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***Pegram v. Herdrich*: The Supreme Court Confronts Managed Care**

Timothy S. Jost, J.D.*

ERISA, adopted a quarter century ago to reform private pension law, imposed by the end of the twentieth century a seemingly insurmountable barrier to managed care reform. The Supreme Court's decision in *Pegram v. Herdrich*¹ blocked one path out of the ERISA morass—broader use of breach of ERISA fiduciary obligations suits in federal court. On the other hand, it opened another path to holding HMOs accountable in malpractice cases in state court—and suggested that ERISA might impose fiduciary obligations to disclose incentives on HMOs. It is therefore an important decision.

ERISA was intended to give the federal government primary authority for regulating employee pension and benefits plans. As the vast majority of Americans with private health insurance (88%) obtain it through their place of employment, ERISA effectively gives the federal government primary responsibility for regulating private health insurance. Section 514(a) of ERISA² provides that ERISA “supersedes” all state laws that “relate to” employee benefits plans. Early Supreme Court decisions read this clause very broadly as preempting state laws that had any “connection with or reference to” a benefits plan.³ In particular, *Pilot Life v. Dedaux* read ERISA as preempting state tort law challenges to egregious coverage denials.⁴ While § 514 contains a “savings clause” excluding the traditional state function of insurance regulation from preemption,⁵ the Supreme Court initially read this provision very narrowly to cover only regulation of traditional insurance functions.⁶ Moreover, § 514(b)(2)(B) prohibits the states from “deeming” ERISA plans themselves to be insurers,⁷ which the Court has read as precluding state regulation of self-funded plans.⁸ The net effect of the Court's early interpretations of these provisions was to severely restrict the ability of the states to regulate employee benefits plans.

ERISA, of course, neither leaves health plans entirely unregulated nor

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health plan beneficiaries without any remedy. ERISA itself imposes fiduciary obligations on plan administrators⁹ and minimal procedural obligations on plans with respect to benefit determinations.¹⁰ Section 502 of ERISA permits a plan beneficiary to bring a civil action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”¹¹ ERISA further provides for equitable relief against acts or practices that violate ERISA,¹² including violations of the fiduciary obligations imposed by ERISA.¹³ Again, however, the Supreme Court has interpreted ERISA’s remedial provisions very narrowly, limiting beneficiary recoveries under § 502 actions to compensatory contractual damages, and precluding individual damage actions for breach of fiduciary obligations.¹⁴

ERISA’s remedial scheme may have made sense in the 1970s, when a benefit denial was effectively a dispute over whether the plan, provider, or beneficiary would end up bearing the cost of a service already provided. In today’s managed care environment in which benefit denials are prospective or concurrent, however, ERISA has left beneficiaries effectively without remedy when urgently needed care is refused. Because of ERISA preemption, the states have limited authority to fix this problem.¹⁵ Federal managed care reform, however, has been blocked by intense lobbying and the political gridlock that has seized Washington for the past decade.

Into this legal environment came Cynthia Herdrich. Herdrich sued Carle and her physician, Pegram, a physician owner of Carle, in state court for malpractice and for fraud. Carle, under well-established ERISA jurisprudence, removed the case into federal court, where Herdrich’s fraud claims were dismissed as preempted by ERISA. Herdrich ultimately recovered \$35,000 in a jury verdict on the malpractice claims, but also amended her complaint to state a claim that the defendants had breached their ERISA fiduciary obligations.

Herdrich’s claim attacked the structure of the Carle plan. Carle’s physicians were, Herdrich alleged, vested with the authority to determine which services they would provide their beneficiaries, and rewarded with a year-end bonus if they denied services, saving on costs.¹⁶ Herdrich sued under ERISA provisions, which make a fiduciary personally responsible to the plan for any ill-gotten gains obtained through breach of fiduciary obligations.¹⁷ Under ERISA’s remedial structure, Herdrich could not benefit personally from a favorable judgment on this claim, but the Court could award the benefit plan profits resulting from Carle’s alleged breach, enjoin the continuation of Carle’s incentive structure, and award Herdrich attorneys’ fees. Though the trial court dismissed Herdrich’s ERISA claim, the Seventh Circuit Court of Appeals reversed this judgment in a divided

judgment.¹⁸ The Seventh Circuit *en banc* refused a rehearing on the case, but four judges dissented from the rehearing denial in a decision written by Judge Easterbrook.¹⁹

