In the

ORIGINAL

Supreme Court of the United States

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

Appellant,

v.

WILLIAM McCLURE, ET AL

NO. 81-212

Washington, D. C.

Monday, March 1, 1982

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

APPEARANCES:

KENNETH S. GELLER, ESQ., Office of the Solicitor General, Department of Justice, Washington, D.C.; on behalf of the Appellant.

HARVEY SOHNEN, ESQ., Oakland, California; on behalf of the Appellee.

C O N T E N T S

P R O C E E D I N G S

CHIEF JUSTICE BURGER: We will hear arguments next in Schweiker against McClure.

We will just wait for a little bit of clearance here.

Mr. Geller, I think you may proceed when you are ready.

ORAL ARGUMENT OF KENNETH S. GELLER, ESQ.,

ON BEHALF OF THE APPELLANT

MR. GELLER: Thank you, Mr. Chief Justice, and may it please the Court, this case and United States against Erika, the following case, involve challenges to the procedures established by Congress for determining medical reimbursement claims under Part B of the Medicare program.

The Medicare program is divided into two parts. Part A provides insurance for hospital and related post-hospital services, and is fully funded by payroll taxes paid to the federal government through the social security system. Part B, which is involved here, provides a voluntary program of supplementary medical insurance covering in general 80 percent of the reasonable charges for certain other services, primarily physicians' services and such items as medical supplies, laboratory tests, and ex-rays.

Benefits under Part B are financed in part by direct federal government contributions and in part by monthly premiums paid by people who are 65 years of age or older or disabled and who choose voluntarily to enroll in the Part B program.

Under the Medicare statute, the Secretary of Health and Human Services determines whether an individual is eligible to enroll in the Part B program. If the Secretary determines that an applicant is not eligible, the applicant has an opportunity for a hearing before an administrative law judge, and if necessary, to judicial review of that determination.

Now, in contrast to these eligibility determinations, the individual benefit reimbursement determinations under the Part B program are not handled directly by the Secretary. The day to day administration of the Part B program requires a determination of a vast number of individual claims for reimbursement submitted by or on behalf of some 27 million beneficiaries. In 1980 alone, more than 150 million medical reimbursement claims were processed.

When it enacted the Medicare Act in 1965, Congress concluded that a reimbursement program of this magnitude and complexity could be administered most efficiently and conveniently by private insurance

carriers, because these carriers, in conducting their own insurance business, had acquired considerable experience and expertise in determining whether, for example, physicians' services are medically necessary and in calculating the reasonable charge for a variety of medical services in their particular community.

Accordingly, Congress in the Medicare Act authorized the Secretary to enter into contracts with private insurance carriers under which the carriers would determine and pay Part B benefits on a reimbursible non-profit basis. Under these contracts, the carriers receive advances of funds which they then pay to claimants in reimbursement for medical services that are found by the carriers to be covered by Part B, medically necessary, and reasonable in amount.

The contracts also provide for the government to pay the carriers' necessary and proper costs of administering the Part B system. In all of these functions, the carriers act as agents of the Secretary.

Now, the challenge in this case is to the procedures provided under Part B when a claimant is dissatisfied with a carrier's reimbursement decision. Under regulations promulgated by the Secretary, if a claimant does not agree with the carrier's initial decision regarding the amount of reimbursement for

particular services, the claimant may require a review of that initial determination. A review of the entire file is then conducted by an employee of the carrier other than the employee who made the initial determination, and the claimant may submit additional evidence or legal or factual argument in support of the claim at issue.

If after that review determination the claimant is still not satisfied with the carrier's decision, the Medicare Act requires the carrier to hold a "fair hearing" on all claims in which there is more than $100 in controversy. Now, this fair hearing is conducted by a hearing officer appointed by the carrier who cannot have participated personally at any prior stage of the claim. The hearing officer is empowered to inquire fully into the claim at issue. He may examine witnesses and call for additional evidence at the hearing, and the claimant is also entitled to submit additional documents or evidence, examine witnesses, and present argument.

QUESTION: Mr. Geller, does either the hearing officer or the carrier have any financial or pecuniary interest in the outcome of the determination by the hearing officer?

MR. GELLER: No. I hope to develop that point

in a little while. The answer is that if a claim is found to be meritorious, it is paid out of funds that are submitted to the carrier by the Secretary. It doesn't come out of the carrier's own pocket, and the hearing officer's salary is not affected in any way by the decision he reaches at these fair hearings.

QUESTION: You used the term "salary." Are these people salaried?

MR. GELLER: Well, some people -- some of these people are, I understand, full-time employees of the carrier. Most of them are simply independent contractors who are paid on a hearing by hearing basis, although some of them work so often that it approaches a full-time position with the -- with the carrier.

QUESTION: So their only interest -- your opponent argues that they have an interest in getting re-employed over and over again. They are not permanently -- they don't have any kind of tenure.

MR. GELLER: That's -- that's correct, and I assume, and we don't dispute the fact that some of these people may well have that interest. What we dispute is this notion that they increase their chances of being hired and rehired by denying meritorious claims.

QUESTION: Well, Mr. Geller, what is the source of their compensation? Is it the carrier or the

government?

MR. GELLER: Well, they are employed by contracts with the carrier, but what is paid to them by the carrier is considered a necessary administrative expense --

QUESTION: And the --

MR. GELLER: -- and the carrier is reimbursed by the Secretary.

QUESTION: By the government.

MR. GELLER: That's right.

QUESTION: Does that run into considerable -- does that run into much money?

MR. GELLER: Not really. There are only about 100 or 150 hearing officers for the whole country. We are talking about a Medicare program that -- Part B involves more than ten million --

QUESTION: Are there other expenses in addition to the compensation to the hearing officers?

MR. GELLER: Oh, of course. I mean, the hearing officers are an insignificant expense of the total of the entire --

QUESTION: But I mean, for this procedure. I mean, does the carrier get compensated, for example, for --

MR. GELLER: Yes.

QUESTION: -- the rent of hearing rooms and things like that?

