

***Pegram v. Herdrich*: A Victory for HMOs or The Beginning of the End for ERISA Preemption?**

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On June 12, 2000, a unanimous Supreme Court held that treatment decisions made by an HMO, acting through its physicians, are not fiduciary acts under ERISA.¹ Thus the Carle HMO was not liable under ERISA for the harm caused when Pegram, one of Carle's physician/owners, required Herdrich to wait an additional eight days before undergoing a necessary diagnostic procedure and, when Herdrich's appendix ruptured during her wait for the procedure, then required her to receive emergency treatment at a Carle-owned facility fifty miles away, rather than at a nearby hospital.

At first blush, this seemed like yet another judicial decision insulating managed care organizations (MCOs) from liability under ERISA. Advocates of expanding patients' rights to sue health plans under legislation before Congress² might have been expected to bombard members of Congress with outraged communications decrying *Pegram* as another illustration of how inadequate ERISA was in protecting participants in employer-sponsored group health plans. But the early euphoria or dismay quickly dissipated as ERISA experts began to focus on the larger legal questions raised by Justice Souter's opinion. In particular, much discussion has ensued regarding the implications of the *Pegram* decision for preemption cases under which plaintiffs have been permitted to bring state law actions alleging substandard quality of care from their health plans.

Pegram is a complex, yet fascinating, case that reveals the Supreme Court poised on the brink of another major erosion of ERISA preemption,

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even though the case itself did not involve ERISA preemption at all, but rather the scope of ERISA's fiduciary provisions. Under ERISA, state laws that relate to ERISA-covered employee benefit plans are generally preempted. However, certain state laws relating to ERISA group health plans may be saved from preemption if they are laws regulating insurance that do not treat plans as insurance companies.³

At its core, *Pegram* asks a question of intense interest to patients in managed care plans everywhere: Does the common HMO practice of providing financial rewards for doctors who reduce utilization of medical services violate ERISA's fiduciary rules? In other words, is the use of financial incentives for HMO doctors to ration care per se illegal under ERISA? A unanimous Supreme Court said no, because decisions that intertwine questions of eligibility for coverage and treatment judgments ("mixed eligibility decisions") are not fiduciary acts under ERISA.⁴

Most commentators believed that the Court would find that decisions regarding how to structure the MCO delivering medical care to participants under an ERISA-covered plan were not fiduciary decisions. So the Court's ultimate conclusion was hardly a bombshell. However, how the Court reached that result, as well as some of the observations the Court made, and conclusions it drew in arriving at its result, were both surprising and revealing.

Pegram involved a medical malpractice action brought in state court against both the treating physician and Carle. After the malpractice case was brought, Herdrich added two counts of state law fraud. Arguing that the fraud claims were preempted by ERISA, the defendants removed the case to federal court and sought summary judgment on the fraud counts.⁵ The district court granted the defendant's motion on one count, but permitted the plaintiff to amend her complaint to allege that the HMO's practice of rewarding physicians (who also owned the health plan) violated ERISA's fiduciary standards. Herdrich alleged, among other things, that the HMO had breached its fiduciary duty under ERISA because the financial incentives for plan providers were structured to encourage reductions in treatment as a way to increase the bonus pool available at the end of the year. The district court granted the defendant's motion for summary judgment on the amended fraud claim.

Herdrich appealed, and the Seventh Circuit, reversing the district court, held that the HMO was acting as a fiduciary when its physicians made their treatment decisions.⁶ The decisions made by Carle physicians, including the operation of the doctor-referral process, the nature and duration of patient treatment, and the extent to which participants were required to use Carle-owned facilities were all held to be fiduciary acts.

Thus the circuit court allowed the plaintiff to proceed to trial on the breach of fiduciary duty allegations.

Justice Souter, writing for a unanimous Supreme Court, reversed the Seventh Circuit and held that treatment decisions made by an HMO, acting through its physicians, are not fiduciary acts.⁷ To reach that conclusion, Justice Souter first explained how HMOs operate, describing the various mechanisms used by HMOs to control costs as comparable to “other risk-bearing organizations” and “traditional insurers.”⁸ Justice Souter observed that HMOs customarily issue general guidelines to physicians concerning the appropriate levels of care, complemented by a system of financial incentives designed to encourage doctors to provide less care. The countervailing force against these financial incentives to ration care is “the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient’s interest.”⁹ However, “no HMO organization could survive without some incentive connecting physician reward with treatment rationing,” Justice Souter concluded.¹⁰ Although Herdrich’s claim focused on Carle’s for-profit character, ultimately the Court found that to be irrelevant.

The Court next looked at the requirements of ERISA. Carle was charged with a breach of fiduciary duty in connection with carrying out its obligations under the State Farm medical plan. For the first time, the Court tackled two critical questions that lower courts often ignore: What is a “plan” under ERISA, and is the HMO itself an ERISA plan? Relying on the plain dictionary meaning of “plan” (i.e., a scheme decided on in advance), the Court concluded that a plan is “a set of rules that define the rights of a beneficiary and provide for their enforcement.”¹¹ Thus:

...when employers contract with an HMO to provide benefits to employees subject to ERISA, the provisions of documents that set up the HMO are not, as such, an ERISA plan, but the agreement between the HMO and an employer who pays the premiums may, as here, provide elements of a plan by setting out rules under which beneficiaries will be entitled to care.¹²

Fiduciaries exercise discretion or control over the plan investments and plan administration.¹³ But when HMOs contract with an ERISA plan, not every act an HMO performs is a fiduciary act. The Court distinguished between the HMO’s exercise of discretion over its own business (not a fiduciary act) and its exercise of discretion over the ERISA plan (a fiduciary act).¹⁴ In addition, the Court noted that at common law, trustees

only wore their fiduciary hats, whereas under ERISA they can wear several hats, although only one at a time.¹⁵ Justice Souter used the example of an employer who, when acting as an employer or as a settlor of a plan, can take actions that disadvantage participants (e.g., amending the plan to provide less generous future benefits), yet when the employer is acting as a fiduciary, the duty of loyalty and the exclusive benefit rule preclude such actions.¹⁶

Herdrich argued that Carle and its physicians/agents breached their fiduciary duty under ERISA to act solely in the interest of participants and beneficiaries because their medical treatment decisions were influenced by financial incentives to maximize profits. However, the Court rejected that argument for two reasons: (1) since a plan sponsor's decision about the content of the ERISA plan is a settlor, not a fiduciary, decision, the HMO's comparable decision to include financial incentives in its organizational structure cannot be a fiduciary act either, and (2) since the financial incentive structure adopted by Carle preceded its contract to deliver benefits to State Farm's employees under the company's ERISA plan, acts prior to the establishment of the plan could hardly be fiduciary acts with respect to that plan.¹⁷ When Carle became a fiduciary as a result of its plan administration activities, however, the question arose whether the HMO's treatment decisions (which were alleged to be compromised by the existence of the financial incentives) were fiduciary decisions.

In making that determination, the Court first distinguished between "pure eligibility decisions" and "treatment decisions."¹⁸ The former depend on whether or not the plan covers a particular treatment or provider, while the latter are "choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?"¹⁹ Because treatment and eligibility are often inextricably bound, "mixed eligibility decisions" (i.e., those involving medical judgment by a physician) are not fiduciary decisions under the Court's analysis, but rather must be measured against state malpractice standards.²⁰

In considering why a plaintiff might be interested in pursuing a breach of fiduciary duty case under ERISA in the first place, the Court posits that in states that do not allow malpractice actions against HMOs, the plaintiff may believe that he or she will be able to go after a deeper pocket than the treating physician if federal fiduciary duty claims could be brought against the HMO. But the Court gives short shrift to its own speculation. What is significant about this speculation is that the Court appears to assume that these state liability laws are valid (i.e., not preempted by ERISA), thus implicitly endorsing them.²¹

Interestingly, the Court also makes several important points in footnotes to the opinion. Although *dicta*, these comments both illustrate and illuminate the next set of battles likely to come under Court scrutiny. First, the Court raises the intriguing possibility that even though Carle’s decision to include financial incentives for its doctors does not violate ERISA’s fiduciary rules, Carle may be required to disclose the existence of these financial incentives, even if they are not illegal. This is because Carle’s discretion with respect to plan administration makes it a fiduciary to an ERISA plan.²² Second, the Court indicates that because this case involves a breach of fiduciary duty claim under ERISA § 502(a)(3)²³ and not a claim for benefits under ERISA § 502(b)(1)(A),²⁴ the Court does not need to address the question of whether, if the same set of facts came before the Court styled as a benefit claim case,²⁵ various state causes of action would be preempted. This latter statement is the source of some of the most intense speculation regarding the ultimate direction in which the Court is heading.

Pegram tells us that challenges under ERISA regarding the nature of managed care itself (i.e., the structure of an MCO delivering care to participants in an ERISA-covered plan) will not be successful. However, other aspects of how the MCO actually provides that care (the “when-and-how question”²⁶) as it administers an ERISA plan are fair game—but probably under state law, not ERISA.

