ORIGINAL

OFFICIAL TRANSCRIPT

PROCEEDINGS BEFORE

THE SUPREME COURT

OF THE

UNITED STATES

CAPTION: LORI PEGRAM, ET AL., Petitioners v. CYNTHIA HERDRICH

CASE NO: 98-1949 c.1

PLACE: Washington, D.C.

DATE: Wednesday, February 23, 2000

PAGES: 1-56

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1 IN THE SUPREME COURT OF THE UNITED STATES

2 - X

3 LORI PEGRAM, ET AL., :

4 Petitioners :

5 v. : No. 98-1949

6 CYNTHIA HERDRICH :

7 - X

8 Washington, D.C.

9 Wednesday, February 23, 2000

10 The above-entitled matter came on for oral

11 argument before the Supreme Court of the United States at

12 10:18 a.m.

13 APPEARANCES:

14 CARTER G. PHILLIPS, ESQ., Washington, D.C.; on behalf of

15 the Petitioners.

16 JAMES A. FELDMAN, ESQ., Assistant to the Solicitor

17 General, Department of Justice, Washington, D.C.; on

18 behalf of the United States, as amicus curiae,

19 supporting the Petitioners.

20 JAMES P. GINZKEY, ESQ., Bloomington, Illinois; on behalf

21 of the Respondent.

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

2 (10:18 a.m.)

3 CHIEF JUSTICE REHNQUIST: We'll hear argument

4 now in Number 98-1949, Lori Pegram v. Cynthia Herdrich.

5 Mr. Phillips.

6 ORAL ARGUMENT OF CARTER G. PHILLIPS

7 ON BEHALF OF THE PETITIONERS

8 MR. PHILLIPS: Thank you, Mr. Chief Justice, and

9 may it please the Court:

10 I think it is no exaggeration to suggest that

11 the future of medical care, both in its delivery and in

12 its regulation, are in some way implicated by the Court's

13 decision today. The health care plan involved here is a

14 standard health care plan within the employee benefits

15 plan under ERISA. Carle offers vanilla, plain vanilla

16 managed care operations. As Judge Easterbrook said in his

17 denial of rehearing, that if Carle's set-up violates

18 ERISA, then all managed care does so as well.

19 Accordingly, the question is whether or not the

20 court needs to have that kind of a dramatic effect on the

21 managed care industry in this particular context, and I

22 suggest to you that the answer to that is no, because

23 there is a perfectly available and valid remedy for the

24 people in Ms. Herdrich's position, and that is medical

25 malpractice law. She had --

1 QUESTION: Well now, I gather that the Ms.
2 Herdrich did recover in a malpractice action in this very
3 case.
4 MR. PHILLIPS: In this very case, Justice
5 O'Connor, she -- the defendants were found liable, and she
6 received $35,000 as full compensation for her -- for the
7 injuries that she suffered. There's no question, based on
8 that determination, that there's been an error in judgment
9 and that it fell below the standards of care for medical
10 malpractice purposes, and that there are available
11 perfectly valid remedies under State law to her.
12 The question then is, is there some reason to
13 add over those perfectly complete remedies under State law
14 an ERISA remedy as well, and while I think that question
15 can be posed out of narrowly --
16 QUESTION: The question isn't whether there's
17 some reason. The question is whether it's been added,
18 right?
19 MR. PHILLIPS: That's absolutely true, Justice
20 Scalia. The question -- does Congress intend for --
21 QUESTION: I mean, it's really not a policy
22 question that's up to us. It's either there or it's not
23 there.
24 MR. PHILLIPS: That's right. The question is
25 whether Congress intended to add ERISA over and above the

1 malpractice law, and I think it's important in making that
2 determination to realize that this is essentially a zero-
3 sum situation. That is, to the extent you expand Federal
4 law under ERISA, the more you have to narrow State law
5 because of the ERISA preemption provision under section
6 514(a).
7 That says that every matter that is within plan
8 administration, everything that relates to an ERISA plan,
9 right, and therefore is protected under Federal law,
10 preempts all State law that's related to it, and it seems
11 to me quite clear under those circumstances that the court
12 should be quite loath to expansively interpret ERISA, and
13 certainly there's very little evidence that Congress meant
14 to do so.
15 QUESTION: Mr. Phillips, would you clarify one
16 thing? You said all HMO's would fall because this is a
17 plain vanilla scheme, and yet your opponents say that it's
18 only a particular kind of HMO, one where the physicians
19 have this incentive because of their bonuses, and that not
20 all HMO's work that way.
21 MR. PHILLIPS: I think actually Judge
22 Easterbrook, in his dissenting opinion below, had the
23 better of that argument, and he argued, and I think quite
24 rightly, that the allegations in the respondent's
25 complaint basically lay out the kinds of incentives that

1 are inherent in any managed care operation in terms of
2 questions of medical necessity, experimental treatment --
3 all of the elements that go into trying to control what
4 was in the 1980's an extraordinarily expensive health care
5 system are embodied in the Carle Clinic's managed care
6 plan, so in that sense I don't think it is significantly
7 different from any other managed care operation, Justice
8 Ginsburg.
9 QUESTION: Mr. Phillips, could you just clarify
10 one simple point for me? Perhaps I should ask your
11 opponent, but given the fact that she's already recovered
12 for the malpractice, what do you understand the nature of
13 her recovery would be? Assume she's right and you're
14 wrong.
15 MR. PHILLIPS: I think it's very difficult to
16 know. Maybe you should ask him that question.
17 My understanding is, first she's made no claim
18 for damages under ERISA, and for good reason. There are
19 none available. There are no benefits that she has not
20 been provided under any plan, however you want to define
21 it, and so there's no basis for recovery there. She seeks
22 no injunctive relief, so I don't know that, and indeed the
23 amended Count III focuses on some kind of a treatment with
24 respect to a pot of money when -- and with respect to a
25 plan that simply doesn't exist, so I have no idea what it

1 is that respondent thinks that she will gain from this,
2 except perhaps attorney's fees.
3 Obviously there is a provision for attorney's
4 fees under ERISA, but in terms of her own stake in this,
5 it seems to me it is quite ephemeral, and -- I'm sorry, go
6 ahead.
7 QUESTION: You don't contend there isn't really
8 a live case here, though?
9 MR. PHILLIPS: Oh, no. I don't contend there
10 isn't a live case. What I do contend is that it's -- you
11 know, if you go down this path, at the end of the process
12 you're going to be hard-pressed to come up with much of a
13 remedy that's going to make any difference to her at this
14 stage in the process.
15 QUESTION: Mr. --
16 QUESTION: Well, you agree there's not a live
17 case if she's not seeking any remedy?
18 MR. PHILLIPS: Well, she is -- I mean, what she
19 is seeking --
20 QUESTION: Is a judgment, but not a remedy.
21 MR. PHILLIPS: Is a judgment with --
22 QUESTION: A judgment is not a remedy.
23 MR. PHILLIPS: No, no, I understand that,
24 Justice Scalia, but what she is seeking is -- I mean, her
25 claim is that there is a pot of money and that that pot of

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1 money can be moved around. I don't think there's any
2 basis for that logically in terms of how this scheme works
3 out, but that's not a basis to claim there's no
4 jurisdiction.
5 That's simply a basis to answer Justice Stevens'
6 question which is, at the end of the day, when it's all
7 said and done, if she got everything she wanted out of
8 this, what's likely to come out of it? My sense is there
9 isn't much but, again, respondent may be in a better
10 position to analyze that.
11 QUESTION: Mr. Phillips, are there any
12 circumstances under which an HMO can be found to be a
13 fiduciary, for instance, in administering claims or
14 benefits to which a covered employee is entitled?
15 MR. PHILLIPS: I think there are some
16 circumstances in which that would be certainly the case
17 under the narrower of -- narrowest of the theories that we
18 put forward in opposition to the judgment below.
19 We do have one theory in this case regarding the
20 scope of the definition of the term, plan. Under that,
21 I'm not sure there would be any circumstances where the
22 HMO would be -- have fiduciary responsibilities, but under
23 our narrower interpretation we don't really disagree with
24 the United States that if, in fact, you're talking about
25 an HMO that's making coverage or claim determinations

1 wholly apart from medical treatment decisions, and I want
2 to get to that in a second, it could potentially be a
3 situation where there would be some potential fiduciary
4 responsibility, but then that raises a whole slew of
5 questions with respect to what kinds of incentive plans,
6 or incentive arrangements might breach that fiduciary duty
7 and the issues that stem from that inquiry, none of which,
8 I submit to you, is posed in this particular case.
9 QUESTION: Why is that? Do we know that there
10 are no such coverage determinations being made by this
11 HMO?
12 MR. PHILLIPS: There is no allegation in the
13 complaint as it's defended before this Court with respect
14 to coverage allegations. If you look at the respondent's
15 brief at page 9, she could not be clearer in arguing that
16 the exclusive focus of the case is -- let me see if I can
17 find the language here. The sole focus of attention of
18 amended Count III, which is --
19 QUESTION: Where are you reading from, Mr. --
20 MR. PHILLIPS: I'm sorry. It's on page 9 of the
21 blue brief. I mean, of the red brief. I apologize.
22 QUESTION: Whereabouts on page 9?
23 MR. PHILLIPS: It's sort of in the middle, as I
24 recall. I'm sorry, the last sentence of the second full
25 paragraph --

1 QUESTION: Thank you.

2 MR. PHILLIPS: -- and I'll just quote it. The

3 sole focus of attention of amended Count III is the design

4 and administration of an undisclosed physician incentive

5 to withhold treatment.

6 I think the only fair way to interpret that

7 language is to say that what we're talking about here is

8 basically the provision of care, the provision of medical

9 care and the methods of compensation.

10 QUESTION: To people who are covered?

11 MR. PHILLIPS: Yes.

12 QUESTION: To people who are covered, not

13 excluding people from coverage?

14 MR. PHILLIPS: Right, exactly.

15 QUESTION: Suppose you --

16 QUESTION: But Mr. Phillips, maybe -- maybe your

17 opponent thought it unnecessary to say anything to that

18 effect because in your very own memorandum in opposition

19 to the plaintiff's motion to remand to the State court you

20 allege that -- and this is on page 24a of the brief in

21 opposition -- you allege that Health Alliance was the

22 administrator and fiduciary of the plan within the meaning

23 of ERISA, so if you yourself alleged that Health Alliance

24 was the administrator, then certainly you lull the other

25 side into security on that point. You had conceded it.

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1 MR. PHILLIPS: Well, I think you have to read
2 that in context, Justice Ginsburg. I mean, we certainly
3 conceded it for purposes of the disclosure issues and the
4 bad faith claims that were the basis for the remand order,
5 or the remand issue in that context. We have never
6 conceded that we were a fiduciary for purposes of the
7 amended Count III complaint.
8 We have consistently argued that we have no
9 fiduciary responsibilities with respect to claims in Count
10 III, and in any event, even if the respondent's memory
11 lasted long enough to sort of have that uppermost in her
12 mind at the time she filed her brief in this Court, we had
13 clearly laid out our theory of this case, which is that we
14 are not a fiduciary for these purposes.
15 Her defense of the judgment below is very
16 focused, and I think it spares the Court a significant
17 amount of time and energy having to sort out a variety of
18 the issues that have frankly divided the Solicitor General
19 and the petitioners in this case, questions of what goes
20 into plan design as opposed to fiduciary responsibilities,
21 questions of how broadly do you define the plan and its
22 benefits. None of those issues are any longer on the
23 table.
24 What is on the table is whether the provision of
25 medical care and the methods of compensation for medical

1 care, right, are part of, quote, plan administration
2 within the meaning of section 1002(21)(A), which is the
3 definition provision in ERISA for a fiduciary, and it is
4 completely counterintuitive to suggest that plan
5 administration extends to the provision of medical care,
6 just as a matter of simple language of the statute.
7 And then second, and what I think is really the
8 most driving force in all of this, is the relationship
9 between Federal and State law, because it seems to me
10 absolutely inconceivable that if the Court were to decide
11 that these kinds of medical treatment judgments and the
12 compensation schemes that go into them are, in fact,
13 administration of an ERISA plan, that that then doesn't
14 preempt all State law that relates to those issues, which
15 means --
16 QUESTION: Suppose that you go to your doctor
17 and you give him or his staff your health care policy,
18 your HMO policy and you say, I can't understand this
19 stuff. Is my operation covered or not? And the doctor
20 says, no it isn't, because he doesn't want to do it, it's
21 too expensive, et cetera. Then you elect not to have it
22 and something happens.
23 Is there some gray areas where the doctor may be
24 wearing two hats and really be determining eligibility for
25 you, because you do -- I'm sure patients do rely on

1 doctors to tell them this type of thing.

2 MR. PHILLIPS: I think there is a possibility of

3 a situation like that arising. That's certainly not the

4 allegation in the complaint here. I think in that

5 situation, though, you still have to take a very careful

6 look at, you know, if we're just talking about a physician

7 making a statement and making a mistake, I don't think

8 that's part of the exercise of discretion in plan

9 administration. That's simply potentially a breach of

10 contract that somebody could deal with differently.

11 You know, the key here is, to what extent do you

12 want to drive in the elaborate mechanisms of ERISA as part

13 of an effort to interfere with the relationship between

14 the physicians and the patients in the HMO context, and my

15 own judgment is the Court would be quite better served by

16 trying to move ERISA back further in the scheme of things,

17 but at a minimum it certainly shouldn't be intruded into

18 the physician-patient relationship to the extent of

19 deciding what kinds of medical treatment judgments are

20 valid, and what kinds of compensation schemes are

21 permissible.

22 QUESTION: Do we talk about the employee or the

23 patient's legitimate expectation as to what that employee

24 is receiving from the doctors? They go to the doctor

25 either for medical care or for advice about what the plan

1 means. Is that the beginning point, the legitimate
2 expectations of the covered employee?
3 MR. PHILLIPS: I think it would be a mistake to
4 hinge ERISA scope on the subjective intent of the patient
5 under these circumstances.
6 QUESTION: Reasonable legitimate expectations.
7 MR. PHILLIPS: Well, even that I think is
8 probably a mistake, because the question -- the question
9 is, you know, you're in a fiduciary world when you're
10 administering a plan, and the question is -- and then you
11 have -- because then you have a whole series of questions,
12 is there a breach of fiduciary duty, and what the remedy
13 for it is, and what I'm suggesting is, I don't think the
14 Court wants to get into the business of saying that this
15 is, in fact, a fiduciary relationship based on ERISA.
16 It's certainly a physician-patient fiduciary
17 responsibility.
18 QUESTION: But how do we get out of -- I mean,
19 the statute says that a fiduciary is a person under ERISA.
20 An ERISA fiduciary is a person who exercises discretionary
21 authority or control respecting management of a plan who
22 has any discretionary authority or responsibility in the
23 plan's administration. That's what the statute says.
24 MR. PHILLIPS: Right.
25 QUESTION: Then what they've alleged -- whether

1 it's true or not, they've alleged it. They say that these
2 people here, the HMO, have been given by contract the
3 authority to administer disputed claims. I take it that
4 they've been given by contract the authority to decide, am
5 I covered by the policy that my employer bought, or am I
6 not, and in particular they say that's true of emergency
7 treatment, that's true as to whether something is -- is it
8 routine, is it experimental, which plans are covered,
9 which claims are covered, which are not.
10 Now, that's their allegation, so how in your
11 view is that not administering the discretionary
12 administration of the employer purchase plan itself?
13 MR. PHILLIPS: Well, there are two answers to
14 that, Justice Breyer. Under our broader theory none of
15 this is within the -- an employer welfare benefit plan, in
16 which case none of this is subject to any kinds of ERISA
17 requirements, but the second, and I think the more pointed
18 answer to that really comes to the question of what has
19 she in fact alleged, and can you read the complaint
20 potentially to embrace what you've described --
21 QUESTION: Oh, I just read, was reading from
22 the --
23 MR. PHILLIPS: -- Justice Breyer, but the
24 question is, what does she mean by those particular words,
25 because all she's really doing there is alleging how the

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1 plan operates and then using the statutory language.

2 But go back to page 9 of her brief, Justice

3 Breyer, and analyze exactly what it is that she says. The

4 sole focus of that complaint, that entire count of that

5 complaint, is limited to the question of financial

6 incentives to deprive someone of particular medical

7 treatment.

8 That's what she's defended the judgment of the

9 Seventh Circuit reinstating her claim on, that's what's

10 before the Court, and I don't see why the Court should go

11 beyond that analysis in trying to resolve what otherwise

12 seems to me a very significant thicket that it would

13 other -- that it would have to address.

14 QUESTION: So you say forget Roman numeral ii,

15 small ii, just focus on i.

16 MR. PHILLIPS: Just read it in the way the

17 respondent has asked you to read it. I'm not asking you

18 to do any more than the respondent has pitched this

19 argument to you herself. There's no reason to start over.

20 Let's start where the respondent starts and analyze the

21 case.

22 QUESTION: But then you're making of this a

23 pleading case. You're saying she didn't allege it, not

24 that she couldn't allege it.

25 MR. PHILLIPS: Right.

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1 QUESTION: So if we accept your position it goes
2 back, and they amend the complaint to say no, we're
3 talking about the role of this HMO in making eligibility
4 and coverage determinations.
5 MR. PHILLIPS: You assume, Justice Ginsburg,
6 that she simply somehow made a mistake here rather than a
7 conscious judgment to attack what it is that is the
8 gravamen of her complaint.
9 Her complaint is not a coverage issue. Her
10 complaint is the quality of care that she received. It is
11 bound up in the malpractice claim that she brought, so
12 that's --
13 QUESTION: In a sense this has to be a pleading
14 case, because the district court granted a motion to
15 dismiss.
16 MR. PHILLIPS: Oh, absolutely, Mr. Chief
17 Justice. On the other hand, it is also a case that comes
18 to the Court as presented by the parties, and the
19 respondent has told you how she defends the judgment
20 below, and I think the Court ought to accept that.
21 QUESTION: Mr. Phillips, is it clear that making
22 a determination as to coverage is the exercise of
23 discretion in the administration of a plan?
24 MR. PHILLIPS: No, it's not clear. I mean,
25 there are a whole slew of questions.

1 QUESTION: I hate to depart from that as a
2 premise, because I'm not sure that premise is correct.
3 MR. PHILLIPS: I don't accept that premise
4 either, but what I'm asking the Court to do is to avoid
5 having to address that issue by reaching what I think is a
6 narrower and much simpler ground for reversal in this
7 particular case.
8 QUESTION: Let me ask you a -- it may be a too-
9 simple question, but I understand your answer to Justice
10 Breyer, but I think, like him and maybe some others here,
11 I can't help but think of what the next case is going to
12 be, depending on how narrowly or broadly we might decide
13 this, if we decide it in your favor.
14 Is there a kind of a simple-minded
15 administrative answer to some of our problems, and what
16 I'm thinking of is this. Let's assume that there can be
17 some decisions about coverage which, if made in bad faith,
18 would, in fact, be decisions about the management of the
19 plan and that would, in fact, if made in bad faith,
20 involve a breach of fiduciary duty.
21 The assumption that I have made is that
22 characteristically those decisions are not made by
23 physicians, that someone walks into a clinic or an office
24 and gets some treatment. In an HMO, when they go in the
25 person at the front desk says, the plan doesn't cover

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1 appendixes.

2 Doctors don't make decisions like that, by and

3 large. When there's a true reimbursement scheme the

4 procedure is done, the claim is submitted to the insurance

5 company, and somebody in an office somewhere says, oh,

6 this plan doesn't cover appendixes, so most of the

7 decisions which might be called management decisions,

8 which, if made in bad faith could arguably be breaches of

9 fiduciary responsibility, are probably not going to be

10 physician decisions.

11 Am I being too simple-minded in looking at it --

12 MR. PHILLIPS: No, Justice Souter, and I don't

13 have --

14 QUESTION: If I am, you're going to be in

15 trouble later.

16 (Laughter.)

17 MR. PHILLIPS: I might be in trouble already,

18 but -- no, I don't have any problem with that. All I'm

19 saying is that in this context what she's complaining

20 about is the physician decision to withhold treatment.

21 QUESTION: Right.

22 MR. PHILLIPS: The Court ought to just focus on

23 what it is she has alleged and leave for another day the

24 situation you pose. I don't concede it, but I don't think

25 the Court needs to address it at this time.

1 QUESTION: In his hypothetical the person at the
2 front desk may be an employee of the physician's. I mean,
3 that's -- that's the gravamen of this complaint.
4 MR. PHILLIPS: I assume that was --
5 QUESTION: The whole HMO is owned by
6 physicians, so you know, if some secretary at the front
7 desk -- it's the physician's, because they own the HMO and
8 employ the secretary.
9 MR. PHILLIPS: That's true. I mean, I
10 understand that, but again, I don't know why we would go
11 beyond the specific allegations in the complaint, as
12 defended by the respondent here.
13 I'd reserve the --
14 QUESTION: Mr. Phillips, wasn't it emphasized by
15 the other side that if only there were somebody else
16 making the coverage and eligibility decisions, if only
17 that, they would have no complaint? I thought that that
18 was very clear from the respondent's presentation, that
19 they weren't complaining about treatment, that the only
20 thing they were complaining about was having the coverage
21 eligibility determination made by the physician.
22 MR. PHILLIPS: Well, I would read page 9 of
23 their complaint once again and tell you what the sole
24 focus of their claim is, which is that the physician-
25 incentive system causes the physician to withhold -- I

1 mean, the compensation system causes the physician to
2 withhold treatment. That's the allegation that she's put
3 before the Court.
4 QUESTION: Thank you, Mr. Phillips.
5 Mr. Feldman, we'll hear from you.
6 ORAL ARGUMENT OF JAMES A. FELDMAN
7 ON BEHALF OF THE UNITED STATES, AS AMICUS CURIAE,
8 SUPPORTING THE PETITIONERS
9 MR. FELDMAN: Mr. Chief Justice, and may it
10 please the Court:
11 It's our position that the treatment allegations
12 of the complaint, which regard the incentive to the
13 physicians, to the treating physicians concerning their
14 treatment of their patients, are governed -- essentially
15 State claims that are governed by State law but are not
16 governed by ERISA because they don't have to do with
17 fiduciary duty under ERISA.
18 On the other hand, the administration
19 allegations of the complaint, if there are any there, and
20 it's unclear to me whether there are or not, but insofar
21 as the complaint is alleging that there was deficiencies
22 that have to do with the claims processing function of the
23 HMO, that is an activity that is governed by ERISA and not
24 State law. However, it's our position that they did
25 not -- that the complaint does not allege a violation of

1 ERISA's fiduciary duties with respect to those issues.

2 QUESTION: It's also your position, I take it,

3 that not every claim of an error in the claim processing

4 function without more would state a breach of -- a claim

5 for breach of fiduciary duty?