MR. GELLER: Yes, I mean, they -- well, normally they would be held, for example, at the attorney's office. Many of these people are attorneys. Let me put into perspective what we are talking about here. There are 158 or in 1980 there were 158 million Medicare claims submitted. As -- Out of that figure, only about two million went beyond the stage of the initial determination by the carrier and went to the review determination stage, and out of that two million, there are only about 26,000 that went to the fair hearing stage. So the administrative expenses of the carriers would be figured on processing 158 or whatever it is million claims, and the hearing officer would only be compensated for conducting a very, very minor percentage of the total Medicare picture, so the administrative expenses that are attributable to the carrier are very, very small.

QUESTION: Mr. Geller, if a person has the job of being a hearing examiner in one of these, what body of law does he look to to decide reasonableness? Is there a body in the private sector of interpreting the same contractual provisions and so forth?

MR. GELLER: Well, the -- this is all laid out

with -- in great detail in the regulations that the Secretary has promulgated and that are published in CFR. The hearing officer has to follow the statute, obviously.

QUESTION: Right.

MR. GELLER: Those regulations. In addition, the Secretary publishes a carriers' manual and the hearing officer handbook, portions of which, by the way, are reprinted in the Joint Appendix, and to which I would ask the Court to turn. And all of those sources explain in great detail to these hearing officers how they are to go about computing the reasonable charge, and frequently it is a -- it is a mathematical computation. They have to take into account things such as the --

QUESTION: Do they take into account the same kind of things they would take into account if it were simply a private --

MR. GELLER: Yes, well, one of the things -- Yes. One of the things that the hearing officer has to take into account is the carrier's particular charge in his own -- in its own private insurance --

QUESTION: Well, then, doesn't the carrier have an interest because of its possible impact on its private operations in how certain contractual provisions

are construed, or how certain reasonable determinations are made?

MR. GELLER: Well, the carrier's private business serves as a ceiling beyond which a Medicare payment cannot be made, so there is no reason to think that -- it is not a floor. There is no reason to think that the carrier in its private business would be hindered or in any way encouraged to do anything --

QUESTION: Yes, but wouldn't it be interested in having precedents establish the fair and reasonableness of the ceilings it has used in its private business?

MR. GELLER: No, the hearing officer has to take into account in determining the reasonable charge the same sorts of things that the carrier takes into account in his private business.

QUESTION: Right.

MR. GELLER: For example, the physicians' customary charge, the prevailing charge in the community. Now, after the hearing officer has done all of that, the fact is, he still under the statute cannot pay anything more than the carrier itself would pay for the same sort of claim in its private insurance business.

I think there is an important point to be made here. We can't lose sight of what the district court

found to be the due process violation, and what the district court advanced as the remedy for that due process violation. How reasonable charge is figured, including the fact that the reasonable charge can't be more than what the carrier pays in its private insurance business, is in the statute and in the regulations. The administrative law judge that the district court has ordered appointed in all of these cases would have to follow those exact same procedures in figuring out what the reasonable charge is, so there is no reason to think that because the hearing officer is appointed by the carrier, that that introduces an institutional bias into the system. The -- how reasonable charge is computated is not something that the carrier decides. It is in the statute and it is in the Secretary's regulations.

Now, this case is a nationwide class action brought on behalf of persons whose claim for reimbursement under Part B was denied in whole or in part by a carrier hearing officer. The district court agreed with the plaintiffs that the Part B hearing procedures established by Congress violate the due process clause of the Fifth Amendment. In the district court's view, Part B beneficiaries are entitled under the Constitution to have final determinations with respect to their claims for reimbursement of medical

expenses made by hearing officers who are totally independent of the carriers that administer the Part B program, and the district court gave essentially two reasons for suspecting that the carriers' hearing officers were not and could not be impartial.

One was this notion that Justice O'Connor alluded to earlier, that perhaps the hearing officers have some financial interest in the decisions that they make, and the second reason that the district court gave was what the district court termed the hearing officer's "vicarious involvement in the claim." By that the district court meant that the hearing officer works for the carrier that has twice before denied the claim, and the notion is that the hearing officer might be reluctant to overturn a decision made at two previous levels of the carrier.

What the -- Based on these conclusions, the court struck down the review provisions of the Part B Medicare program, and ordered that the Secretary afford the right to a de novo hearing before an administrative law judge in the Department of Health and Human Services to every person whose Part B claim was denied in whole or in part by a carrier hearing officer after May 1, 1980, provided that the amount remaining in issue is at least $100.

Now, the government has taken a direct appeal to this Court under 28 USC 1252 to challenge this extraordinary holding of the district court. The district court has declared unconstitutional the specific procedural mechanism devised by Congress to deal with a massive medical insurance program involving, as I said, some 27 million beneficiaries, nearly 200 million in this fiscal year, individual claims for reimbursement, $10.5 billion worth of benefits, and in its place, the district court has ordered the Secretary to establish an administrative review system within the Department of Health and Human Services that Congress expressly considered and rejected.

Now, in reviewing this decision, we believe it is important for the Court to keep in mind that the district court in finding a violation of the due process clause did not point to anything in the Medicare statute or the Secretary's regulations to suggest that the fair hearings offered to Part B claimants by the carriers denied claimants a meaningful opportunity to be heard.

Moreover, the district court did not point to any evidence drawn from the accumulated experience of carrier-conducted hearings in scores of thousands of cases over the last 16 years to demonstrate that Congress and the Secretary were wrong in believing that

carriers could be relied upon to conduct appropriate hearings on these very small claims.

QUESTION: Tell me, Mr. Geller, are there any other models of this type of thing?

MR. GELLER: Models?

QUESTION: This -- letting this sort of thing be done by private judges?

MR. GELLER: I don't -- there may not be any models, but I am not sure there are any models for the Part B Medicare program to begin with.

QUESTION: Yes, I know.

MR. GELLER: I think what Congress had in mind was to sort of parallel and to create as minor an inconvenience as it could for the health care industry when it set up the Part B program, and therefore it assumed that the best way to process these millions and millions of claims was to delegate that authority --

QUESTION: So in that sense, this is an original, isn't it, this kind of procedure?

MR. GELLER: Yes, it is, but -- but my point is that it is not simply the review procedures that are unique. The whole Part B Medicare program is unique, and I think that the review procedures have to be viewed in the context of what Congress was trying to do in setting up in 1965 this entirely new and unique program.

QUESTION: To what extent is it significant that you have two problems here? One is the carriers appointing the hearing officers, and secondly, no right of review thereafter, judicial review or other type review. Is that significant, that you have both alleged problems?

MR. GELLER: The -- Well, in this case, there is only one alleged problem. The plaintiffs have not challenged the absence of judicial review under the statute.

QUESTION: But do we have to look at that and focus on that in weighing the validity of this --

MR. GELLER: I think -- I think the Court, in considering this case and in considering the Erika case, has to, in adjudicating the plaintiffs's claims in each of those cases, consider the entire program, and I think that it would be appropriate in considering whether procedural fairness has been met here, to consider the fact that Congress has not allowed for judicial review, but I think it is important to keep in mind that the Court has to find that the administrative process violates due process. It is not simply enough to sort of merge everything together and say, well, it probably is procedurally proper, but it is close to the line, and since there isn't judicial review, we are somehow going

to restructure the administrative process.

I don't think that the courts have any power to restructure the system that Congress has devised unless they find that the system in some specifically articulated way violates elementary due process, denying the claimant the meaningful opportunity to be heard, or not an impartial decision-maker. I don't think that the Court will be able to identify any aspect of the Part B hearing system in this case that falls below minimal standards of due process.

It is important to emphasize, as Justice O'Connor asked me earlier, that neither the carriers nor the hearing officers have any direct or indirect pecuniary interest in the outcome of the case. The carriers administer the Part B program in their particular locality on a non-profit basis.

QUESTION: Why do they do it, Mr. Geller?

MR. GELLER: Well, there was testimony as to that in the record, and one of the people who is, I think, an officer of the Occidental Life Insurance Company, testified that they do it essentially for two reasons. One is, it is very good public relations, because millions and millions of benefit checks are sent out with the insurance company's name on them. And the second reason that was given, a more substantive one, is

that it helps the insurance companies achieve economies of scale, because they can integrate their private insurance business for -- I assume for purposes of computerization, for example. They can rent a larger computer, and they can achieve economies of scale.

I am not sure it is -- I think -- we don't -- we don't deny the fact that carriers, insurance carriers would like to be part of the Part B program, but if any inference can be drawn from that, it is not the inference, I think, that the plaintiffs draw, which is that they would seek at every turn to deny meritorious claims. I think if any inference can be drawn from the fact that carriers would like to be part of the Part B program and would like to have their contracts renewed by the Secretary --

QUESTION: Well, isn't it possible -- I don't know if this is true or not -- to infer that they may want to be sure that the decisions are consistent with the way their private business operates, that they do have an interest in consistency, not in outcome in any particular case?

MR. GELLER: Well, I think the --

QUESTION: That they always treat claims for -- we have dialysis in the next case. They want those always resolved according to the same standards.

MR. GELLER: Well, except that they are obliged by the contract they sign to follow the standards that Congress and the Secretary --

QUESTION: But which in turn refer back to the ones they use themselves, as I understand it.

MR. GELLER: Well, on reasonable charge, but not, for example, on what, for example, is covered by the Part B program, or what is a medically necessary --

QUESTION: But aren't most of these questions reasonable charge questions?

MR. GELLER: Yes. Yes, but still, it doesn't seem to us there is any incentive on the part of any carrier to deny a meritorious claim. It would seem that if they want to continue to be part of the Part B program, if they wanted to have good public relations, they would be scrupulously fair. In fact, if any, as I was saying, if any inference can be drawn from this desire to maintain -- to be part of the program, it might be that they would -- they would grant benefits in non-meritorious claims, in order to have the benefit checks go out with their name captioned on them.

QUESTION: Well, but then they would have to grant non-meritorious claims in their private business, too, to be consistent.

MR. GELLER: Not necessarily. I mean, many of

these cases are very, very fact-bound, and there is no record kept. They are not precedents in which they could go back and look and see what they did in a similar situation in 1978. Even the plaintiffs have not alleged, and believe me, the plaintiffs have conjured up every conceivable, imaginable way in which the carriers or the hearing officers might violate their solemn duties. Even the plaintiffs have not suggested that the carriers might do that.

Now, the district court acknowledged that the hearing officer's fee in connection with a given case is unaffected by the decision he reaches in that case, but the court speculated that the hearing officer has a pecuniary interest in "currying the carrier's favor" by ruling against the claimant, because the hearing officer's future income might somehow be affected by how often the carrier decides to call upon his services.

This concern again strikes us as totally unrealistic and fanciful, and certainly -- this is an important point -- is an insufficient reason to strike down a federal statute. First, as I noted earlier, the carrier has no financial personal interest in how a claim is decided. In addition, and perhaps more important, there was no evidence in the record that a carrier had ever engaged in conduct so improper as to

terminate or substantially alter its relationship with a hearing officer based upon how that hearing officer was deciding particular claims in favor of Part B claimants.

In fact, the HHS official who is responsible for monitoring the Part B hearing process testified that he didn't know of any instance in which such conduct had ever occurred or even been alleged. In fact, there was no evidence in the record that a hearing officer had ever been fired by a carrier for any reason.

Quite apart from the lack of factual support for the district court's conclusion, we submit there is no support for it in logic. To the extent that a carrier wishes to ingratiate himself -- itself with the Secretary in order to maintain its Medicare contract, or to the extent that a hearing officer wishes, to use the district court's terms, to "curry favor with a carrier," we submit that they would have an exceedingly strong incentive to correctly determine the amount of every Part B claim, and to pay every meritorious claim to the full extent required by statute.

That, of course, is the carrier's contractual obligation, and the Secretary could terminate the contract of any carrier that failed to satisfy that obligation. In fact, the Secretary carefully monitors the performance of the hearing officers and the carriers

in general in at least four different ways, perhaps the most important of which is that every three months, the carriers must send to the Secretary 10 percent of their hearing decisions, determined on some random basis based on the claimant's social security number, so that every -- and they must send at least one hearing decision from every single hearing officer, so that allows the Secretary to determine how the process is actually working and how each hearing officer is adhering to the carriers' handbook and the hearing officers' manual.

QUESTION: But doesn't the record reveal that is a pretty cursory review, Mr. Geller?

MR. GELLER: I don't believe that the record reveals that, Justice Blackmun, and that is only one of four ways in which the -- the hearing officers' and the carriers' carrying out of their contractual obligations are monitored. There is also an on-site representative at every one of these carriers, and he frequently will monitor a hearing officer -- a hearing being conducted by a hearing officer.

In addition, there is an annual contractual review system whereby the Secretary sends a fairly lengthy, and the record contains at least one of these, a fairly lengthy critique of how the carrier is doing during that year, and will often have suggestions.

And finally, there is evidence in the record that even on individual cases, in response to a particular complaint, the Secretary will review a hearing officer's decision.

QUESTION: Mr. Geller, while I have you interrupted, this went out for summary judgment against the government?

MR. GELLER: Yes.

QUESTION: Is it your position that you are entitled to summary judgment --

MR. GELLER: Yes.

QUESTION: -- or do you merely want it to go back for --

MR. GELLER: No. It is our position that we are entitled to summary judgment, because there is nothing on the face of the statute and the plaintiffs have not suggested any lines of factual inquiry that could lead a judge to conclude that the Part B system violates due process.

I might add that there -- there were a great amount of evidentary materials submitted here, both depositions and answers to interrogatories, that were submitted to the district court both in favor of and in opposition to the plaintiffs' motion for summary judgment.

QUESTION: Well, in the mind of the district court, would a right to appeal to the Secretary cure the entire problem?

MR. GELLER: Yes, and that is what the district court has ordered, which is --

QUESTION: That would cure all the possible bias in the case?

MR. GELLER: Apparently, that is what the district court thought, although there is a line of cases in this Court, such as Ward versus Village of Monroeville, which seems to suggest that if there is a bias at some sort of adjudicatory level, it is not cured by having a de novo level of review on top of that.

QUESTION: Even judicial review?

MR. GELLER: Even judicial review. That's right. That is what was involved in a case like Ward, but the district court here thought that that would solve the problem, which I think comes back, once again, to the fact that the district court simply had some vague unease about how -- the way the system was working, but he could not really point to any evidence of any particular unfairness. In fact, he went out of his way in the district judge's opinion to praise the actual conduct of the hearing officers.

QUESTION: Well, the district court didn't

suggest that if there were some review by the Secretary, then the Secretary's review in turn was subject to judicial review, did it?

MR. GELLER: No. No. In fact, the district court, as I recall, pointed out that no one had challenged the judicial preclusion provisions of the Part B Medicare Act.

Therefore, I don't think there is any reason to believe that a carrier would jeopardize its relationship with the Medicare program by exerting influence on a hearing officer to deny an otherwise meritorious claim, or that a hearing officer would act in that unseemly fashion on his own in the belief that it would somehow place -- please the carrier and make it more likely that he would be hired as a hearing officer in the future.

Exactly the opposite is the case. The hearing officer and the carrier have every incentive to be scrupulously fair.

If the Court has no further questions, I would like to reserve the balance of my time.

CHIEF JUSTICE BURGER: Mr. Sohnen.

ORAL ARGUMENT OF HARVEY SOHNEN, ESQ.,

ON BEHALF OF THE APPELLEES

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

please the Court, this case presents two issues. The first issue is whether the due process rights of Medicare claimants are violated when the hearing officers who make final, unreviewable decisions on claims appeals serve at the pleasure of the insurance companies that have denied the claims. The second issue is one of the remedy, whether the appeal ordered by the district court to the Secretary is the appropriate remedy.

Counsel has made a number of comments about evidence in this case, and I think it is important to understand that the standard that this Court has recognized about the requirement of a fair tribunal is that our system of justice seeks to avoid the possibility and even the appearance of bias, and thus the standard is one of whether the circumstances presented pose to the average man sitting as a judge a possible temptation not to decide fairly.

It is important, therefore, that we grasp the critical facts of this complex program to understand why in fact carriers do have a direct financial interest in the outcome of Medicare claims, and why it is not an extraordinary exercise of the imagination, as counsel has stated, to so find.

As Justice Stevens commented, there is a very

close connection between policy decisions that are made with respect to the private carriers' own claims and to their functions as Medicare contractors. In fact, whether they are holding a Medicare contract or administering their own private plans, they have the same dual mission. First, they are to protect the funds of their policyholders, or in the case of Medicare, federal funds, and secondly, they are to honor the claims benefit -- the claims decisions -- excuse me, the claims that are submitted to them under a prudent and cautious interpretation of their policies.

If the carrier treats federal funds less cautiously than its own, its own financial interest is jeopardized, as the Secretary has the option not to renew a carrier's contract, which is only for a one-year term, without a showing of cause. Thus, the statute mandates carriers to treat Medicare claims in essentially the same manner as if it were their own money being spent.

In addition, it is important to understand that there is a very straightforward way in which carriers have a direct financial stake in the outcome of Medicare claims decisions. This is through supplemental private policies for the elderly, commonly known as Medigap insurance. These supplemental policies have

become more needed as medical care costs have gone up and as the differences between actual costs of care and Medicare reimbursement have increased.

Medicare carriers, as counsel has indicated, have the name recognition that accompanies their names going out on thousands of checks to the beneficiaries. This name recognition gives them a competitive advantage in obtaining business under the Medigap programs. Thus, and in fact, the Secretary's relationship with the carriers does not deny the existence of the Medigap programs, but in fact in Article 24 of the contract, which appears in the record, the carrier specifically authorizes the -- the carrier is specifically authorized to integrate its Medicare and Medigap claims processing.

This leads to an inevitable financial stake for carriers in the outcome of Medicare claims, since when the carrier pays less on a Medicare claim, the result is that there is less paid on the Medigap claim. This happens because Medicare does not pay the actual charges for covered services, but only what a carrier determines to be an allowed charge. Assuming a deductible when a claim has been met, Medicare pays 80 percent of an allowed charge, and Medigap pays 20 percent. The supplemental plan, or Medigap plan, is not

liable for the difference between the allowed charge and the actual charge, which is ordinarily picked up by the beneficiary.

Thus, and similarly, when a carrier is holding a Medigap policy and the issue is one of medical necessity, if there is a determination that the procedure is not medically necessary under Medicare, that also means that the Medigap policy does not -- does not cover the claim. Moreover --

QUESTION: Mr. Sohnen --

MR. SOHNEN: Yes.

QUESTION: -- the other side of that coin, I suppose, is that the individual has a remedy in court for the 20 percent claim, doesn't he?

MR. SOHNEN: Well, the way the contracts are written, the Medigap contracts simply refer to what Medicare has decided, so that ordinarily under a private plan which had no connection with Medicare, there would be the right of review by arbitration or the courts, but here, the Medigap plans simply refer to the level that is set by Medicare.

QUESTION: I see. By its terms, it is measured by what is allowed as reasonable under Medicare?

MR. SOHNEN: That's right.

QUESTION: I see.

MR. SOHNEN: And this is -- this is the problem that is at the heart of this system, because in their private operations, the carriers do not have to make the final review of their own claims. If they are striking -- if they make an error in striking the balance between the interests of their stockholders on the one hand and the interests of the policyholders, these questions are referred to arbitration and the courts for independent review, yet under the Medicare statute, there is no independent review, and the carriers are essentially required to police themselves in this manner, notwithstanding the fact that they have no experience in conducting hearings that comes from the normal course of their business outside of Medicare.

QUESTION: Well, they have had -- How many years of it have they had now?

MR. SOHNEN: Well, Your Honor, there are new -- there are new carriers being contracted all the time. There are some carriers that --

QUESTION: Well, what about an old one?

MR. SOHNEN: Well, the -- I would -- I would agree that the experience of the carriers varies. However, they cannot draw on their private business --

QUESTION: Well, what about this one?

MR. SOHNEN: Well, this is -- this is a

nationwide class action, so this concerns all, all the carriers. Blue Shield of California, which was a named defendant, has been with the Medicare program since its inception, and I think that the -- the facts pertaining to Blue Shield show that just having a long experience with the Medicare program does not provide independent review. Of the seven hearing officers who work for Blue Shield, four of them are retired Blue Shield employees, one of them has a current -- a current consulting contract, and one of them there was no information about. So, we -- we think that the facts of the relationships between the hearing officers and the carriers presented an extreme picture.

QUESTION: What remedy did you ask for in this case?

MR. SOHNEN: The remedy we asked for -- we presented one remedy. Actually, we -- Our position was that there were two alternative remedies that would satisfy constitutional standards. The one that the court chose, and one that might have been --

QUESTION: Why is review by the Secretary going to cure the bias? I mean, this -- Why is that?

MR. SOHNEN: Well, because it will be de novo review. If --

QUESTION: You mean, a new hearing?

MR. SOHNEN: Yes. Our concern is that anything short of de novo review would not provide protection from biased findings of these hearing officers.

QUESTION: Is that what -- Is that what the district court, you think, granted you?

MR. SOHNEN: Yes. The judgement specifically refers to a de novo hearing to be provided by the Social Security Administration.

QUESTION: Was there any consideration given to the added cost that the district court's judgment would impose on this structure?

MR. SOHNEN: Well, we take -- we take the position that a fair hearing costs no more than an unfair hearing, because what we are -- what we are questioning in this case is not the whole procedures of the Medicare program, or even the whole procedures of the appeals process, but simply the identity of these hearing officers who cannot provide independent review, and the remedy that -- one of the remedies that we proposed --

QUESTION: But in Goldberg against Kelly --

MR. SOHNEN: Yes.

QUESTION: -- the Court said, some ten or twelve years ago, that just so another person was having

a look at it was sufficient to satisfy due process.

MR. SOHNEN: Hearing officers in the Medicare program are not simply reviewing the decisions of other employees who have clerically processed the claim at the initial stage. They are reviewing all decisions of the carrier, including decisions of management as to policy matters, as to claim -- as to how claims are handled generally, so this is not a situation where we simply have -- we can solve the problem by making sure there has been no personal involvement. The carriers are connected with the hearing officers by the way that the selection, training, and employment relationship works, and I think it is important to understand the critical facts about why independent review is impossible in connection with the hearing officers and the -- and the carriers.

First of all, the carriers have complete control over the selection of hearing officers. The Secretary does not review the selection decisions for these positions, and in fact its role is limited to issuance of general guidelines which are lacking in specific criteria for these positions.

Thirdly, the carriers are free to recruit hearing officers in any manner they please, such as by word of mouth, with the result that many hearing

officers, such as in the case of Blue Shield of California, are current or retired employees of the insurance company.

Hearing officers, as was noted, are generally appointed on a hearing by hearing basis, and have no tenure whatsoever in their jobs, or any guarantees that they will be called in for a future hearing. Thus, the carriers can sever their relationships with the hearing officers without stating cause, and it is implicit in this relationship that hearing officers have no real protection against retaliation.

QUESTION: Counsel --

MR. SOHNEN: Yes.

QUESTION: -- was there any evidence, though, that there was actual bias involved on the part of the hearing officers?

MR. SOHNEN: It is our position that we don't -- we don't identify actual bias in the record. It is our position that --

QUESTION: And there was no evidence of it? Your answer is no?

MR. SOHNEN: Yes. In our position, the standard of this Court is whether there is a possible temptation for -- for biased decision-making.

QUESTION: Was there any evidence in the

record to explain why an administrative law judge employed by the Secretary would make fewer presumably erroneous decisions than the hearing officers?

MR. SOHNEN: Yes. First of all, I -- I want to focus that the constitutional issue presented in this case is not whether a lawyer has to be the final decision-maker in a case, but it is whether independent review is necessary, and there was substantial evidence in the record that there were erroneous decisions that were not being corrected. In one of the annual contractor reviews that appeared in the record, there were notations indicating that the Secretary was finding a higher degree of mistakes than the carrier was in its own reviews.

And I think that given the complexity of the Medicare program, and the wide range of issues, the fact that there were no selection criteria in any meaningful sense except for what the carriers wanted, I think it must be assumed that some -- some review by a body which has some knowledge of the law would decrease the risk of erroneous deprivation.

QUESTION: But you are asking us to decide that, or the district court decided it on the basis of assumptions rather than evidence?

MR. SOHNEN: No, there was -- there was -- the

evidence in the record showed -- some of which has been included in our Joint Appendix, showed an extremely high error rate of processing claims in the Medicare program.

QUESTION: Well, it showed, did it not, that perhaps the hearing officers were granting as many as 50 percent of the claims that came before them?

MR. SOHNEN: There was -- there was that evidence, but there was also evidence indicating that the Secretary's own staff viewed those statistics as being distorted. There was evidence that these statistics fluctuated according to technical variations in the carriers' policy as to when they conducted a -- when they resolved matters at the review stage as opposed to the hearing stage. More importantly, these statistics mix corrections of computer type errors, which abound, with substantive decisions where the carrier's policy was at stake. And finally, any modification whatsoever in the amount of the claim, whether for 50 cents or some other small amount, would be counted as a reversal under the way the statistics were kept.

QUESTION: Mr. Sohnen?

MR. SOHNEN: Yes.

QUESTION: In responding to Justice O'Connor's question, it seems to me you are arguing as though you

had prevailed after trial and gotten a judgment or a verdict below, and simply saying there is evidence to support the verdict, but as I understand, it went off on summary judgment, so that any point of disputed evidence would be resolved against you.

MR. SOHNEN: We think that the -- the constitutional issue in this case is whether there is a right of independent review, and the relationships that prevent an independent review are undisputed, and appear in the face of the statute essentially as I have described. The training, the selection, lack of job security, lack of review, all those factors were undisputed in the factual record. There may have been certain facts that were subject to different interpretations, but --

QUESTION: Mr. Sohnen, in the --

MR. SOHNEN: -- but in terms of the -- yes.

QUESTION: In the next case --

MR. SOHNEN: Yes.

QUESTION: -- concerning the court of claims jurisdiction, if this Court should rule there that there is jurisdiction in the court of claims, are your concerns alleviated?

MR. SOHNEN: No, they will not be, Your Honor.

QUESTION: Why?

MR. SOHNEN: As I indicated in response to Justice White's question before, something short of de novo review does not cure the problem of biased decision-making. The court of claims has indicated that if its -- as it sees its jurisdiction under the Tucker Act, it would be for a review of an extremely narrow scope.

QUESTION: On the record.

MR. SOHNEN: Well, even narrower than that.

QUESTION: Oh, really?

MR. SOHNEN: I believe that it would be -- it would be limited to questions of constitutionality and questions of statutory interpretation. Thus, erroneous findings of fact and applications of the law to the facts would not be reviewable, and these are so many of the cases that we have before us.

For example, Mr. McClure's case involved -- Mr. McClure was a resident of a remote community in northern California. He suffered a heart attack. His physician in that community felt that immediate surgical intervention was necessary to save his life. He therefore concluded that a facility in San Francisco was the nearest appropriate place for him -- for him to be treated, and he went -- he was sent to San Francisco. His life was saved. But when he submitted his claim for

an air ambulance under Medicare, despite the fact that there was no evidence indicating that his doctor's physician -- his physician's testimony -- his physician's opinion was incorrect, the Medicare hearing officer decided that there was a closer appropriate facility.

Now, that is the type of case that would never be reviewable in the court of claims under the jurisdiction that they have asserted.

QUESTION: I am trying to sort out to what extent you are claiming bias taints this result, or whether it is just general incompetence, just the general chance of arriving at unsound conclusions.

MR. SOHNEN: I think that -- I think the gravest concern about this system is the fact that no independent review is available, and the fact that --

QUESTION: Well, I know, but --

MR. SOHNEN: Yes.

QUESTION: -- that doesn't answer my question.

MR. SOHNEN: Well, I think I can respond to your question with a followup to that, which is that the fact that the competence of these hearing officers is determined as part of this close relationship between the hearing officer -- between the carrier and the hearing officers aggravates the fact that there is a

concern about bias.

QUESTION: Well, if all the insurance carriers involved in this program together created a pool of hearing officers who didn't work for any of them and never had, gave them some -- the same amount of training that they have gotten now, and drew them by lot, would you be here or not?

MR. SOHNEN: Well, the question that poses is what would be necessary to ensure independent review.

QUESTION: Well, would independent review be required in that -- on those facts? If it is, it must be your objection is basically that this is just an unsound way of deciding cases.

MR. SOHNEN: I think that the -- if a system as you have described assured that a hearing officer was insulated from the carrier whose decision he was reviewing, both in terms of the selection process, which now leaves --

QUESTION: Yes.

MR. SOHNEN: -- there is an extremely close connection, and the job security aspects --

QUESTION: Well, suppose it was.

MR. SOHNEN: Yes. And with -- with some input from the Secretary about qualification, I -- I think that that would be of the nature of independent review.

It is hard to assess such a plan without facts, but I think the essence of independent review turns on the --

QUESTION: That would eliminate a good deal of the so-called bias.

MR. SOHNEN: Yes, if -- if the -- if the individual policies of carriers was -- did not affect the ability of the hearing officers to make decisions, that would be the type of remedy that would reduce the risk of bias.

QUESTION: Mr. Sohnen, what are you arguing other than the possibility of bias?

MR. SOHNEN: Well, we also -- the other issue --

CHIEF JUSTICE BURGER: You can ponder on that. We will take it up at 1:00 o'clock.

(Whereupon, at 12:00 o'clock p.m., the Court was recessed, to reconvene at 1:00 o'clock p.m. of the same day.)

AFTERNOON SESSION

CHIEF JUSTICE BURGER: You may continue, Mr. Sohnen.

ORAL ARGUMENT OF HARVEY SOHNEN, ESQ.,

ON BEHALF OF THE APPELLEES - CONTINUED

MR. SOHNEN: Yes. May it please the Court, in answer to Justice Marshall's question prior to the break, what this case poses is not simply the issue of the possibility of bias, but the extent of the constitutional requirement for a competent and independent review of Medicare claims to protect the integrity of that program, and for that reason I would like to elaborate on my answer to Justice White's hypothetical.

If carriers are given the ultimate responsibility for making decisions on Medicare claims, we still have the problem of the interweaving financial interests between the carrier's own policies and the Medicare program, and in addition, any -- any new program of that nature would certainly involve costs that are -- that are not currently involved.

In our -- It is our position that a fair hearing in the first instance is possible in the Medicare program at no extra cost. There was evidence in the record that the cost of administrative law judge

hearings is essentially the same as the cost of these hearings conducted by insurance company appointees that we have been challenging.

QUESTION: Mr. Sohnen --

MR. SOHNEN: Yes.

QUESTION: -- may I interrupt with a question on cost? Does the record tell us how big -- what the dollar amount involved in the typical claim is of this type?

MR. SOHNEN: Yes. The record indicates that the -- the average is approximately $600. About two years ago is the latest statistic. Of course, these -- the amounts range from the minimum of $100 to the costs of major surgery.

So, it would be our position that rather than creating a new structure that is still in the hands of the carriers, the fairest, most economical method would be simply to replace the current system with --

QUESTION: Well, if you are right, if you are right, why, it seems to me that you really ought to move all of the processing out of the private hands, because an awful lot of people don't request hearings, do they?

MR. SOHNEN: That's true.

QUESTION: The great bulk of them.

MR. SOHNEN: Yes.

QUESTION: And you must -- you must -- if hearing officers are biased, I would think the -- the prehearing officer processing is even more biased.

MR. SOHNEN: Well, I would respectfully disagree. The --

QUESTION: Well, why -- Why would --

MR. SOHNEN: Yes.

QUESTION: Why should people sit still for that?

MR. SOHNEN: We are not objecting to the expertise of the private sector in processing these claims --.

QUESTION: Or their non-bias? Is that it?

MR. SOHNEN: We -- we do -- we do feel that there is a financial interest, as we have stated, that prevents fair decision-making. The issue here is not --

QUESTION: Well, then, with respect to -- I would think you would say with respect to people who don't request hearings, too.

MR. SOHNEN: We don't think that the Constitution requires that people have to demand a hearing. If they are not asking for a hearing, perhaps the matter has been resolved satisfactorily.

QUESTION: Do I correctly remember that you said there were 158 million claims a year?

MR. SOHNEN: That's correct.

QUESTION: So then how many of them go to hearing?

MR. SOHNEN: About 26,000. So the issue in this case is much narrower than the -- than the Congressional judgment --

QUESTION: How about all those other people?

MR. SOHNEN: Yes.

QUESTION: I would think you would think they had been treated even worse, the ones who accept their -- the way the claim is disposed of by the carrier.

MR. SOHNEN: I think that we have to draw a distinction between the choice of Congress to -- to place the administration of a massive system of this nature in the hands of the private sector and this very original characateristic of this program whereby the final decisions are also placed in the private sector, and it was this originality that I believe Justice Brennan referred to --

QUESTION: Well, there are an awful lot of people with an average claim of $600 who think they are being jobbed but who can't possibly afford to contest it.

MR. SOHNEN: Yes, and --

QUESTION: Why don't you urge -- The whole thing ought to go under the government, shouldn't it?

If you are making really any sense?

MR. SOHNEN: I think that there is -- in our -- in the history of governmental operations, there has been a great deal of experience with using the competence of the private sector. What distinguishes this case is that the final say is in the private sector. This is what is so distinctive about the case, and in fact, it is not just the district court that has noted this, but also the National Commission on Social Security reviewing this Act, as it is charged to do by Congress, the American Bar Association, in its amicus brief --

QUESTION: Mr. Sohnen --

MR. SOHNEN: Yes.

QUESTION: -- you would take the same position, I take it, if there were no appeal procedure at all. You would say that would be equally unconstitutional?

MR. SOHNEN: Well, that issue isn't presented in this case, because there is a statutory right to appeal.

QUESTION: Well, there is a statutory right to have the carrier take a second look at the problem. I mean, it is not like -- there is no statutory right to appeal to an independent -- to an independent

decision-maker, though.

MR. SOHNEN: Well, the statute does say, a fair hearing, and we would --

QUESTION: Well, then, Congress knew exactly what it meant by a fair hearing. It is the fair hearing prescribed by statute.

QUESTION: And could it not be reasonably said that out of the 158 million claims, 157,900 of them apparently were satisfied with the result.

MR. SOHNEN: Well, in fact, I think --

QUESTION: At least that is arguable, is it not?

MR. SOHNEN: I think that there was evidence in the record that indicates that there are many reasons why people don't appeal. In fact, a study was done of beneficiary appeals which appears in the Joint Appendix which indicates that the low appeal rate reflects the age and infirmity of the Medicare claimant. So, I think that -- and also the dollar amounts that were involved.

QUESTION: Well, is it unreasonable -- is it unreasonable to -- for someone to argue that this suggests that this practical solution is working out pretty well, as Congress anticipated that it would and said that it should?

MR. SOHNEN: I think that in any system there

is a mix of different kinds of cases, different -- and different concerns. The Medicare system is distinguished by the wide range of issues that are covered, and so -- and it also -- and it is also important to note that the 27 million individuals in this system are elderly for the most part, or disabled, and that the kinds of claims in their very nature often don't lead to extensive litigation.

As I was indicating before in my response pertaining to the Erika decision and the idea of review in the court of claims, there are certain -- there are some kinds of cases that simply don't generate massive litigation, but to -- but to draw the inference that a system is completely fair because -- because it is not used is, I think, a not completely wise position.

I think, if I could continue with the -- the statement -- my concerns about the originality of this system, the experience of our system with private boards, private operations of this kind has always allowed a wide scope of review. The Medicare system, which allows no review from the insurance companies, is to be contrasted with private occupational licensing boards, where there is extensive judicial review.

For example, in the case of Gibson versus Berryhill, which was the Alabama Optometry Board, that

is a case in which there were bias concerns about the tribunal, and the tribunal was struck down notwithstanding the fact that there was extensive judicial review.