In reiterating its primary holding that mixed eligibility decisions (i.e., those that involve medical judgment) are not fiduciary acts, the Court is breaking new ground with profound implications for ERISA’s current preemption jurisprudence. Until this point, courts have generally rejected state law challenges to so-called “coverage” decisions, even those involving medical judgment.²⁷ With the exception of the *Dukes v. U.S. Healthcare, Inc.* line of cases described below,²⁸ lower courts have routinely found preempted state law causes of action in cases involving challenges to decisions that defendants have successfully argued concern coverage questions—whether or not the treatment or services sought are covered by the plan. As the Court acknowledges in *Pegram*, these questions are rarely simple. Rather, they often concern questions of medical judgment such as whether a particular treatment is “medically necessary.”²⁹ But is that determination a coverage decision or a medical one? Prior to *Pegram*, if a court found that an aspect of the decision was a coverage question, even if medical judgment was also involved, state law was preempted.

After *Pegram*, the Court appears to be on the brink of an even more fundamental restriction on the sweep of ERISA preemption than the Third Circuit’s approach in *Dukes*.³⁰ *Dukes* is the seminal case in which courts

imposed vicarious liability on HMOs for the negligence of their doctors. In *Dukes*, the circuit court distinguished between allegations concerning coverage and those concerning the quality of care the participant received. Because the *Dukes* court agreed that the dispute was not centered on the plaintiff's failure to receive the services promised under the ERISA plan, but rather the allegations that the care the plaintiff received was substandard, the Third Circuit held that the state law negligence case was not preempted by ERISA. The court noted that had the case only involved coverage questions, state law would have been preempted.

Dukes is significant, not only for the standards the court sets, but also because it marked the first time that the U.S. Department of Labor, as *amicus curiae*, weighed in to support the argument that state law medical malpractice claims were not preempted. The courts that have refused to follow *Dukes*³¹ have done so in part because they believe that the distinction between coverage and quality is an artificial one designed simply to provide more generous relief under state law in cases that would otherwise be limited by ERISA's narrow remedies.

But applying *Pegram*'s analysis to allegations of medical malpractice in preemption cases may be even more helpful to plaintiffs. The claims at issue in *Dukes*, in the view of the Supreme Court in *Pegram*, were either simple treatment decisions, or at worst, mixed eligibility decisions. Even under the *Dukes* rationale, however, if the decision implicated coverage issues, the Third Circuit would have found state law preempted, even if the decision was a "mixed eligibility decision." However, applying the *Pegram* rationale, the Court would presumably decide differently and uphold the application of state law because a decision requiring the exercise of medical judgment (such as whether or not an otherwise non-excluded service or treatment was medically necessary) is a "mixed eligibility decision."

Thus the Court in *Pegram* appears to be ready to push even more types of decisions out of the ERISA ambit and into state courts by holding that HMO decisions requiring physician judgment, even those also involving coverage issues, are not covered by ERISA. Although consistent with the overall direction of this Supreme Court in upholding state prerogatives over federal regulation, *Pegram* holds the potential for further eroding ERISA preemption. This is good news for participants who are injured by delay or denial of treatment by HMOs and who are attempting to hold HMOs more accountable for their allegedly negligent decisions in connection with ERISA-covered group health plans.

References

1. *Pegram*, 530 U.S. 211 (2000).
2. *E.g.*, H.R. 2990, 106th Cong. § 1302 (1999); H.R. 2723, 106th Cong. (1999). On October 6, 1999, the U.S. House of Representatives passed H.R. 2990, which incorporated both the provisions of the original H.R. 2990, the Quality Care for the Uninsured Act of 1999, and H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. The bill passed by the House amended Title I of ERISA to expand the current right to sue and the remedies available for participants in ERISA-covered plans (both fully insured and self-insured). It permitted injured participants to recover damages under state personal injury or wrongful death laws in certain circumstances after all applicable administrative appeals, both internal and external, had been exhausted. Punitive damages would be available under state law only if the group health plan or health insurance issuer had not complied with the decision of the external reviewer. The Senate passed a much more limited version of the bill. When the 106th Congress adjourned, no final action was taken on the bills, although they were the subject of heated debate and discussion.
3. ERISA § 514, 29 U.S.C. § 1144 (1994).
4. *Pegram*, 530 U.S. at 230.
5. Herdrich prevailed on her original state malpractice claims, and the jury awarded her \$35,000. See *Herdrich v. Pegram*, 154 F.3d 362, 367 (7th Cir. 1998) for history of the case.
6. *Id.* at 370 (“We can reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims.”). *Id.*
7. *Pegram*, 530 U.S. at 231.
8. *Id.* at 219.
9. *Id.*
10. *Id.* at 220.
11. *Id.* at 223.
12. *Id.*
13. The test of whether a person is a fiduciary under ERISA is a functional one. Under ERISA § 3(21), a person is a fiduciary “to the extent” that the person: (1) exercises any discretionary authority or control over the management of the plan or the management or disposition of its assets, (2) renders investment advice regarding plan assets for a fee or other direct or indirect compensation, or has the authority or responsibility to do so, or (3) has any discretionary authority or control over plan administration. 29 U.S.C. § 1002(21) (1994).
14. *Pegram*, 530 U.S. at 223.
15. *Id.* at 225.
16. *Id.* at 225-26.
17. *Id.* at 227.
18. *Id.* at 228.
19. *Id.*
20. *Id.* at 237.
21. *Id.*
22. The Court notes that although the fraud claims in the original complaint filed by Herdrich in state court could be described as claims alleging that failure by Carle to disclose the existence of its financial incentives was itself a fiduciary breach, the amended complaint before the Court does not raise that point and therefore the issue is not properly before the Court. *Id.* at 228 n.8.
23. 29 U.S.C. § 1132(a)(3) (1998).
24. 29 U.S.C. § 1132(a)(1)(B) (1998). Individuals who are challenging improper

benefit denials can file suit under ERISA § 502(a)(1)(B). Herdrich could have brought a benefit claim action challenging the HMO's decision to make her wait eight days to have the sonogram or the decision requiring her to bypass her local hospital and seek emergency treatment at a distant Carle-owned facility as violating her rights as a beneficiary under the terms of the ERISA plan. This action could have been brought in either state or federal court. Instead of suing under ERISA, where remedies for successful plaintiffs in benefit claims actions are limited to the provision of the denied benefit, plaintiffs typically allege various state law negligence claims, such as the medical malpractice counts raised by Herdrich in her original suit. Then the issue before the courts would have been whether those state law claims were preempted by ERISA § 514. Under ERISA § 514, state laws that "relate to" ERISA plans and are not otherwise saved by ERISA's insurance savings clause are preempted. 29 U.S.C. § 1144 (1998).

25. *Pegram*, 530 U.S. at 229 n.9.

26. *Id.* at 228-29.

27. *E.g.*, *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992). In *Corcoran*, the treating obstetrician sought precertification for a hospital stay during the plaintiff's high-risk pregnancy. In performing utilization review for the employer's self-funded medical plan, the defendant determined that hospitalization was not necessary and instead authorized ten hours per day of home nursing care. During a period when no nurse was on duty, the fetus went into distress and died. The Fifth Circuit affirmed the district

court's decision that ERISA preempted the plaintiffs' state law tort claim for the wrongful death of their child allegedly resulting from defendant's erroneous medical decision. Although the defendant made medical decisions and gave medical advice, the court determined that it did so in the context of determining the availability of benefits under an ERISA plan and therefore its decision to deny hospitalization was a coverage decision. Accordingly, the court held that plaintiffs' malpractice claims related to the plan and were preempted by ERISA.

28. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *cert. denied*, 516 U.S. 1009 (1995). These cases distinguish between claims that the plaintiff allegedly failed to receive covered services under the plan and claims in which the plaintiff alleges that the services provided under the plan were substandard ("quality of care" cases). In the former cases, state law is preempted by ERISA. In the latter cases, however, courts have permitted the plaintiff to pursue state law tort challenges to the quality of care received.

29. Plans and insurance contracts routinely cover only specified services when medically necessary. That necessitates an individualized decision at the point at which treatment is requested—with respect to a particular patient, an otherwise covered service (i.e., a service that is not excluded under the terms of a plan) ought to be provided because it is medically necessary to treat this patient, given his or her symptoms or condition.

30. *Dukes*, 57 F.3d 350, *cert. denied*, 516 U.S. 1009. Two other circuits have followed this approach; one has explicitly rejected it.

Compare *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995), amended, *reh'g denied en banc, sub nom Rice v. Kanu*, 1995 U.S. App. LEXIS 31419 (7th Cir. 1995), and *Pacificare of Ok. v. Burrage*, 59 F.3d 151 (10th Cir. 1995), with *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), *cert. denied*, 528 U.S. 1189 (2000). In addition, the Third Circuit recently expanded upon the *Dukes* principles in *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999) (this case is sometimes referred to as *Bauman v. U.S. Healthcare*).

31. E.g., *Hull*, 188 F.3d 939, *cert. denied*, 528 U.S. 1189 (2000).