6 MR. FELDMAN: That's true.

7 QUESTION: In other words, if they just get it

8 wrong, if a fiduciary just gets it wrong, that's not a

9 breach of fiduciary duty without something more.

10 MR. FELDMAN: That's true, but insofar as the

11 fiduciary is someone -- it's an error that had to do with

12 the exercise of discretion under the plan in deciding

13 what -- whether a certain kind of procedure is covered,

14 then it would be a breach of fiduciary duty. I'm not sure

15 it makes that much difference, because if it's just an

16 error in construing the plan, the claimant would have a

17 claim under 502(a) for the benefit that was due in any

18 event.

19 QUESTION: How do you -- you see, I never

20 thought that a judge has discretion in deciding whether

21 the law means this or that. There's a right answer and a

22 wrong answer. The judge tries to find the right answer,

23 and isn't it the same thing when somebody determines plan

24 coverage?

25 It seems to me strange to talk about discretion

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1 in determining plan coverage. Why is that a discretionary
2 administration of the plan?
3 MR. FELDMAN: I think discretion in this sense
4 is used in the terms of applying the plan terms to a wide
5 variety, sometimes fairly vague plan terms to a wide
6 variety of different cases, and that does have something
7 in common with what judges do, and judges do exercise
8 discretion sometimes, but in the Varity Corporation v.
9 Howe, the Court said -- I'm reading from page 511, 516
10 U.S. on 511 -- a plan administrator engages in a fiduciary
11 act when making discretionary determination about whether
12 a claimant is entitled to benefits under the terms of the
13 plan documents.
14 So at some point there is a fiduciary, and --
15 who -- where that person has some discretion, is making a
16 judgment about applying some broad terms to maybe a
17 particular set of facts, or construing what the terms
18 mean, that person does become a fiduciary under ERISA.
19 Now, it's our position that a doctor doesn't
20 merely by accepting a patient and forming a doctor-patient
21 relationship. Within a doctor-patient relationship, as it
22 has long been understood, the doctor's duties are governed
23 by principles of medical ethics and by State law, and
24 ERISA basically has nothing to do with that, whether it's
25 provided by an HMO or not.

1 But where -- and if -- and in this case that's
2 all that apparently happened, in fact, to the plaintiff,
3 but where there is a claim made, not -- which is generally
4 not -- may or may not be made to a doctor, it may be some
5 other functionary, but somebody who's not -- doesn't have
6 a doctor-patient relationship with the plaintiff, if a
7 claim is made that somebody wants something covered, that
8 triggers the claims processing function of the plan and
9 can trigger ERISA's fiduciary duties.
10 QUESTION: May I ask you a question? The
11 definition of what fiduciary duty is, that they must
12 always discharge the duties solely in the interests of the
13 participants and the beneficiaries, so that if you take
14 this literally, and if you say that's a fiduciary
15 responsibility, every debatable case would have to be
16 ruled in favor of the beneficiaries.
17 MR. FELDMAN: Right. I don't think that's
18 right. They have to faithfully apply the terms of the
19 plan. That's their primary duty, and I will say that --
20 well, the primary duty is to --
21 QUESTION: It doesn't mean you always have to
22 rule in favor of the --
23 MR. FELDMAN: That's right. In fact, the
24 fiduciary 1104 -- it's capital (D) there, I think --
25 specifically says that the fiduciary has to comply with

1 the plan documents and with the plan --

2 QUESTION: If you have an ambiguous plan

3 document, if its duty is to act solely in the interests of

4 the participant or the beneficiaries, it's a pretty tough

5 standard.

6 MR. FELDMAN: Well, I -- I don't think it's,

7 though -- I think the sense of, in the interests of the

8 participant or the beneficiary, what that means there is

9 to make determinations under -- as to what's covered and

10 what's not covered in accordance -- strictly in accordance

11 with the terms of the plan, not in accordance with other

12 considerations either for or against the particular

13 individual, because that beneficiary doesn't have the

14 right to anything, other than what the plan document's

15 entitles him or her to.

16 QUESTION: But Mr. Feld -- that makes perfect

17 sense except when you bear in mind what you said a moment

18 ago to Justice Scalia. We have language in these plans in

19 which there's a range in which reasonable judgments can be

20 made and still be faithful to the language, and in that

21 situation I think Justice Stevens, the answer to Justice

22 Stevens' question has got to be, it's always got to be

23 made in the patient's favor.

24 MR. FELDMAN: No, I don't think that that's --

25 QUESTION: You've always got to choose the point

1 in the reasonable spectrum that gives the plaintiff what
2 the -- the patient what the patient wants.
3 QUESTION: Either that or it's not a
4 discretionary judgment.
5 QUESTION: Yeah.
6 QUESTION: I don't see -- I don't see any --
7 MR. FELDMAN: In fact, the Court --
8 QUESTION: Or it's not a fiduciary --
9 MR. FELDMAN: In fact, the Court has held, I
10 think, quite to the contrary, that where a fiduciary under
11 ERISA is given discretion by the plan to make those kinds
12 of determinations, courts will accord deference to the
13 discretion given to the fiduciary --
14 QUESTION: Mr. Feldman, I had thought --
15 MR. FELDMAN: -- within some range where the
16 fiduciary doesn't have -- isn't -- the plan documents
17 don't give the fiduciary any discretion and the courts
18 don't accord it and will decide any legal suits that arise
19 from it based just on the terms of the plan.
20 QUESTION: You seem not to be taking the
21 position that I thought would be the one that you would
22 take, which is that the word beneficiaries is plural, and
23 sometimes what may be in the best interests of a
24 particular plaintiff could be against the interests of the
25 class of beneficiaries. That came up in the former pay-

1 for-services --

2 MR. FELDMAN: The -- it's -- there are certainly

3 many circumstances under which ERISA fiduciaries do have a

4 duty to the plan as a whole, where, for example, they are

5 sitting on a trust, on some assets. How they spend

6 that -- which does not -- was not true here. How they

7 spend that money, they have a duty to the plan and to all

8 of the beneficiaries there, but I think when you're

9 talking about a claims administrator at an insurance

10 company or an HMO, their duty is to apply the plan

11 documents to this individual and however it comes out, it

12 comes out.

13 They shouldn't be saying, well, I don't want to

14 give this individual benefits because it might somehow

15 save money for the employer and the employer might

16 therefore --

17 QUESTION: Mr. Feldman, couldn't the

18 administrator say, if I resolve every single debatable

19 point in favor of each beneficiary, other beneficiaries

20 are going to suffer?

21 MR. FELDMAN: Well, you know, I just don't think

22 that that's quite right, because this person, fiduciary,

23 this kind of limited purpose fiduciary -- it's not a

24 general fiduciary who's a trustee of the plan, but it's

25 someone who's just a fiduciary insofar as this person is

1 making -- is ruling on a claim for benefits. This
2 person -- all this person should be keeping in mind is,
3 what are the terms of the plan, and how does that apply to
4 this particular claim.
5 QUESTION: Yes, that's --
6 MR. FELDMAN: And because there's a contract
7 here the fiduciary is supposed to be applying that
8 contract to the terms of this claim, and whatever it
9 permits --
10 QUESTION: You yourself had said the terms can
11 be very vague.
12 MR. FELDMAN: Right, and they should be
13 construing them in a reasonable, consistent way, and so
14 on, not always -- certainly not always in favor of the
15 beneficiary, not against the beneficiary.
16 QUESTION: Well, what we're talking about here
17 is not a particular decision in relation to a particular
18 beneficiary, I thought. I thought we were talking -- what
19 they allege is that a plan that sets up a certain
20 structure with economic incentives is wrong, and when you
21 decide what kind of a plan, can't you take the interests
22 of all the beneficiaries into account?
23 MR. FELDMAN: That's -- yes.
24 QUESTION: And that, isn't that the issue before
25 us?