When the Herdrich case reached the Supreme Court, three different, carefully reasoned opinions had already been written in the case by Seventh Circuit judges Coffey, Flaum, and Easterbrook. Judge Coffey's majority Seventh Circuit opinion held that Herdrich ought to be allowed to proceed to trial on her theory that Carle had violated its "fiduciary obligations to act solely in the interest of the Plan participants and beneficiaries," by creating an incentive system that "depleted plan resources so as to benefit physicians who, coincidentally administered the Plan, possibly to the detriment of their patients."²⁰ Coffey's opinion included a lengthy diatribe against HMOs, curiously faulting them for transferring the responsibility for decisions involving medical care from physicians to insurance executives, even though Herdrich's case challenged the decision of a treating physician as corrupt.²¹

Judge Flaum's Seventh Circuit dissent rejected Herdrich's fiduciary claim, recognizing well-established ERISA law that tolerates some conflicts of interest on the part of administrators, who must not only provide benefits to particular beneficiaries, but must also look after the interests of the plan as a whole. Flaum also warned against the court taking on the job of determining permissible managed care incentive programs on a case by case basis.²² Flaum did, however, suggest that the court should have followed the lead of the Eighth Circuit's decision in *Shea v. Esensten*,²³ requiring ERISA plans to disclose their financial incentive programs to plan sponsors and beneficiaries.²⁴

Easterbrook's *en banc* dissent went much further. It observed that the Carle HMO, rather than the services it provided its patients, was the benefit afforded by the ERISA plan.²⁵ Thus the physicians who owned Carle could not be plan fiduciaries, and, presumably, beneficiaries had no ERISA recourse, even under § 502, against Carle for the denial of services. Easterbrook matched Coffey's anti-managed care diatribe with his own complaints about managed care backlash.

In reversing the Seventh Circuit's decision, Justice Souter, writing for a unanimous Supreme Court, took yet another course, which preserves the ability of ERISA plans to manage the delivery of health care, leaves the door open to beneficiaries who are adversely affected by such arrangements to obtain relief, and, perhaps most importantly, protects the institutional interests of the federal courts.

The Court first attempted to characterize Carle's status as a plan administrator. The Court identified the ERISA plan at issue as the

contractual arrangement between Carle and the plan sponsor, Herdrich's husband's employer.²⁶ Thus the Carle HMO itself was not an ERISA plan, and its internal arrangements were not directly subject to ERISA supervision. On the other hand, the Court rejected Easterbrook's position, as it recognized that Carle could be a plan fiduciary with respect to at least some coverage decisions—i.e. medical services themselves were ERISA benefits, not just access to the Carle HMO.

The Court, however, decisively rejected the position of Judge Coffey, asserting that Congress could not have intended ERISA to outlaw HMOs. Indeed Congress, only a year before ERISA was adopted, had enacted a law explicitly encouraging the formation of HMOs as part of Nixon's health care reform plan.²⁷ Moreover, in perhaps the most widely noted passages of the case, the Court explicitly accepted that "whatever the HMO, there must be rationing and inducement to ration."²⁸ While the Court recognized that the lower court sought only to ban excessive incentive plans, not HMOs as a whole, the Court concluded that establishing workable standards for determining when HMO incentive systems violated ERISA fiduciary obligations would prove an impossible task.²⁹ The decision, therefore, disappointed those who saw the case as an opportunity to define the role of trust and loyalty in the managed care setting.³⁰

The Court resolved the dilemma before it by creating a distinction new to ERISA jurisprudence. Beginning with *Dukes v. U.S. Healthcare*³¹ in the mid-1990s, a series of lower court decisions, seeking to rectify the injustice wrought by *Pilot Life* on persons injured by ERISA HMOs, had adopted a distinction between benefit coverage (eligibility) decisions—for which there was no remedy under state law—and medical treatment decisions—which were subject to state malpractice suits. Acknowledging that HMO determinations often cannot be simply characterized as purely eligibility or treatment decisions, the *Pegram* Court recognized a new category of "mixed eligibility and treatment decisions," which decided whether a particular service would be covered, but made this determination based on medical judgment.³² While this category would exclude pure coverage decisions (whether ultrasound was a covered procedure or appendicitis a covered condition under the plan), it would sweep in the vast majority of decisions currently made by managed care plans, including, in the Court's words, "physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition."³³

In the Court's opinion, these mixed decisions are not subject to

ERISA's fiduciary requirements, i.e. the HMO won the case. On the other hand, this result was based on a belief that these decisions are already subject to state malpractice law, which would be preempted if these decisions were subject to ERISA's fiduciary requirements.³⁴ In reaching this result the Court seems to have significantly moved the line established by *Dukes* and its progeny.³⁵ Though the Court's discussion of this issue is technically dicta, the decision strongly suggests that HMOs themselves are now liable in state court under state malpractice law for a host of decisions previously thought to be immunized by ERISA preemption. Indeed, *Pegram* quite explicitly contemplates direct state corporate negligence litigation against HMOs themselves in states that permit such litigation.³⁶ Since mixed eligibility and treatment decisions are apparently not governed by ERISA, it is not necessary for states to adopt legislation authorizing such litigation under the savings clause,³⁷ and even self-insured plans are subject to suit. In sum, those who favor holding HMOs accountable for injuries that result from denial of treatment, lost a small battle, but advanced significantly in a much larger war.³⁸

Those who seek accountable managed care advanced also, at least slightly, on another front as well. While not addressing Judge Flaum's dissent directly, the Supreme Court, in note eight, suggested that ERISA plans may in fact have a fiduciary obligation under ERISA to "disclose characteristics of the plan and of those who provide services to the plan, if that information affects beneficiaries' material interests."³⁹ Although the value of plan incentive disclosure is contested,⁴⁰ the question about whether such disclosure is required remains open after *Pegram*.

The biggest winners under *Pegram*, however, were arguably the federal courts. Had the Court adopted the Seventh Circuit's position in *Pegram*, every ERISA HMO would have been exposed to fact-intensive, time-consuming federal litigation contesting its incentive structure. *Pegram* not only spares the federal courts this burden, but also suggests that a large number of mixed eligibility and treatment cases, now being litigated in the federal courts under the complete preemption doctrine, can be moved back to the state courts as simple malpractice cases. In the end, therefore, *Pegram* may not be so much about rationing health care as about rationing the limited resources of the federal courts.

References

1. *Pegram*, 530 U.S. 211.
2. 29 U.S.C. § 1144(a) (1998).
3. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983).
4. 481 U.S. 41 (1987). In *Pilot Life*, and in another case decided on the same day, the Court read § 502 of ERISA, which permits beneficiaries to sue to recover benefits wrongfully denied, both to preempt state court actions aimed at contesting benefit denials and state court jurisdiction over actions contesting benefit decisions (so called, “complete preemption”). *Pilot Life*, 481 U.S. at 52-54; *Metropolitan Life Ins. v. Taylor*, 481 U.S. 58, 63-66 (1987).
5. 29 U.S.C. § 1144(b)(2)(A) (1998).
6. *Pilot Life*, 481 U.S. at 50-51.
7. 29 U.S.C. § 1144(b)(2)(B) (1998).
8. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).
9. 29 U.S.C. § 1104(a)(1) (1998).
10. 29 U.S.C. § 1133 (1998).
11. 29 U.S.C. § 1132(a)(1)(B) (1998).
12. 29 U.S.C. § 1132(a)(3) (1998).
13. 29 U.S.C. §§ 1109, 1132(a)(2) (1998).
14. *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993); *Massachusetts Mut. Life Ins. v. Russell*, 473 U.S. 134 (1985).
15. *See, e.g., Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 215 F.3d 526 (2000) (holding that a Texas statute permitting civil suits against HMOs for physician negligence is not preempted by ERISA, but independent review requirements are preempted).
16. *Pegram*, 530 U.S. at 216 n.3.
17. 29 U.S.C. § 1109(a) (1998).
18. *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998).
19. *Herdrich v. Pegram*, 170 F.3d 683 (7th Cir. *en banc* 1999).
20. *Herdrich*, 154 F.3d at 380.
21. *Id.* at 374-78.
22. *Id.* at 383.
23. 107 F.3d 625 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997).
24. *Herdrich*, 154 F.3d at 384.
25. *Herdrich*, 170 F.3d at 686.
26. *Pegram*, 530 U.S. at 222.
27. The Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (1998); *Pegram*, 530 U.S. at 233.
28. *Pegram*, 530 U.S. at 221.
29. *Id.* at 221-23, 234-35.
30. Gregg M. Bloche, *U.S. Health Care After Pegram: Betrayal at the Bedside*, HEALTH AFF., Sept.-Oct. 2000, at 224.
31. 57 F.3d 351 (3d Cir. 1995).
32. *Pegram*, 530 U.S. at 229-30.
33. *Id.*
34. *Id.* at 253-36.
35. *See* William M. Sage, *UR Here: The Supreme Court's Guide for Managed Care*, HEALTH AFF., Sept.-Oct. 2000, at 219, 223.
36. *Pegram*, 530 U.S. at 235-36.
37. *See UNUM Life Ins. v. Ward*, 526 U.S. 358, 377 n.7 (1999) (suggesting that the savings clause might cover such legislation).
38. It must be noted, however, that this war is far from over. For one thing, the Court in note nine explained that it was not deciding whether a denial of emergency care, like that at issue in *Pegram*, was subject to litigation under § 502(a)(1)(B), and suggested that the right to a § 502(a)(1)(B) action might have ramifications for rights under state law. