GEORGE E. PATAKI, GOVERNOR OF NEW YORK, ET AL.,
Petitioners
v. : No. 93-1414
TRAVELERS INSURANCE COMPANY, ET AL.;
and
HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner
v. : No. 93-1415
TRAVELERS INSURANCE COMPANY, ET AL.

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Washington, D.C.

Wednesday, January 18, 1995

The above-entitled matters came on for oral argument before the Supreme Court of the United States at 10:17 a.m.

APPEARANCES:

M. PATRICIA SMITH, ESQ., Assistant Attorney General of New York, New York, New York; on behalf of the Petitioners.

EDWIN S. KNEEDLER, ESQ., Deputy Solicitor General, Department of Justice, Washington, D.C.; on behalf of the United States, as amicus curiae, supporting the Petitioners.

CRAIG P. MURPHY, ESQ., New York, New York; on behalf of the Respondents Travelers Insurance Company, et al.

HAROLD N. ISELIN, ESQ., Albany, New York; on behalf of the Respondents New York State Health, et al.

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PROCEEDINGS

(10:17 a.m.)

CHIEF JUSTICE REHNQUIST: We'll hear argument first this morning in Number 93-1408, New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Company, and the consolidated cases.

Ms. Smith.

ORAL ARGUMENT OF M. PATRICIA SMITH

ON BEHALF OF THE PETITIONERS

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

In an effort to contain rising health care costs and assure wide availability of affordable health insurance, New York has long regulated hospitals and other providers in the health care marketplace. New York has traditionally regulated differing segments of the marketplace differently.

While these laws may affect the prices which ERISA plans and others pay for health care services, they do not relate to plans. Any other result would severely limit the State's effort to regulate in the health care marketplace, since much State regulation affects costs and therefore may affect choice.

In superseding State laws that relate to employee benefit plans, there is no indication that

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Congress intended to displace traditional State authority over the regulation of health care, creating a regulatory vacuum.

However, if these types of laws do relate to plans, two of the assessments in this case which are imposed upon hospital bills regulate insurance within the meaning of ERISA's insurance savings clause, because they are designed to moderate insurance rates of certain insurers in order to support the underwriting and rate-setting practices of open enrollment and community rating which New York has determined allows health insurance to be more widely available at a lower cost.

Traditionally, New York has treated different segments of the health care marketplace differently. Blue Cross, even before the State regulated hospital rates, was used by the State as the insurer of last resort.

They traditionally practiced community rating and open enrollment. They enrolled people without regard to whether or not their age, their sex, or their health, and they community rated. They had one rating pool for a large number of people, thereby people with high risks whose insurance would be very expensive would be able to obtain insurance at lower costs.

QUESTION: Ms. Smith, New York's scheme applies to hospitalizations that are covered by ERISA plans as

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well as those that aren't.

MS. SMITH: Yes, Your Honor, they --

QUESTION: It's a law of general applicability.

MS. SMITH: Yes. They apply --

QUESTION: What percentage of the patients in New York are covered by ERISA plans, would you think?

MS. SMITH: Your Honor, there's nothing in the record. The Hospital Association's brief has quoted a citation of 25 percent of the total hospital bills covered --

QUESTION: And what if the effect of New York's law were to sweep in only people covered by ERISA plans? Would your argument change at all?

MS. SMITH: Your Honor, if somehow New York's law had a disproportionate impact on ERISA plans, in other words somehow ERISA plans were singled out or treated differently from other purchasers of hospital services, then that would be a different case. That would be a much more difficult case.

But in this case, all of the categories of the patients in all of the payor rates cover both ERISA plans and non-ERISA plans.

QUESTION: Now, some ERISA plans are self-insured, I believe.

MS. SMITH: That's correct, Your Honor.

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QUESTION: Do you think this law can be applied to ERISA plans that are self-insured?

MS. SMITH: Yes, Your Honor.

QUESTION: It's a very direct effect, is it not?

MS. SMITH: Your Honor, the effect on ERISA plans that are self-insured is that it may raise their hospital bills over what they would have been if the law was exactly the same but the payor differentials were taken out. I think it's appropriate --

QUESTION: Well, it does even more than that. In the 9-percent HMO case, for instance, it would have the effect of trying to require them to cover Medicaid patients.

MS. SMITH: No, Your Honor. HMO's are not self-insured plans, they're --

QUESTION: They can't be?

MS. SMITH: They can't be. They're totally different entities, so when -- a regulation of a health maintenance organization has nothing to do with self-insured plans. New York is not in any way attempting to force self-insured groups, whether they be ERISA plans or not, to enroll Medicaid recipients.

QUESTION: Ms. Smith, one way New York could have achieved the purpose it has in mind here is simply to require everyone to purchase health insurance, if at all,

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from the Blues and from no other -- from no commercial insurance company. That would achieve the same result. Now, suppose New York did that. The only health insurance that anyone can purchase is from Blue Cross and Blue Shield. Would that relate to ERISA plans?

MS. SMITH: Your Honor, if the marketplace was such that there were -- that would be -- if the marketplace was such that there were many other insurers out there, and that New York made a rule that said all small groups must go to Blue Cross, that would relate to ERISA plans. That, however, Your Honor, is not the effect of this particular law.

QUESTION: Yes, well, you know what the next question is going to be. New York doesn't say you have to go with Blue Cross and Blue Shield, but you pay, you know, an exorbitant surcharge if you go with anybody else --

MS. SMITH: Your Honor --

QUESTION: -- which is effectively a prohibition.

MS. SMITH: You --

QUESTION: Would that be bad, too?

MS. SMITH: You pay a surcharge if you do go with Blue Cross and Blue Shield. You pay the surcharge of the added cost of open enrollment and community rating. What New York is trying to do is to --

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QUESTION: No, but you're jumping ahead of me. I just want an answer to that question. Suppose New York just puts a heavy surcharge on the purchase of health insurance from anybody except Blue Cross and Blue Shield, would that relate to ERISA?

MS. SMITH: No, that would not relate to ERISA plans.

QUESTION: That would not relate. So --

MS. SMITH: That would not relate to ERISA plans.

QUESTION: I see, so I can't prohibit going somewhere else absolutely, but I can make it effectively impossible by imposing an enormous penalty. You see a distinction between those two?

MS. SMITH: One is a regula -- is a requirement, and one is an incentive in the marketplace.

QUESTION: I see. Well, that's an interesting -- interesting way to get things done. Don't prohibit them, just make them exorbitantly expensive.