1 MR. FELDMAN: That's correct, except --

2 QUESTION: All right. Except --

3 MR. FELDMAN: Except --

4 QUESTION: When you apply it you have to look at

5 this beneficiary, but when you're deciding specifically

6 whether to have a rule that gives an incentive to doctors

7 to do X, Y, or Z, that's a matter for all the

8 beneficiaries, isn't it?

9 MR. FELDMAN: Except that if the HMO -- as far

10 as the treatment, what we call the treatment

11 allocations --

12 QUESTION: Well, you -- yes.

13 MR. FELDMAN: -- the HMO is deciding that as a

14 matter of how to pay its employees, and it really has

15 nothing to do with ERISA at that point.

16 QUESTION: Well, but that's on your question as

17 to assume --

18 MR. FELDMAN: As far as the other side --

19 QUESTION: Assume they are a fiduciary for the

20 sake of argument.

21 MR. FELDMAN: We're -- and they are a fiduciary

22 insofar as people go and make claims, not in the doctor-

23 patient relationship, but to the --

24 QUESTION: All right, so your argument is that

25 what gets them out of this is, they're not fiduciaries in

1 respect to making up the incentive rules under the plan.

2 MR. FELDMAN: But as far as the doctors are not.

3 Now, as far as how they are paying the people who are

4 making the claims, when the claims are being processed

5 it's both the HMO and the individual who's doing it who

6 become fiduciaries -- who become fiduciaries for that

7 purpose, and insofar as they're doing that, there may be

8 some fiduciary limits that ERISA places on the kinds of

9 incentive structures.

10 We gave an example in our brief. If the HMO

11 said to its claims people something which -- you know, I'm

12 not suggesting anybody has done this, but we're going to

13 give you a bounty of $100 for every claim you've denied --

14 QUESTION: Okay. That's my question.

15 MR. FELDMAN: -- I think that would raise a

16 serious problem.

17 QUESTION: All right, fine. If in some

18 circumstances it can, a particular incentive structure,

19 created by some administrators who maybe are a part of the

20 organization they're suing, could, in fact, violate ERISA,

21 and in other times it wouldn't violate ERISA, what's the

22 principle as to when it does and when it doesn't?

23 MR. FELDMAN: And I would -- our position is

24 that the -- you start off from the point that ERISA

25 specifically recognizes that benefits can be provided

1 through insurance or otherwise. Now, an insurer is always
2 in a position, whenever a claim is made against an
3 insurance policy, just like an HMO --
4 QUESTION: Thank you, Mr. Feldman.
5 Mr. Ginzkey, we'll hear from you.
6 ORAL ARGUMENT OF JAMES P. GINZKEY
7 ON BEHALF OF THE RESPONDENT
8 MR. GINZKEY: Thank you, Mr. Chief Justice, may
9 it please the Court:
10 Mr. Phillips indicated that it's no exaggeration
11 to indicate that this particular lawsuit is an attack on
12 managed care as a whole, that what we have is a standard
13 plain vanilla HMO. I beg to differ with that. We don't
14 have, in this case, a standard, plain vanilla HMO, and
15 maybe drawing a comparison to another type of HMO is the
16 best example of what I'm trying to describe here.
17 Take an HMO like Humana. Humana is a publicly
18 traded corporation. There are over 167 million
19 outstanding shares of Humana stock. The owners of the
20 Humana stock, as owners, are a group of people that are
21 separate and distinct from Humana, the company that
22 employs the claims reviewers and the medical directors.
23 Separate and apart from that group is then the
24 contracted physicians that provide the services, so in
25 many, if not most HMO's, you've got three distinct groups.

1 You've got the owners, separate and apart from the
2 employees of the company making the claims decisions,
3 separate and apart from the doctors who are providing the
4 primary care. Here, all three groups are one. They're
5 all one entity.
6 QUESTION: But what has that to do with it,
7 because if they had it separate, then your clients or some
8 future clients would simply sue the right group.
9 I mean, I take it the underlying substantive
10 question is, whoever is making this decision, you're
11 saying it's a breach of a fiduciary relationship to have a
12 set of economic incentives that makes them look at costs
13 as well as health.
14 Now, the separation issue is one, that even
15 assuming you're right on that, it's very hard for me to
16 believe in respect to cost incentives that the same
17 Congress that in 1973 wrote an HMO act, and the same
18 Congress that has provided for incentives that encourage
19 HMO's throughout, in ERISA, without saying anything,
20 wanted to gut its own HMO legislation.
21 Now, that's where I start on this, and I put
22 that up front, because I want to know how your theory
23 doesn't achieve a result that I just find it very hard to
24 believe Congress wanted.
25 MR. GINZKEY: The Health Maintenance

1 Organization Act was passed in 1973. ERISA was passed in
2 1974. In 1974, we did not have the forms of managed care
3 that we now have.
4 With respect to the HMO act of 1973, that is
5 enabling legislation. It does not specify anywhere in
6 that act what cost containment mechanism should or should
7 not be used. That is not specified, and it to my
8 knowledge is not specified by any -- in any regulation by
9 the Department of Labor or any other bureaucracy of the
10 Federal Government.
11 The phenomenon that we have with respect to
12 these physician bonuses, the physician incentives, is a
13 relatively recent phenomenon. It first came to the
14 Government's attention in the 1986 report by the GAO,
15 where they concluded that incentives seem to have a
16 deleterious effect on the health of the patients being
17 treated by the doctors who are incentivized.
18 QUESTION: What they're saying is that we think,
19 for example, if you have a group of people who look after
20 a child from the time it's born to the time it dies,
21 they'll get interested, through our incentives, in what's
22 called preventive care, and will end up with a lot less
23 disease.
24 Now, to do that, you have to have doctors who
25 pay attention to patients all across the board, and you

1 also have to tell those doctors, don't use the most
2 expensive treatment before you look at what will actually
3 benefit the patient throughout the cost of his life.
4 MR. GINZKEY: And we're not suggest --
5 QUESTION: The whole course of his life. Now,
6 that, I take it, is the theory that underlies these kinds
7 of cost incentives that are built into the plan.
8 Now, if Congress -- doesn't Congress make that
9 judgment with HMO's, or similar kinds of judgments?
10 MR. GINZKEY: No, I don't believe that Congress
11 does make --
12 QUESTION: What is your -- but I'm asking not my
13 theory, I'm asking your theory on this.
14 MR. GINZKEY: Well, and I want to come back to
15 the question that you posed immediately before that, and
16 that question was, why does it make a difference that in
17 this particular structure, this corporate structure of
18 this HMO, you've got the employees who are making a claims
19 decision, the medical directors, all four of them, being
20 the same doctors who profit from that bonus at the end of
21 the year. You don't have an independent third party
22 administrator making those claims decisions. That's one
23 of the major distinctions in this case.
24 It also explains some of the Solicitor
25 General's, I think misconceptions with respect to various

1 relationships of the parties, because the doctors that are
2 the owners, the sole owners of the HMO, and employ
3 themselves as the primary care physicians, aren't dealing
4 at arm's length.
5 One of the positions of the Solicitor General is
6 that you can't have any limitations, as we suggest in this
7 particular case, upon an HMO's right to contract with
8 doctors. That assumes that the contracting that's going
9 on is at arm's length. It's not here. They're one and
10 the same entity.
11 QUESTION: How many HMO's fall in this pattern
12 of physician-owned -- you said that you thought most were
13 not that way. Do you have any idea how many are?
14 MR. GINZKEY: I don't have percentages, Justice
15 Ginsburg. I can tell you that there are a substantial
16 number of doctor-owned HMO's, but I'm not aware of one
17 that is structured like this, where the doctors not only
18 are the owners, and employing themselves on the opposite
19 end, they're also the decisionmakers in the middle.
20 QUESTION: But if you don't have many doctors,
21 they presumably can't afford to hire an independent
22 administrator. I mean, if you're going to have a small
23 organization.
24 MR. GINZKEY: I don't know what the cost of a
25 third-party administrator would be, but I can tell you