So, in a system, as here, where we have given the carriers not only the first say, but the last say in deciding claims, grave constitutional problems arise.

Thank you.

CHIEF JUSTICE BURGER: Very well.

Do you have anything further, Mr. Geller?

ORAL ARGUMENT OF KENNETH S. GELLER, ESQ.,

ON BEHALF OF THE APPELLANT - REBUTTAL

MR. GELLER: Just a few things, Mr. Chief Justice. First, the statistics show that approximately 50 percent of the claims that are submitted to the hearing officer are reversed, and that statistic, contrary to the suggestion of the plaintiffs this morning, we do not for a minute suggest that those statistics, which have held fairly constant over several years, are in any way distorted or don't reflect realities. They also don't reflect computer coding errors, which is what the plaintiffs suggested this morning. Most of those sorts of errors are caught at the review stage, which is the second stage of the review.

And finally, they don't reflect reversals where only about 50 cents is involved, which is another statement that the plaintiffs made this morning. The statistics in the record, which are printed in the Joint Appendix, show that the average amount at issue, the average amount that is reversed at these hearings is about $200, which is a very substantial amount when, as my opponent just answered in response to Justice Stevens' question, the amount at issue in any of these hearings total is about $600, and even that overstates the actual amount of each claim, because claims can be aggregated over a six-month period.

So, we think that these statistics don't show any timidity on the part of hearing officers to reverse when they think that the claim is meritorious.

QUESTION: Mr. Geller, does the record tell us how much these hearings cost, how much they pay the hearing examiners?

MR. GELLER: Yes, well, the record does. I think it varies. There are various estimates, because of the manner of allocating, but it was several hundred dollars. In fact, that is one of the reasons why Congress in 1972 put in -- put in this provision only requiring a fair hearing when more than $100 is involved, because there was evidence that the hearings

were costing more than $150, and people were requesting hearings --

QUESTION: Is there any danger that the hearing examiners might have a policy that if they are not going to recover -- if they -- it might be cheaper to pay them $200 than to go ahead with the hearing, to save everybody money?

MR. GELLER: Well, that would be a decision for Congress to make. It wouldn't be a concern of the -- of the hearing examiner. Congress --

QUESTION: I mean, they might shorten a lot of hearings --

MR. GELLER: Well, perhaps. Perhaps --

QUESTION: -- instead of spending two or three days arguing about something, you know.

MR. GELLER: -- that would be a good reform for Congress to --

QUESTION: And it is rather strange, because a 50 percent reversal rate, I can't -- that is a very strange --

MR. GELLER: Well, it is not really that strange when you consider that the earlier stages of review are just on paper. A lot of these cases, about two-thirds of these cases are reasonable charge cases. The hearing officer is the first person actually to sit

down face to face with the claimant and perhaps his physician and actually understand why a particular charge was made. So, it is not at all peculiar that at this level of review there would frequently be a different --

QUESTION: What would you mean, say reverse -- you mean reversal, or you mean just there is a different decision?

MR. GELLER: A different -- a different decision.

QUESTION: It might have increased it by $10.

MR. GELLER: Well, the average reversal, as I just said, was about $200. Now, I hate to get into this whole Medigap business, but --

QUESTION: It also occurs to me, if the physician is normally a necessary witness at these hearings, as to the reasonableness issue, that probably explains why there are an awful lot of cases that are not appealed, because doctors do not come that inexpensively.

MR. GELLER: Well, the physician is not always a necessary witness, and in fact the record shows that there is never any problem in getting the physician to show up when he is requested to show up. In fact, a lot of these cases are assignment cases in which it is the

physician that is actually taking the appeal, and not the beneficiary.

Now, if I could just for a minute talk about this Medigap question that the plaintiffs raised, because once again it raises the specter which seems to pervade their entire presentation that there is some sort of sinister force at work here, while it is true that some Medicare beneficiaries have so-called Medigap coverage, the record doesn't show that they have that coverage, for example, with the insurance company that happens to be the carrier, the Medicare carrier for that area. Unless they have the coverage with the insurance company that was also the Medicare carrier, even the plaintiffs' argument on its own terms doesn't make any sense, because that carrier, the insurance carrier would have no reason to vary depending upon whether the claimant had Medigap coverage.

In fact, the record in this case shows that the Occidental Life Insurance Company, which is one of the two carriers in the case, didn't even offer Medigap coverage. And finally, there is no suggestion that the hearing officer, who after all is the person that the plaintiffs are claiming is biased, is ever told whether the claimant has Medigap coverage or not. So once again, we think it is another example of the totally

unsubstantiated speculation that pervades the plaintiffs' argument.

QUESTION: Mr. Geller, if the Act didn't provide for any so-called fair hearing at all, what would be the basis for -- what would be the -- would you think there would be a reasonable attack on it on due process?

MR. GELLER: I think that would raise a much more difficult question, since due process requires, if it requires anything, some sort of a meaningful opportunity to be heard before property is taken away, but here there is no question --

QUESTION: And the property is the -- is the reasonable anticipation of getting reimbursed, according to the statute?

MR. GELLER: Yes, right, after having paid your premium and submitted a claim. I think the point is -- I would like to leave the Court just with this last point -- we don't think there is any due process problem in the Part B hearing appeal system, obviously, but if the Court disagrees, if they think, for example, as the Plaintiffs allege, that there is too close a connection between the carrier and the hearing officer, then it seems to us that the proper remedy is simply to ask the Secretary to take a closer look and pre-screen

who are selected as hearing officers, and not to judicially legislate and superimpose an entire ALJ system on top of the Part B hearing system.

QUESTION: Just try to get rid of the bias.

MR. GELLER: Get rid of the bias, exactly, if there is in fact bias.

Thank you.

CHIEF JUSTICE BURGER: Thank you, gentlemen. The case is submitted.

(Whereupon, at 1:12 o'clock p.m., the case in the above-entitled matter was submitted.)

CERTIFICATION

Alderson Reporting Company, Inc. hereby certifies that the attached pages represent an accurate transcription of electronic sound recording of the oral argument before the Supreme Court of the United States in the matter of:

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BY Sharon Roper Connelly