MS. SMITH: But keep in mind, Your Honor, that the facts of this case are not, in an effect, a requirement. It is not --

QUESTION: I know that. That was going to be my next question. If exorbitantly -- but you answered the wrong way. I mean, if exorbitantly expensive --

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(Laughter.)

QUESTION: If exorbitantly expensive is bad, why isn't moderately expensive bad?

MS. SMITH: Your Honor --

QUESTION: Why doesn't that relate, as well?

MS. SMITH: Exorbitantly expensive -- I believe I answered exorbitantly expensive was not prohibited.

QUESTION: Yes.

QUESTION: I thought you made a distinction that at some point an inducement could become a requirement. I thought that was the position you took in your brief.

MS. SMITH: The -- but it is -- at some point --

QUESTION: You did say that if enrollment in Blue Cross were required, that would relate to ERISA plans.

MS. SMITH: Yes.

QUESTION: And isn't there, in reality, a point where the toll is so heavy that it becomes, in effect, a requirement?

MS. SMITH: There is a point where you're no longer dealing with economic incentives but that it is regulation in disguise, or it is a regulatory requirement. I don't think that point is simply based on the numbers, whether it's 10 or 20 or 1,000, but there may become a point where, looking objectively at this statute, it

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becomes clear that there is no other choice for anyone in the marketplace.

QUESTION: So if it were sufficiently exorbitant, then you would give Justice Scalia a different answer to his --

QUESTION: Exorbitantly exorbitant -- yes.

(Laughter.)

MS. SMITH: It is not a question of the numbers. It is not a question of how exorbitant it is, it's a question of looking at the statute and seeing if there's some -- if there is some point where it simply is a sham. It is regulation in disguise. But it's not a question of, is it 1,000 percent, or 10 percent, or 20 percent.

QUESTION: But why isn't this regulation in disguise? Isn't this essentially simply a means of getting anyone who buys insurance to in effect subsidize the costs of the uninsurable? If that isn't regulation, I don't know what is.

MS. SMITH: Your Honor --

QUESTION: There are many ways to do it. You can say, everybody has to buy from the same insurer, or you can say, well, you can buy from some other insurer, but you're going to help us subsidize the uninsurable by paying a surcharge if you do that. That sounds like regulation to me.

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MS. SMITH: Your Honor, historically the insured have always subsidized the uninsured, whether or not it's in the bad -- whether or not it's the fact that the uninsured, when they're cared for in the hospital, end up on the bad debt and charity rolls, and everyone's hospital costs are increased to support the hospital overhead.

In unregulated markets, the insured subsidize the uninsured. Because the Federal Government in the Medicaid program pays the hospitals generally at less than cost, then the insured subsidized the elderly. The phenomenon of cost-shifting in the hospital market is an old one, and it exists in all kinds of regulated or unregulated markets.

One of the purposes of the New York statute was to minimize the cost-shifting. The cost-shifting that occurred prior to the statute, the differential between Blue Cross and the commercial insurers, was 25 to 40 percent, and one of the main purposes of this was to equalize that.

QUESTION: But you're just justifying the regulation. I'm not suggesting it's not justified. It may well be just doing something that would be done by private ordering anyway, but private ordering is not covered by the relating-to clause, and public ordering by law is, so you know, it may well be that it's doing

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something that the private system would otherwise achieve anyhow.

MS. SMITH: Your Honor, the --

QUESTION: But the issue is whether this public ordering relates to ERISA plans.

MS. SMITH: The result of that would be the displacement of all hospital rate regulation, because all hospital rate regulation has in their components some, whether it's cost-shifting for the uninsured, or cost-shifting for other patients.

In New York's regulatory system, which is not challenged here, for instance, besides a bad debt and charity component, which one could consider be cost-shifting, there's a component that for excess malpractice, which could be considered to be cost-shifting to protect doctors who have committed malpractice, there's a component for rural initiatives, which would be considered cost-shifting from -- to hospitals where there are -- to rural hospitals.

So if the result is that New York may not cost-shift in any manner, then it's going to be very difficult for New York to regulate in the hospital area. It will be difficult for any State to regulate in this area if --

QUESTION: Suppose you take the facts in Metropolitan and Shaw -- pregnancy benefits and mental

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health. Suppose New York had a very substantial, very heavy surcharge on plans that did not cover pregnancy benefits, or did not cover mental health, would that be permissible? Would that be a way to get around the Shaw-Metropolitan holding?

MS. SMITH: Yes, that would -- if there was a surcharge, instead of restricting the plans' choice of not having a policy without mental health, or not having a policy without pregnancy, if the State put a surcharge -- let the plans have their choice. They could structure their plans any way they wanted, but if you didn't want to cover mental health coverage there would be a surcharge in order for -- to support the State psychiatric hospitals.

QUESTION: So it's a formalistic analysis rather than a pragmatic economic analysis that governs us in determining whether there's preemption?

MS. SMITH: What governs you is the purpose of ERISA preemption, which is to provide that plans may be able to choose on a multi-State basis their structure and administration.

So long as the State is not dictating or restricting the choices, they may place economic incentives when they regulate in the marketplace so long as --

QUESTION: But in order to determine whether or

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not the State is dictating the choice, we make a formalistic or juridical inquiry, rather than a pragmatic economic inquiry.

MS. SMITH: Yes.

QUESTION: That seems to be what you're saying.

MS. SMITH: Unless -- unless the pragmatic economic inquiry is such that the State, although it appears that its incentive is in the marketplace, is actually foreclosing everyone's choice.

QUESTION: But --

QUESTION: But if that's all that Congress meant, which is a very narrow thing, it could have expressed that by the choice of a much different phrase than relating to. As we've said in our opinions, that is an enormously broad phrase. If they wanted to say, you know, no law that will coerce the administration of a plan, they could have said that. They prohibited, though, any laws that relate to ERISA plans.

MS. SMITH: They did say that, Your Honor, in the legislative history. It is quite clear in the legislative history, in describing the meaning of "relate to" --

QUESTION: That they didn't mean it.

MS. SMITH: -- that they -- they were concerned with laws that impose requirements on plans' structure and

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administration, but they --

QUESTION: Well, your position boils down to saying, any law of general applicability which has only an indirect economic effect on ERISA plans is okay.

MS. SMITH: Yes.

QUESTION: I mean --

MS. SMITH: So long as that --

QUESTION: It's as simple as that.

MS. SMITH: So --

QUESTION: Regardless of whether, in fact, the State is trying to get plans to offer certain types of coverage rather than others.

MS. SMITH: In --

QUESTION: That could be behind the State scheme, but it's okay as long as it is carried out only indirectly by an economic effect.

MS. SMITH: So long as it's regulating in the marketplace, and it's treating everyone in the marketplace the same, and it's not singling out plans for different treatment than any other consumer of health care.

QUESTION: But don't you have an easier case in a Shaw situation than you do in the hypothetical that Justice Kennedy gave you? I mean, in the Shaw situation -- I don't mean you have an easier case, but in the Shaw situation the effect of the regulation is to

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determine the subject matter of coverage.

MS. SMITH: Yes.

QUESTION: In this case, what you're concerned with is simply what is paid for a given coverage, whether -- if, indeed, that coverage is written. Isn't this an easier case than Shaw?

MS. SMITH: Yes, that is, Your Honor.

QUESTION: If I didn't agree with you on the formalistic thing -- suppose I think it isn't supposed to be formal.

The figures I read here in the SG's brief are that somewhere over 60 percent or so of all the buyers of this thing -- of all the buyers, the relevant buyers of insurance are ERISA plans. Not 25 percent, but 60 percent.

And also, suppose that I -- I mean, in other words, if I don't think it should be formal, I think it should be practical, on this point, then, do I have to be against you, or is there -- I mean, is --

MS. SMITH: Because 60 percent --

QUESTION: I mean, it looks like 25 -- they're increasing the thing enormously, that their purpose in increasing the charge is to make the ERISA plans, who constitute 60 percent of the buying public, along with the other 40 percent, switch to the Blues, that that's the

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purpose of this big increase, or restructure the commer -- what they buy, and therefore, if I don't think formally but think practically, I'd have to be against you on this. I'm asking you, is that right?

MS. SMITH: No, Your Honor.

QUESTION: Okay, good.

MS. SMITH: Whether or not ERISA plans are 25 percent or 60 percent or 88 percent of the marketplace shouldn't make a difference in this case.

ERISA plans are there not by operation of law but because this is a benefit area, and under that sort of theory that the larger percentage they are of the marketplace the less the State is able to regulate ERISA plans, sort of as, by the dint of their collective purchasing power occupy the marketplace and therefore displace the State from regulation, I don't think there was any intent that Congress when it passed ERISA, and ERISA plans were a larger percentage of the economic health care marketplace then, was intending to displace the States from health care authority because they constituted a large percentage of the marketplace.

They do -- are a large percentage of the health care marketplace. In 10 years they may be a large percentage of the day care marketplace.

QUESTION: No, but it's not just that. It's

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that they have -- they're a large percentage of the marketplace, and the very object of this plan is in a significant way to effect a decision of a matter that's at the heart of their very existence, what kind of insurance they buy, or what -- who they buy it from.

That is, there's nothing more important than that to them, and the purpose of the New York law is significantly to affect that choice. That's the argument that this has a big practical impact.

MS. SMITH: Two points, Your Honor. First of all, the point of New York law is not to -- and its objective purpose, the way it works, is not to drive everyone to Blue Cross, it is to level the playing field. It is to make Blue Cross as competitive as anyone else, not more competitive than anyone else.

QUESTION: Do we have a record that allows us to judge whether in fact the act is carrying out an equalization purpose rather than a shifting purpose?

MS. SMITH: Yes, you do, Your Honor.

QUESTION: What do we know -- what do we know about the resulting rates? I mean, is -- presumably you're going to say, well, Blue Cross is higher anyway, so that the surcharge does not have the effect of driving people away as it would if the rates were equal, to start with. Do we have that in the record?

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MS. SMITH: What we know in the record is that commercial insurers, even after the surcharges, offer lower rates.

The other thing that we can see in the record is that in years where the commercial insurance rates were going up, again with the surcharges, 7.5 percent, Blue Cross rates were going up 28 percent.

QUESTION: Maybe they're very inefficient. Maybe they're enormously inefficient, and the reason people are buying this other insurance is they do a better job. They charge -- I mean, that's how any businesses compete in the marketplace. We can provide it for less because we're better. We do it more efficiently.

MS. SMITH: The record also shows that the commercials do it more efficiently and better because when you exclude the high risks you save 30 percent on your premiums, so that the reason that the Blues' rates are higher are because they do insure the higher risks.

QUESTION: Is there something in the record that shows that is the only reason for the differential between the Blues and the commercial insurers?

MS. SMITH: The commercial insurers have indicated that the reason for the differential is to pay Blue Cross for the added costs of open enrollment and community rating.

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QUESTION: Well, I'm sure that's the purpose, but is there anything in the record that shows that it doesn't go beyond what is necessary to achieve that purpose?

MS. SMITH: I would think that the -- the record shows that it didn't achieve the purpose, and that's why the State felt it necessary to impose for the 1-year period the 11 percent.

QUESTION: Is your essential point that New York is attempting to regulate health care, ERISA plans happen to be a large part of that market, but that New York would be doing essentially the same thing in that -- were there no ERISA plans, and that if you read related-to as any time that it's going to have an impact on ERISA plans you essentially take New York out of the business of regulating health care costs. Is that --

MS. SMITH: Yes, Your Honor.

QUESTION: -- the nub of your argument?

MS. SMITH: Yes.

QUESTION: Thank you, Ms. Smith.

Mr. Kneedler, we'll hear from you.

ORAL ARGUMENT OF EDWIN S. KNEEDLER

ON BEHALF OF THE UNITED STATES, AS AMICUS CURIAE,

SUPPORTING THE PETITIONERS

MR. KNEEDLER: Mr. Chief Justice, and may it

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please the Court:

This Court has stated on several occasions that ERISA preemption analysis must be guided by the respect for the separate spheres of governmental authority under our Federalist system.

ERISA -- the ERISA preemption clause is designed to identify the separate sphere that is carved out in this context for Federal law and not State law. In Shaw, this Court addressed extensively the background and the legislative history of the preemption clause, which shows that it was intended to preempt the field of benefit -- employee benefit plan regulation and to prevent employee benefit plans from conflicting and inconsistent regulation.

As a matter of both common sense and tradition, the field or sphere of benefit plans is distinct from the field or sphere of health care or related health insurance. This --

QUESTION: Why is that? Can I question that? I -- it seems to me that perhaps the -- certainly the most significant, and I would imagine close to the most expensive portion of any employee benefit plan is health insurance. I mean, it is absolutely central to ERISA plans.