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1 that the cost in-house is getting paid for by the premiums
2 being charged in any event.
3 QUESTION: Mr. Ginzkey, I didn't get your
4 response to Justice Breyer's question about what
5 difference does it make whether there's separation or not.
6 Let's assume that doctors don't make the decisions, so you
7 have some other organization that makes the decisions. So
8 long as that organization has the same incentive of
9 keeping costs down, wouldn't that organization fall prey
10 to the same complaint that you make here?
11 MR. GINZKEY: No.
12 QUESTION: It isn't -- nothing distinction about
13 doctors making it. Your complaint is that whoever is
14 making the decision about what treatment ought to be given
15 has a financial incentive that is not necessarily
16 coincident with the best interests of the patient. That's
17 going to be the case whether it's the doctor doing it or
18 somebody further up the line, so long as you have this
19 kind of an HMO.
20 MR. GINZKEY: The difference is, Your Honor,
21 that the claims administrators with a third party
22 administration firm aren't getting paid to deny the
23 claims, and that's what's happening here, because the
24 claims administrators of this HMO are the very owners of
25 the HMO that share in the year-end distribution.

1 The year-end distribution is not something that
2 isn't controlled by the physicians to a certain extent,
3 because these are actuarially underwritten plans, and by
4 that I mean this. When the HMO makes a bid to State Farm
5 Insurance that we're going to cover this particular
6 individual at $100 per month, that's what it's going to
7 cost us to provide that health care for that much for that
8 individual, that's not the premium that is charged.
9 There's a premium loading factor that is added in here,
10 and what --
11 QUESTION: You say that they have to bring in
12 not only somebody other than the doctors, but somebody
13 other than the doctors who has no financial interest in
14 the whole enterprise.
15 MR. GINZKEY: No, not --
16 QUESTION: Hire some firm to make medical
17 decisions of whether you get this operation or not --
18 MR. GINZKEY: Not some --
19 QUESTION: -- some firm that is not the owning
20 doctors of the HMO and that also has no financial interest
21 in the whole enterprise.
22 MR. GINZKEY: No, Your Honor, that's not what
23 I'm saying.
24 QUESTION: Well then, I don't know --
25 MR. GINZKEY: I'm saying that you've got to have

1 somebody that is making those claims decisions that
2 doesn't have a basis, isn't receiving money to deny the
3 claims, because that's what's going on here.
4 QUESTION: But that's --
5 QUESTION: Well, supposing you hire --
6 QUESTION: That's what I said.
7 QUESTION: Supposing a small group of doctors
8 hires an administrator and the administrator administers
9 claims, and then the doctors tell him, you know, you're
10 just allowing a lot of stuff we don't think you should
11 allow, and as a result our income is going down. What's
12 the result there?
13 MR. GINZKEY: Here, if I can draw on the
14 analogy, or the explanation I was trying to give earlier,
15 here what you have is the, let's say $100 per member per
16 month cost of providing the medical care. That's
17 increased. There's premium loading factors, generally
18 about 20 percent, that's added on right on top. That $120
19 then is paid on a monthly basis to the HMO.
20 The $20 profit is taken off the top. That
21 constitutes profit, administration costs and costs of
22 advertizing, but--
23 QUESTION: Well, but you're giving your own
24 hypothesis, but I put a hypothesis to you that I wish you
25 would respond to.

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1 MR. GINZKEY: And I'm trying to respond to that.
2 QUESTION: Would you respond a little more
3 directly?
4 MR. GINZKEY: I think that there is a difference
5 between the scenario that you have suggested and a
6 scenario where the claims determiners are the ones who are
7 doing the determination of the actuarial underwriting so
8 that they know what's going to be in that risk pool at the
9 end of the year and, to the extent that they can deny
10 claims, there's more money in the risk pool for
11 distribution at year-end to them.
12 QUESTION: Well, there's a difference perhaps in
13 degree. There is a difference in the degree of finesse,
14 but isn't -- at the end of the day, isn't the operative
15 fact that in any HMO the interest of the HMO and the
16 interest of every employee, whether -- of the HMO, whether
17 it be a doctor or a nondoctor administrator, is to hold
18 down health cost, because unless they do so the HMO is
19 going to go out of business?
20 And it seems to me that that interest is there,
21 whether it is in the stark shape that it takes here, or
22 whether it's in a more subtle shape which it takes on your
23 hypothesis of what is right, but the same interest is
24 there, and it seems to me that it is equally -- if the
25 interest in this case is at odds with fiduciary duty, I

1 don't see why the interest in the more subtle case isn't
2 equally at odds with fiduciary duty.
3 MR. GINZKEY: It's the mechanism that we're
4 focusing on here, Your Honor.
5 QUESTION: But why -- I know it is, but why does
6 the mechanism make a difference, because what you say is
7 wrong with the mechanism is that it induces these so-
8 called fiduciaries to say, no care for you, but that same
9 mechanism operating at a perhaps less obvious level is
10 inherent in any HMO, so I don't see why the mechanism
11 makes the difference.
12 MR. GINZKEY: The mechanism makes the difference
13 here because these physicians in their capacity as owners
14 of this HMO are getting paid bonuses to deny care, and let
15 me explain that a little bit further.
16 Counsel indicates that on page 9 of our red
17 brief we took the position that the sole focus of
18 attention of amended Count III is the design and
19 administration of an undisclosed physician incentive to
20 withhold treatment. That's taken out of context.
21 That entire paragraph on page 9 deals with cost
22 containments, and what we're saying is, we're only
23 focusing on one cost containment mechanism. We're not
24 arguing about, for instance, pre-certification. Pre-
25 certification is a cost containment element that can be

1 used, employed by managed care, that is going to lower
2 health care costs, but it's not going to be a situation
3 where the doctor is getting paid a bonus to look the other
4 way when somebody is sick so --
5 QUESTION: In effect, the -- the rule of
6 decision that you want us to come down with I think is,
7 we've just got to draw lines here and say, the breach of
8 fiduciary duty is clear when the doctors get a year-end
9 payment and make the decision. There is, however, no
10 breach of fiduciary duty, or at least not a cognizable
11 one, when the interest between denying coverage and
12 ultimate compensation is more subtle than that. That's
13 the rule of decision that you want?
14 MR. GINZKEY: I am not asking this Court to
15 outlaw physician incentives, to declare them illegal.
16 QUESTION: Right, and in order not to do so,
17 aren't you asking us for a rule of decision something like
18 what I just put to you?
19 MR. GINZKEY: There is going to have to be a
20 line drawn, and I think that the line is drawn with
21 reference to incentives reaching the level of undue
22 influence so that it affects patient care.
23 QUESTION: Now, suppose -- you may have a very
24 good answer to this, and I'm on exactly the same track,
25 but take as separate a person as you want, you know,

1 somebody who has nothing to do with doctors, that works
2 for the ERISA trust plan of a company, and that person
3 says, here's what our plan's going to do. We're going to
4 take a bunch of doctors, and we're going to pay them
5 $3,300 per patient per year, and we say, doctors, you take
6 on some patients. Now, we'll tell you about this money.
7 What you don't spend, you keep. All right? That's our
8 rule.
9 And now what's sort of -- what's bothering me is
10 that the rule that you want would outlaw the rule that I
11 just said, and why isn't that so?
12 MR. GINZKEY: Because the rule that we're
13 suggesting here is not that broad, Your Honor.
14 QUESTION: I know, but what I -- see, my rule
15 draws its strength from the fact that we know there are a
16 group of ethical rules governing medicine, and doctors, we
17 believe, governed by this when they take the $3,300, will
18 try to look for the best way of saving the patient anyway,
19 and if they can do so with a little saving extra money,
20 that's to their benefit.
21 So that's why my rule sounded okay. Maybe it's
22 true, maybe it's not, but your role sounds as if it
23 abolishes my rule, so now, how -- why not?
24 MR. GINZKEY: Because that type of incentive
25 doesn't rise to the level of undue influence that is going

1 to have a deleterious effect, necessarily, on patient
2 health care, and let me point the Court to the study that
3 was performed in 1998 out in California. Excuse me. It
4 was published in 1998, in the New England Journal of
5 Medicine. It was 766 primary care physicians in the State
6 of California.

7 A questionnaire went out. I believe it was
8 anonymous. A questionnaire goes out, do you have any
9 incentives in your managed care or HMO plan? Yes. 40
10 percent of them have incentives.

11 Do they influence you, at least to some degree?
12 Over 50 percent say, yes, they influence us to some
13 degree.

14 Third question, are they unduly influencing you,
15 and that's not the word that's used in the report. What
16 they say is, or what the doctors say, 17 percent of them
17 in that study, and I think that that study is probably
18 representative of health care in the United States, what
19 17 percent of those doctors in California say is that
20 those incentives are high enough, large enough that they
21 feel it does compromise quality of care. That's what the
22 physicians say. That's what they're telling us. We don't
23 have to hypothecate.

24 QUESTION: Well, do you think they all
25 attributed the same meaning to the word unduly, which is

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1 extremely vague?

2 MR. GINZKEY: That was my term, Your Honor, and

3 that was a bad term. The --

4 QUESTION: What did the questionnaire say?

5 MR. GINZKEY: Are the incentives high enough

6 that it is having a significant, deleterious effect on

7 health care that you're providing, and 17 percent of them

8 said yes, so --

9 QUESTION: Well then, I take your answer to be

10 that you're saying that I thought what was a good legal

11 rule isn't, and you don't mind that if I decide for you we

12 also make unlawful under ERISA the rule that I talked

13 about, the $3,300 per patient, or are you going to

14 distinguish it?

15 MR. GINZKEY: I think you have to distinguish

16 it.

17 QUESTION: All right. Now, can you tell me --

18 maybe you've said this already, and I'm sorry if I'm

19 asking you to repeat it, but the distinction precisely

20 between the one I had and the one you want is?

21 MR. GINZKEY: Depending on what the rate of

22 capitation is in your hypothetical, it might be a

23 violation of the rule that I'm suggesting, but what I'm

24 suggesting is that the courts should make that

25 determination on a case-by-case basis and just not exempt

1 entire groups --

2 QUESTION: Well, Mr. Ginzkey --

3 MR. GINZKEY: -- from ERISA.

4 QUESTION: -- why should the courts get into

5 this slippery slope problem that you're posing for us when

6 Congress has designed a scheme that's built on private

7 furnishing of health care through health maintenance

8 organizations that are privately owned, and where there

9 are inherently incentives to keep costs down at the HMO in

10 order to provide the care and make it pay for itself?

11 And that's the scheme Congress has authorized,

12 and they are served by doctors that have ethical

13 obligations in the treatment of patients, and I suppose

14 Congress relied on the ability of the enforcement of those

15 ethical obligations to curb what otherwise might appear to

16 be an unfortunate financial incentive to cut costs, and

17 I -- why should the courts get involved in this messy

18 business of deciding what scheme is an undue infringement

19 and what isn't?

20 MR. GINZKEY: Let me respond firstly by saying

21 I'm only aware of one case where a Federal court

22 specifically addressed the issue of whether or not the

23 ethical opinions promulgated by the American Medical

24 Association are enough to counterbalance an incentive that

25 a doctor might have to cut care, and that decision I cited

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1 in my -- I believe it was the reply at the writ stage, and
2 that court decided that the ethical opinions aren't enough
3 to counterbalance strong financial incentives, and
4 therefore we can't rely on the physicians' ethics in
5 situations like this.
6 But let me get also to the question that you
7 posed concerning why should you get involved. This Court
8 in Varity v. Howe said that Congress, when it passed
9 ERISA, adopted the common law principles of trusts.
10 Congress didn't specify what the courts were supposed to
11 do in each and every case.
12 Congress said that the courts across this land
13 should look at pension benefit funds, or pension benefit
14 programs, or welfare, health care programs, applying the
15 law of trusts, and try to determine, using the principles
16 of equity under the law, common laws of trust, what is
17 acceptable and what's not acceptable.
18 QUESTION: Can I ask you the question I asked
19 your opponent at the beginning of the case? What's really
20 at stake for your client in this case, at this stage?
21 MR. GINZKEY: My client does not stand to profit
22 individually or personally from this case. What we are
23 seeking is to recoup the bonuses that we believe are paid
24 in violation of fiduciary duties under ERISA.
25 QUESTION: Recoup it for the plan?

1 MR. GINZKEY: For the plan, and hopefully a
2 couple of different things happen. Premiums come down for
3 a period of time, or coverage is broadened for a period of
4 time, or a combination of the two for a period of time,
5 but with reference to a broad attack on managed care, that
6 can't happen under ERISA, because under ERISA the
7 plaintiff can sue only on behalf of the plan, unless it's
8 a denial of benefits, and then you get the cost of the
9 benefits back, but under no circumstances do plaintiffs
10 get compensation for pain and suffering, mental anguish,
11 and there's no compensation or payment for --
12 QUESTION: And who would the -- if there's this
13 money that should -- that's been accumulated, who would
14 get the fund? Would it go back into the HMO, or would it
15 go to the --
16 MR. GINZKEY: To the risk pools. To the risk
17 pools.
18 QUESTION: Is that --
19 QUESTION: I thought she was suing on her own
20 behalf.
21 MR. GINZKEY: No, on behalf of the plan.
22 QUESTION: On behalf of the plan? Well, let
23 me -- I'm a little confused by some of your presentation,
24 because you talked about coverage determinations, and as I
25 understand what occurred here, there was no denial of

1 coverage to your --

2 MR. GINZKEY: That's correct.

3 QUESTION: To your client.

4 MR. GINZKEY: That's correct.

5 QUESTION: It was acknowledged that what she was

6 suffering from was covered by the plan, and what her

7 complaint was is that she got procedure A whereas she

8 should have had procedure B, which was more expensive, and

9 they didn't give her B because of the cost. Isn't that

10 right? So how do we get into the coverage determination

11 question at all? Why is that even involved in the case?

12 MR. GINZKEY: This is not a denial of benefits

13 case. What --

14 QUESTION: So we don't have to consider that,

15 then, right?

16 MR. GINZKEY: It's not a denial of coverage

17 case. That's not what we're alleging.

18 QUESTION: Okay.

19 MR. GINZKEY: The benefits, or excuse me, the

20 expenses that were incurred for her hospitalization and

21 emergency surgery were paid in full. We're not seeking to

22 recover those.

23 QUESTION: You say she should have had some

24 other kind of treatment, which would have been more

25 expensive, right?

1 MR. GINZKEY: No.

2 QUESTION: No?

3 MR. GINZKEY: No.

4 QUESTION: I thought it was.

5 MR. GINZKEY: This is not a medical malpractice
6 case. There is no individually named physician that's a
7 defendant in amended Count III. This is not about quality
8 of care. This is exclusively --

9 QUESTION: But explain something else to me, if
10 you would. The HMO here contracted with State Farm
11 Mutual, is it, and who would get the money if there is --
12 the doctors had to pay some money? The HMO wouldn't get
13 it, because they are the doctors.

14 MR. GINZKEY: It would go back into the risk
15 pools.

16 QUESTION: To the risk pool?

17 MR. GINZKEY: If I can go back to the analogies
18 example that I was trying to draw previously, say you have
19 somebody in relatively good health, and the per member per
20 month charge for the cost of --

21 QUESTION: I have a -- forgive my stupidity, but
22 what is the risk pool? Who -- what fund of money -- who
23 owns that? Is that the insurance company's property?

24 MR. GINZKEY: That's plan assets.

25 QUESTION: It's a plan asset.

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1 MR. GINZKEY: That's a plan asset.

2 QUESTION: Well, who would physically --

3 supposing you get this money, who actually gets title to

4 it?

5 MR. GINZKEY: It's managed by the HMO.

6 QUESTION: So it goes back to the HMO.

7 MR. GINZKEY: Well, it goes back into the risk

8 pool --

9 QUESTION: Well, but --

10 MR. GINZKEY: -- but it's for the benefit, for

11 the health benefit of the participants, as opposed to

12 being available for bonuses for physicians.

13 QUESTION: And what qualifies you as a

14 representative of the people in the risk pool?

15 MR. GINZKEY: ERISA specifically states that any

16 plan participant can bring a suit on behalf of the plan.

17 QUESTION: Mr. Ginzkey, may I go back to your

18 answer to Justice Scalia? You were telling him what this

19 case was not. You said, it's not a malpractice case.

20 MR. GINZKEY: It's not.

21 QUESTION: It's not a coverage case. It's not a

22 denial of benefits case. What is it?

23 MR. GINZKEY: It's a brief of fiduciary duty

24 case.

25 QUESTION: Resulting in what kind of harm? I

1 mean, in a malpractice case we know what the harm is. In
2 a coverage case, we -- and so on. What exactly is the
3 harm? The harm is simply that the risk pool is smaller
4 than it otherwise would be?
5 MR. GINZKEY: The harm is that the money that is
6 paid into the risk pool by State Farm and the employee --
7 because this is a contributory plan. 50 percent of the
8 premium is paid by the employee. The harm here is that
9 that money, which is supposed to be used exclusively for
10 health care, is not being used exclusively for health
11 care.
12 QUESTION: So you're basically making a
13 financial management claim. You're saying, they're
14 misapplying funds?
15 MR. GINZKEY: Yes, absolutely. They are
16 breaching their fiduciary duties with respect to the
17 management of the risk pools. The risk pools have
18 exclusively in them money to be used for the funding of
19 medical expenses.
20 And you asked what the harm is. What strikes me
21 about this case, unusual about this case is that the
22 courts zealously protect money for money's sake with
23 respect to pension plans, and let me explain that. If you
24 look at the John Hancock v. Harris Trust case that this
25 Court decided in 1993, or some other cases that are

1 dealing with pension benefits, any fiduciary under one of
2 those plans has never been able to deal with the funds in
3 that plan in profit, self-profit from the dealing of --
4 with those funds.
5 QUESTION: Well, I will-- you know, I will
6 assume that, but may I just come back to a follow-up
7 question. Assuming, and you know your case, this is a
8 mismanagement of funds case --
9 MR. GINZKEY: Yes.
10 QUESTION: -- am I right that in order for you,
11 which I think we've all been assuming, am I right that in
12 order for you to make out your case that there has been
13 mismanagement of funds, it's necessary for us to accept
14 the proposition that whenever a physician in an HMO has a
15 strong financial incentive to make a medical decision,
16 that that medical decision is therefore a fiduciary
17 decision, and is therefore -- and therefore a claim
18 against him is preempted from State malpractice law in
19 favor of ERISA fiduciary law?
20 MR. GINZKEY: No, you do not make that
21 assumption.
22 QUESTION: Then it's not the median term. Why
23 isn't it the median term in order to get your result?
24 MR. GINZKEY: We're confusing a couple of two
25 different issues, because there's more than one level

1 involved in this case. One of the lower levels that is
2 involved, if I can use that terminology, is the
3 determination by the primary care physicians as to what is
4 and what is not medically necessary. That not only is a
5 treatment decision, but based upon the wording of this
6 plan, it's also a coverage decision, so --
7 QUESTION: And that kind of decision was
8 involved in this case?
9 MR. GINZKEY: But we're not --
10 QUESTION: Isn't it? I mean, isn't that your
11 understanding of what you're claiming, that that kind of
12 decision was crucial to your claim in this case?
13 MR. GINZKEY: No, because there was nothing that
14 the physician felt that was medically necessary that was
15 denied.
16 QUESTION: Are you saying that it just happens
17 to be a coincidence that you are bringing this financial
18 mismanagement claim under the same -- with the -- joined
19 with the same pleadings that happen to make malpractice
20 claims? Are you saying that out of the blue, even if your
21 client had lived a totally healthy life and never been
22 denied an immediate appendectomy, that you could bring
23 this claim, and it's a mere coincidence that you happen to
24 be here in the context of this case?
25 MR. GINZKEY: Essentially that's correct, Judge.

1 QUESTION: Okay.

2 MR. GINZKEY: That's correct, because --

3 QUESTION: I didn't realize --

4 MR. GINZKEY: Because --

5 QUESTION: I didn't realize you were making any

6 ERISA claim. I thought you were making State claims, and

7 the reason all of this comes up is that the objection to

8 your Count III and Count IV State claims was that they

9 were preempted by ERISA.

10 MR. GINZKEY: No. We're making an ERISA claim.

11 QUESTION: Where does that appear in your --

12 MR. GINZKEY: It's amended Count III. That's in

13 the joint appendix.

14 QUESTION: Amended Count III.

15 QUESTION: So we've actually -- now, your

16 client's appendectomy is irrelevant, the malpractice is

17 irrelevant, has nothing to do with it, it's entirely --

18 which is -- I mean, and then it's going to come down to

19 either the fiduciary issue, or if you are fiduciaries, we

20 have to figure out what the standard is on what incentives

21 could be so extreme that they violate the obligation to

22 everybody. Is that basically where we are?

23 MR. GINZKEY: That's exactly right, Judge.

24 QUESTION: And what in your view is the standard

25 for determining whether -- because you concede that some

1 incentive plans could be okay, so what's the standard for
2 determining -- and I think the Government concedes that
3 there could be some that weren't okay.
4 MR. GINZKEY: And I agree.
5 QUESTION: All right. I know.
6 MR. GINZKEY: I agree.
7 QUESTION: So now we've got a lot of agreement
8 here, and what we've got to --
9 (Laughter.)
10 QUESTION: What, in your view, is the difference
11 in the standard, then, as to when they're okay when
12 they're not okay?
13 MR. GINZKEY: That's going to be a difficult
14 line to draw. It's kind of like the line that the Court's
15 going to have to draw with respect to the Webster Hubbell
16 case that was argued yesterday. It's going to be a
17 difficult line to draw, but the fact that it's difficult
18 to draw doesn't mean we don't draw it.
19 QUESTION: All right. How would you draw it?
20 MR. GINZKEY: The phrase that I have used is
21 undue influence, because again, drawing on the study from
22 California, the median incentive was $10,400, but some of
23 those incentives got up to $40-$50,000.
24 If I'm a physician, and I have a $100,000 annual
25 salary by contract, and I've got two kids in college, and

1 I can make another $50,000, that's a lot of incentive.
2 That's an improper -- that's an undue influence. That's
3 an improper incentive.
4 CHIEF JUSTICE REHNQUIST: Thank you. Thank you,
5 Mr. Ginzkey. The case is submitted.
6 (Whereupon, at 11:19 a.m., the case in the
7 above-entitled matter was submitted.)
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LORI PEGRAM, ET AL., Petitioners v. CYNTHIA HERDRICH
CASE NO: 98-1949

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BY Ann Mari Federico

(REPORTER)