MR. KNEEDLER: Yes, in the sense that an -- so

in the sense that an employee benefit purchase -- purchases health insurance, there is a transaction between them, but that does not make the State law relate to the ERISA plan --

QUESTION: Well, it's not --

MR. KNEEDLER: -- in a relevant sense.

QUESTION: -- just that it happens to purchase it, it's that the purchasing of it is central to the whole function of a benefit plan.

MR. KNEEDLER: It is, but it's -- as we understand the way the ERISA preemption clause operates, it is primarily designed to preserve for Federal regulation the things that speak to ERISA plans themselves, their internal operations, their internal selection from among the choices that are made available to them under State law or the market, but it's not intended to reach outside that sphere and regulate the choices that are made available to --

QUESTION: What about Metropolitan Life?

MR. KNEEDLER: In Metropolitan Life, that statute operated directly on the choice being made by the insurance plan, or the ERISA plan, when it purchased insurance.

QUESTION: And so does this. It operates directly on the choice. If you pay one insurer, you pay

more. If you pick the other, you pay less.

MR. KNEEDLER: No, in our view, the effect here is both indirect and economic, and for that reason it is not preempted, and --

QUESTION: So do you agree with cocounsel that if the State had put a very, very heavy surcharge on plans that do not have pregnancy benefits or mental health benefits, that that would have been not preempted?

MR. KNEEDLER: I think that would raise a more difficult question, for this reason, in that the surcharge would be designed to affect the internal operation of insurance or coverage that plans and others offer. In this case --

QUESTION: Well, why isn't this intended to operate the internal selection of which plan to enroll in?

MR. KNEEDLER: But without regard to choices of coverage, without regard to whether certain benefits will be covered at all. What it does is simply regulate --

QUESTION: It would seem to me that this would be a greater infringement on the autonomous choice of the plan than the pregnancy benefit hypothetical.

MR. KNEEDLER: But going back to a question that was asked earlier, whether a State law that required all -- that basically reserved the health care market for Blue Cross, it is not evident that that would relate to

plans. It would be saved by the insurance savings clause.

But what it does is, it constricts, perhaps, the choices available to the ERISA plan when it is going out into the market, but it does not reach into the ERISA plan and dictate the choice or create impermissible incentives for the ERISA plan to choose among the options that are made available in this instance here.

QUESTION: Are you sure about that? Is it the case that every type of coverage that is offered by commercial insurers is also offered by the Blues?

MR. KNEEDLER: It --

QUESTION: May it not be that if you want to get Blue Cross coverage it has to be a certain type of coverage?

MR. KNEEDLER: It may well be, but again, that impact is without -- is irrespective of the existence of ERISA plans, which is an important test for whether a law is one of general applicability.

What this State regulation may well do, historically Blue Cross, as distinct from HMO, as distinct from commercial insurance, in those segments of the market, Blue Cross has a lot of ERISA plans, but the availability of those various options is important to ERISA plans, but it also is a variety of choices for other --

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QUESTION: But what about a self-insured plan? There, the effect is hardly indirect --

MR. KNEEDLER: Right.

QUESTION: -- is it?

MR. KNEEDLER: In our view, self-insured plans do present distinct questions for exactly that reason.

QUESTION: And what should we do there, in your view?

MR. KNEEDLER: Well, in our view the Court should remand -- if the Court concludes the statute does not relate as a general matter, the Court should remand to the court of appeals, because it's not clear whether the self-insured plans are included in the case.

QUESTION: Mr. Kneedler, are the parties -- and I take it the Court, when it write the opinions, thrust in different directions when they argue first that it doesn't relate to insurance and second, that even if it does, it's saved by McCarran -- by the insurance exemption?

MR. KNEEDLER: Well, we think respondents are -- meet themselves coming and going on that because --

QUESTION: Everybody -- don't they --

MR. KNEEDLER: Well, we think -- if the objection is that the State laws somehow have an impact on -- among plan choices, in other words impact on insurance coverage, then that -- then to that extent it is

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a law regulating insurance within the meaning of the insurance savings clause, in our view.

But in our view, you don't have to get to that point, because it doesn't relate to -- because that is -- even though there may be a differential effect on different sorts of insurance coverage, it is still indirect and economic.

And I would like to, if I could, tie that point to this Court's test for determining whether something relates to an ERISA plan, and that what this Court has said is something relates to if it refers to or has a connection with.

The court of appeals here said there was no reference to, so the question is whether there's a connection to. Connection means joined with, or linked together. Under this scheme and its general application, there is no joining or linking of the hospitals whose rates the surcharges are attached to and the ERISA plans.

In fact, there is a disconnect, because in the general run of cases, except for self-insured plans, there is an intermediary, the insurer, who stands between the ERISA plan that is furnishing coverage to its members and the hospital, so --

QUESTION: The impact is primarily felt by ERISA plans. At least, that seemed to be the theory of one of

the judges who has written in these cases. Is that enough?

MR. KNEEDLER: No. Impact on ERISA plans is not enough, particularly since the statute is one of general operation that operates with -- irrespective of ERISA plans. Each of the --

QUESTION: One could read the words, relate to, to mean, have an impact on, couldn't one?

MR. KNEEDLER: Perhaps, but we think that in Shaw, where the Court looked to the dictionary definition, there is -- the dictionary definition in total suggests a joining together, an association between the two.

And again, we think an indirect market impact, which is what the State regulation causes, really breaks the connection, and particularly when one goes back to the purpose, which this Court has emphasized, of the ERISA preemption clause, which is to preser -- which is not to impose conflicting regulations directly on the plan itself, so a plan perhaps operating interstate would be subject to different plan structures, or different choices internally imposed on it by State law.

There's no -- nothing having the force of law that bumps up against an ERISA plan in this case. The impact is solely economic in terms of what the insurer intermediary may choose to pass on.

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QUESTION: Didn't you say, in answer to the question that Justice Scalia asked Ms. Smith, that -- I thought you said in your brief that there could come a point where the toll was so exorbitant that you couldn't tell the difference between a requirement and an inducement, and in that case you might say it's preempted?

MR. KNEEDLER: Well, that would turn on whether the -- whether, if the State prohibited it outright, it would be preempted, and it's not clear that a law that required -- that preserved the insurance market for Blue Cross, for example, would relate to ERISA plans.

It's a very ERISA-centered view to say that that will --

QUESTION: Are you saying that Justice Scalia's exorbitant-exorbitant example, then, would never change your answer?

MR. KNEEDLER: No. I think if the exor -- first of all, that's not this case, because there isn't --

QUESTION: I realize that --

MR. KNEEDLER: But -- but --

QUESTION: -- but if we've got to draw a line, I want to know how we're going to draw it.

MR. KNEEDLER: Right. The exorbitant-exorbitant would matter, of course, if what the State was trying to drive the ERISA plan to do was something that it

couldn't do directly, and in that case, yes, a State plan is designed to reach into an ERISA plan and effect what benefits it offers to its employees would be --

QUESTION: No, but isn't --

MR. KNEEDLER: -- would be preempted.

QUESTION: Doesn't that criterion get us in kind of an open-ended world, because under the insurance savings clause it can do a lot of things directly, and if I understood what you were just saying, you're saying, if they could do it directly, which would include under the insurance savings clause, they can do it by this kind of regulation. Do you stand by --

MR. KNEEDLER: I meant directly, not by virtue --

QUESTION: But not by virtue of the clause.

MR. KNEEDLER: -- of the insurance savings clause, although we do say -- take the position in our brief that this law is saved by the insurance savings clause.

QUESTION: Thank you, Mr. Kneedler.

Mr. Murphy.

ORAL ARGUMENT OF CRAIG P. MURPHY

ON BEHALF OF THE RESPONDENTS

TRAVELERS INSURANCE COMPANY, ET AL.

MR. MURPHY: Mr. Chief Justice, and may it

please the Court:

When Congress enacted ERISA, it made a determination that ERISA plans, the type of benefits they offer and the systems that an employer uses to deliver those benefits, should be left to the decision of the employer.

Congress therefore, when it enacted ERISA's preemption clause, used a very broad formulation, the formulation being, does a State law relate to any ERISA plan?

I think Justice Souter's exorbitant-exorbitant formulation would be a question that might have some interest and meaning in this case in the context of a regulating formulation, but Congress made the decision here not to preempt only those laws which regulate ERISA plans, which in my view any kind of an exorbitant-exorbitant surcharge would, but made the determination to preempt any law which relates to an ERISA plan.

The State's entire argument in this case comes down to the point that to fall within ERISA's relating-to clause, a law has to restrict or dictate plan choice.

In Morales -- and I speak to Morales with some trepidation, realizing the Court today issued another airline deregulation case which I haven't had a chance to read, but in Morales, this Court made it abundantly clear

that under a relating-to formulation the test is not whether a law relates -- excuse me, whether it dictates or restricts, it's whether the law has a connection with the thing that -- the subject matter.

QUESTION: Well, I suppose regulating wage rates has a remote connection. What would your position be there?

MR. MURPHY: I'm sorry, regulating --

QUESTION: I suppose a law regulating wage rates which would affect hospital charges would have that kind of a connection.

MR. MURPHY: Your Honor, in the end, what this Court has to --

QUESTION: No, but you wouldn't argue in that case --

MR. MURPHY: Of course not.

QUESTION: -- that it's preemption.

MR. MURPHY: And let me explain why.

QUESTION: And how do you -- tell us how you want us to draw the line.

MR. MURPHY: Okay. In each case, what this Court has to do is examine the nexus between the law at issue and ERISA plans.

If you're talking about the regulation of what a hospital pays for wage rates, what it does with its

medical waste, what it does in terms of the licensing of its physicians, what kinds of taxes the physicians pay on their income, you are dealing with things --

QUESTION: How about the taxes imposed on the hospitals --

MR. MURPHY: Well, if you're talking --

QUESTION: -- on their gross receipts, for example?

MR. MURPHY: If you're talking about the taxes on the benefits which an ERISA plan pays, then I believe you do have a relation to --

QUESTION: I'm talking about a tax on the gross receipts of hospitals which will include in part payments they receive because of ERISA plans.

MR. MURPHY: ERISA -- section 514(a) preempts laws only insofar as they relate to ERISA plans. That law, the tax, to the extent it was imposed on revenue paid by ERISA plans, would relate to plans, in my view.

QUESTION: Okay. Mr. Murphy, would you go -- you were giving a series of examples --

MR. MURPHY: Yes.

QUESTION: -- when Justice Ginsburg added one to the series, but what is the -- kind of what is your general statement that distinguishes those examples from what we've got?

MR. MURPHY: My general statement is, with regard to those things what the State is doing is, they are regulating an upstream supplier of ERISA plans in a way which simply has an indirect impact on the plan.

In this case, what they are doing is fundamentally different. What the State of New York is doing here is, it is imposing an assessment on the amount a plan pays in hospital benefits, and it's making the amount of that assessment turn on the very plan -- the very form the plan adopts to deliver its benefits.

Under subdivision 1, section 3 of ERISA, an ERISA plan is defined to be an arrangement, through the purchase of insurance or otherwise, by which an employer provides his employees with hospital care, among other benefits.

The two essential characteristics of an ERISA plan are its delivery of hospital care through an arrangement, insurance or otherwise, and in this case, these statutes impose a surcharge on the very benefit, hospital care, which makes a plan a plan, and makes the amount of that assessment turn on the fundamental decision of the plan as to how best to deliver its benefits.

What we're dealing with here is simply a State which has decided to try to drive the conduct of ERISA plans by using a system of economic sanctions rather than

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direct regulation.

QUESTION: According to New York, they're trying to regulate the availability of medical care to patients, even high risk patients, even Medicaid patients, and the -- and to control costs. Are we to say -- to second-guess that that was New York's purpose?

MR. MURPHY: Your Honor, that was their purpose, although I disagree with the statement that they were trying to control costs when they imposed what are in effect taxes on hospital services, but the way they tried to provide hospital care to the needy here was by making ERISA plans operating in New York use New York's financially distressed Blue Cross-Blue Shield system.

They can't do that directly by mandating it, nor, under a relating-to formulation, can they do the same thing by imposing a series of economic sanctions.

QUESTION: Did that in fact result? Did they make ERISA plans switch to Blue Cross en masse?

MR. MURPHY: Well, that was the purpose of the laws. In fact, if Your Honor reads the appendix here and looks at the affidavits from the State officials and the Blue Cross people who were responsible for these laws, there's no doubt that was the purpose.

They clearly acknowledged that was the purpose, that the purpose of these laws was to drive ERISA plans --

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what was happening, Your Honor, is, in the late 1980's, Blue Cross was experiencing a financial crisis. We can argue and debate what the cause of that crisis was, whether it was mismanagement, as Justice Souter noted, or some other things.

The fact is, ERISA plans --

QUESTION: I thought the purpose was to make Blue Cross a more viable choice, not to make it the -- in effect, to require Blue Cross in lieu of commercial insurers.

MR. MURPHY: That is correct, Your Honor, but the way New York chose to make it more viable was to give ERISA plans an incentive to switch their coverage from either self-insurance or commercial insurance to Blue Cross.

QUESTION: Could they have done it in a different way, simply by requiring all insurers, commercial, including those who insure ERISA, simply to adopt those characteristics of Blue Cross which had broadened the coverage and hence made it difficult for Blue Cross, the community rating and open enrollment, and so on?

MR. MURPHY: Your Honor, effective April 1st, 1993, New York did precisely that, which is, they required that every insurer operating in New York State engage in

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community rating and open enrollment in the small group market, which was the only market in which Blue Cross and Blue Shield ever did this and, in fact, even though they did that, they continue to impose the surcharges on --

QUESTION: Is that your next case up here?

MR. MURPHY: What's that?

QUESTION: Is that your next case up here?

(Laughter.)

MR. MURPHY: Well, we will see.

QUESTION: I was going to ask you --

MR. MURPHY: I have to see how I do today before --

(Laughter.)

QUESTION: I was going to ask you to argue it now. Do you concede that that may be done under the savings clause?

MR. MURPHY: Well, no -- which is -- what may be done under the savings clause, open enrollment and community rating?

QUESTION: That's right.

MR. MURPHY: Yes. Yes. I don't think there's any issue under the savings clause that New York State says to an insurer, you have got to provide coverage to the people who meet the following characteristics. That satisfies all of the elements of this Court's tests under

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the savings clause.

QUESTION: Well then, why doesn't this, too, because if your basic argument, which I think personally is a very strong one, is that the whole purpose of this thing, you just said, was to affect in a very significant way the ERISA's plans' and others' choices of which insurance company to buy from, or at least to force the commercial companies to adopt the characteristics like open enrollment, et cetera, then why doesn't that very argument, insofar as it's accepted, require us also to think that what's happening is the regulation of insurance?

MR. MURPHY: Well, because when you deal with open enrollment and community rating, or the law in New York, what the State has said to insurance companies is, this is what you have to do.

In this case -- and, you know, I'll just call your attention to the Metropolitan Life case, where this Court pointed out that mandated mental health benefits was a regulation of insurance, 1) because it established the terms of the insurance contract and 2) because it imposed requirements only on insurance companies --

QUESTION: Yes, and this is a regulation of insurance because it makes certain kinds of policies much more expensive, and therefore it affects the consumer

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choices as to whether this insurance company or that insurance company. If that isn't regulation of insurance, what is? Wasn't price regulation what insurance regulation was about?

MR. MURPHY: First of all, Your Honor, this -- these laws do not make any insurance policy more expensive. What these laws do is, they impose a surcharge on hospital rates on the basis of the form of the ERISA plan. This Court has repeatedly held in cases under the savings clause and under the McCarran-Ferguson Act that in order to regulate insurance -- and let me emphasize that word.

QUESTION: You understand what --

MR. MURPHY: I understand what your point --

QUESTION: My question is, basically you're arguing that the reason it affects ERISA plans is because it will make certain policies a lot more expensive, and therefore they'll switch.

MR. MURPHY: And it affects insurance companies for the same reason.

QUESTION: Exactly, so why is --

MR. MURPHY: But the savings clause doesn't preserve laws which relate to insurance companies, it only preserves laws which regulate insurance companies --

QUESTION: Yes.

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MR. MURPHY: -- and this -- these laws are not regulating insurance companies. They don't impose a single requirement on any insurance company in the State of New York to do anything. What these laws do -- and if there's any doubt on that, let me just call your attention to page 10, footnote 10, of the State's reply brief, where the State concedes that the surcharge laws don't obligate any insurer to pay anything to any hospital.

QUESTION: So you have to say that this law does not regulate -- when we're on the preemption prong, you have to say that this law does not regulate the conduct of ERISA plans.

MR. MURPHY: That is correct, Your Honor. This law relates to ERISA plans, which is a much broader formulation, as this Court noted in Morales.

QUESTION: I suppose that the same result does not necessarily ensue from New York's decision to do what it attempted to do here in the different manner of requiring all insurers to carry these high risk subscribers. If they did that, the plan would still be able to choose among various insurers who, although subject to the same regulation in that respect, might be more efficient.

I mean, there -- it may well be that some of the high cost of the Blues is due not merely to their carrying

these special clients but to their inefficiency, and if you regulated insurance, that would display itself in variable rates by the different companies, I assume.

MR. MURPHY: I believe it would, but again, Your Honor, what this Court has made clear in its cases under both the ERISA savings clause and under the McCarran-Ferguson Act, that the purpose of the exception we're dealing with here was not to make the States supreme in all matters relating to insurance companies. The purpose was to give the States regulatory authority on -- over the actual contract of insurance.

QUESTION: Why is that? I mean, you have quite a good answer, actually, but I thought that if you're reading the words "relate to" to say, let's look to the practical impact of this, the practical impact is that it affects the insurance contract, makes it get much more expensive, and therefore affects ERISA. Look at that practical thing.

Why wouldn't you read the word "regulate" exactly the same, that as a practical matter, this has the effect of raising insurance rates? That's its very object -- its very object, and therefore, for the same practical reason as to the one, you'd read the other. Now, why not?

MR. MURPHY: Well, first of all, Your Honor, you

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have to look at the plain meaning of the words Congress has used here. The term "relate to" means to refer or have a connection with. The term "regulate" -- the term "regulate" means, as the State states in their reply brief when they quote it, it means to either restrict or dictate choice.

QUESTION: Yes, but that only means that not everything that regulates also relates to, but some things that relate to may regulate, and the question is, when they have that practical effect, why don't we regard them as regulation?

MR. MURPHY: Well, because the practical effect you're having here is, is not on an insurance company. The practical effect you are having here is on the ERISA plan. You are moving the ERISA plan to the insurance company. If --

QUESTION: I thought your argument was that you were affecting the insurance company, and for that reason you were affecting the choice of the ERISA plan.

MR. MURPHY: Well, I think what you are --

QUESTION: That's enough, I would suppose.

MR. MURPHY: I think what you are doing, Your Honor, is you are imposing a surcharge on the hospital benefits paid by the ERISA plan, and let me give you an example.

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In the case of a self-insured fund, you're dealing with an entity that is uninsured, is not in the insurance marketplace, you are imposing a surcharge on the benefits with the view that that will make the cost of self -- the self-insured status of the plan sufficiently expensive that the plan will make the decision to move over to New York's Blue Cross system as one of the amici did in this case, the NYSA-ILA plan, which an amici brief made that determination as a result of the surcharges.

QUESTION: Well, maybe self-insured plans are different here, as the Solicitor General appears to concede. Are they actually involved in this suit, do you know?

MR. MURPHY: Yes, I do know, and they are definitely involved in this suit. In fact, I can give you the --

QUESTION: The record is clear --

MR. MURPHY: Your Honor --

QUESTION: -- and you wouldn't have to be concerned about that?

MR. MURPHY: -- in the complaint in this case, the Travelers' suit as a fiduciary of an insured plan and a self-insured plan, the district court concluded that the savings clause couldn't save the laws as to self-insured plans because of the deemer clause.

In the Second Circuit, the Blues in their brief argued that this conclusion was wrong, that the self-insured funds, as to self-insured funds the laws were also saved despite the deemer clause, and in fact the Blues in their reply brief admit that the issue is before this Court.

Having been -- having signed the complaint in this action --

QUESTION: But Mr. Murphy, if the Second Circuit thought that there was preemption, total preemption, then they never focused on perhaps the self-funded plans are different, so --

MR. MURPHY: That is correct, Your Honor --

QUESTION: So it's --

MR. MURPHY: -- and that was why --

QUESTION: So if -- it would be an academic question, if we agreed with your position. It becomes a live question which was never treated below only if we disagree with your position with respect to the private -- with respect to the nonself-funded plans.

MR. MURPHY: Your Honor, it becomes a live question only if you disagree with me on the relating-to issue. Then, only then, under the Solicitor General's formulation, will the separate status --

I would like to return to the issue of the

savings clause for one moment, recognizing that my time is running short here.

In determining whether a law falls within the savings clause, this Court has essentially done two things. First, they have looked at whether or not the law dictates any of the terms of the insurance policy. For instance, Metropolitan Life, the law fell within the insurance savings clause because it imposed the terms of the insurance contract.

FMC, same thing. What it did was, it knocked out any antisubrogation provision.

Pilot Life, on the other hand, the Mississippi law of bad faith provided a damage remedy for any insured whose claim was denied in bad faith. Despite the fact that that law was intimately associated with the relationship of the insurer and the insured, this Court held it was not a regulation of insurance because it didn't actually set the terms of the contract.

The other thing -- and in response to the question you asked earlier, Justice Breyer, let me explain why the courts have focused on the contract of insurance. In 1869, this Court decided a case -- Paul v. Virginia. In that case, it held that the insurance contract was a transaction outside of interstate commerce and couldn't be regulated by the Federal Government.

In 1944, in the Southeast Underwriters case, this Court overruled that decision, and held the transaction, the transaction being the contract of insurance, was in commerce.

In enacting the McCarran-Ferguson Act, all Congress wanted to do was to give back to the States their regulatory authority over the contract of insurance, and this Court has repeatedly held, in National Securities and a number of other cases, that the States do not have regulatory authority with regard to all matters affecting insurance companies.

In fact, in Royal Drug, this Court held that the relationship between the insurance company and the supplier of medical services, in that case pharmacies, was not within the business of insurance that was saved, and if you look at this case, what we're dealing with here are laws that govern the relationship --

QUESTION: Yes, but --

MR. MURPHY: -- between the hospital and the patient. They're even one step removed from Royal Drug.

QUESTION: I see that formally, but at the heart of Southeastern Underwriters and the McCarran Act is the question of the price charged the customer, and so here, you have a regulation designed directly to affect that, though at one remove. Why should the one remove make a

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difference?

MR. MURPHY: Well, Your Honor, again, because under ERISA's savings clause and the McCarran-Ferguson Act, what you're doing is, you're making the States supreme with regard to the regulation of insurance, and again, in Royal Drug -- and let me just emphasize this. When you say something is the business of insurance, it means not only that the States -- it falls within ERISA's savings clause and therefore by that act States can regulate ERISA plans.

It means that the conduct at issue is exempt from the antitrust laws, and it also means, under section 2(b) of the McCarran-Ferguson Act, that any time there is a conflict between Federal and State law, State law prevails. In other words, the normal rules of preemption are reversed.

For all of those reasons, the savings clause has been construed narrowly, and again, I will just note, Your Honor, in Royal Drug, the practice at issue was completely about regulating the costs of an insurance company, what it paid under its pharmacy agreements, so that it could make insurance more available at a lower price, and this Court held that the agreements were not the business of insurance because they did not dictate the terms of the insurance contract.

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Thank you very much, Your Honors.

QUESTION: Thank you, Mr. Murphy.

Mr. Iselin.

ORAL ARGUMENT OF HAROLD N. ISELIN

ON BEHALF OF THE RESPONDENTS

NEW YORK STATE HEALTH, ET AL.

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

Unlike the 13- and 11-percent surcharges, the 9-percent assessment that is imposed exclusively on HMO's and on the employee benefit plans they serve has nothing to do with New York State's hospital reimbursement system or the rates that are paid to hospitals.

Thus, even if petitioners' concerns about the effect this case might have on the State's hospital reimbursement system were relevant to the issue of ERISA preemption, such concerns are clearly irrelevant to the issue of whether the 9-percent assessment is preempted. What is more, the State has conceded that the savings clause does not apply to the 9-percent assessment. Thus, the only question the Court must address is whether the 9-percent assessment relates to employee benefit plans.

Where the 9-percent assessment is similar to the 13- and 11-percent surcharges is that all three interfere with one of the most basic decisions an ERISA plan makes,

namely, how best to provide health care coverage to employee benefit plans.

The 9-percent assessment interferes with this decision by imposing on HMO's, and only on HMO's, a penalty calculated at 9 percent of the cost of non-Medicaid in-patient care. Basically, what the statute requires is for the HMO to calculate all of its costs on in-patient hospital care, then Medicare and Medicaid get subtracted out, and what is left is multiplied by 9 percent and paid directly to the State outside the hospital reimbursement system.

QUESTION: And that's different from the other surcharges?

MR. ISELIN: That is different from both other surcharges, both of which go to the hospitals. One is kept by the hospital, the 13. The 11 is cycled through the hospital back to the State.

The exclusion of Medicaid is particularly significant because that's the piece the State pays, so the State said, well, we'll take ourselves out, and basically once you do that calculation, all that's left are essentially ERISA plans. There may be a few individual subscribers, but well in excess of 95 percent are employer benefit plans.

In other words, the 9-percent assessment targets

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one form of health care coverage and increases its cost relative to other systems of coverage for reasons having nothing to do with the actual costs of the care provider.

In the case of the 9-percent assessment, this interference is particularly egregious because of the unique relationship that employee benefit plans have with HMO's. When an employee benefit plan contracts with an HMO for health care coverage, it is purchasing a system of care. That differs substantially from indemnity insurance.

An HMO by definition is charged with maintaining the health of its members, not simply indemnifying them for treatment that's provided after the member becomes ill and needs services. Thus, every HMO has a network of primary care physicians who have the responsibility for monitoring and maintaining the health of the members, where they have the emphasis on preventive care.

That primary care network is integrated with specialists and hospitals, and the whole web of doctors, hospitals, and members are all subject to a range of rules that are intended to ensure that care is coordinated and delivered in the most efficient manner.

QUESTION: Mr. Iselin, maybe I misperceive it, but isn't there a big difference between the first -- what we heard from the commercial insurers, the attempt to

influence the ERISA plans' choice -- here, the effort is not to affect the ERISA plan's choice, but to get the HMO's to do something, to get the HMO's to service a larger number of Medicaid patients, and if the HMO's respond that way, that's it. It's not attempting to get the ERISA plans to choose Blue Cross over Travelers, for example.

MR. ISELIN: Well, Your Honor, the purpose, the stated purpose of the statutes may be somewhat different, but the effect is identical, because both sets of cases have the State imposing surcharges that are interfering with the decisions ERISA plans want to make as to how best to provide health care, and one of the things, again, that the statute itself talks about, is delivering hospital, medical, or surgical benefits through the purchase of insurance or otherwise.

Now, surely the "otherwise" applies to self-insured, to HMO's, to other types of coverage that are different from insurance. That is a choice that is specifically identified in the statute, so that even if the State's purpose with the 9 percent may be somewhat different, the effect on ERISA plans remains the same.

QUESTION: Which -- so you're saying, because there's an impact on ERISA plans, New York simply cannot regulate the HMO's to require them to take on more

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Medicaid patients?

MR. ISELIN: They can't regulate them in a way that would -- that would relate to, and that would -- relate to ERISA plans and interfere with the choice ERISA plans make.

QUESTION: Can't require them to take on more Medicaid patients, or impel them to or induce them to, as long as they have -- as they're used by ERISA plans. That's essentially your argument.

MR. ISELIN: That they can't require them, again, in a manner that would interfere with the choices or the quality of care that's provided by the HMO, which could also happen if the State required HMO's to enroll Medicaid recipients in a manner that overburdened the delivery system of the HMO, which can --

QUESTION: Well, to some extent could it directly mandate that HMO's take on a different class of patients?

MR. ISELIN: No, Your Honor, I don't believe it could, for the reason --

QUESTION: The equivalent of open enrollment --

MR. ISELIN: Well, I think they could require open enrollment, but open enrollment is very different from what the State has done here with targets, and I

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think any system that relies on targets and compels HMO's to take Medicaid recipients in that manner is problematic, because again, HMO's have a limited capacity to deliver care. Some may --

QUESTION: The effect of your argument is that the HMO's, by virtue of the relating-to-ERISA-plan language, really escape virtually all the regulation on the subjects that we're talking about, whereas the insurance companies would not.

MR. ISELIN: No, Your Honor, because what we have here for HMO's is the Federal HMO Act, and the Federal HMO Act on many of these issues acts as a sort of HMO savings clause because it specifically authorized States to conduct regulation of HMO's in many aspects similar to what we talked about earlier, community rating being one very good example.

Now, that act was passed just 1 year before ERISA, and I think when you read the two together, the Federal HMO Act preserves for the States actually a fairly high level of regulation of HMO's, but it does not preserve differing assessments on what HMO's pay, thereby interfering with employee benefit plans.

There are four specific ways that the 9-percent also very directly interferes with the choice, and since my time is running short, I'd like to talk about one in

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particular, and one result, when you increase costs in this way and it gets passed through from the HMO to employee benefit plans, is not just that the plans pay more, but they also can restructure benefits, increase copayments and, particularly important, sometimes plans drop coverage altogether.

This is particularly common with small businesses, who might be right at the margin of whether they even provide coverage. An HMO tends to be the lowest cost option in the market.

Thus, when we think about the impact, it's not enough just to think about it as increasing costs, which it certainly does here, but also reducing benefits, which is very analogous to Met Life, and in fact causing some employee benefit plans to just say, we have no more money to pay this added cost.

We can't increase our coinsurance or our copayments because they're at the maximum, we can't strip away any more benefits because we're at the minimum level of benefits that we can provide through the HMO. The only choice we have left now is to discontinue coverage.

And one of the ironic things of the State's position is that at the same time that it's trying to increase coverage, and is arguing for that as a justification for these assessments, the actions may have

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the exact opposite effect, which is to price some employee benefit plans, and particularly those of small business, right out of the market.

Finally, I'd like to touch briefly on the Metropolitan Life case, because as some have noted, it's directly analogous here, particularly on the compelling versus inducing point, and again, one of the options in Metropolitan Life, faced with having to pay for the mental health benefit at issue, was that plans had two choices. They could either move to self-insurance, which was directly recognized in that decision, or they could take this other option which I just described, which is to simply drop coverage.

The law in Metropolitan Life, which the Court recognized related to employee benefit plans, was no more compulsory than the assessments at issue here. Plans still retained options, and they could have chosen to exercise those options, just as ERISA plans here may have some theoretical options.

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Iselin.

The case is submitted.

(Whereupon, at 11:18 a.m., the case in the above-entitled matter was submitted.)

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NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., Petitioners v. TRAVELERS INSURANCE COMPANY, ET AL.; GEORGE E. PATAKI, GOVERNOR OF NEW YORK, ET AL., Petitioners v. TRAVELERS INSURANCE COMPANY, ET AL.; and HOSPITAL ASSOCIATION OF NEW YORK STATE, Petitioner v. TRAVELERS INSURANCE COMPANY, ET AL.

CASE NO.:93-1408, 93-1414 and 93-1415

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BY Ann Marie Federico

(REPORTER)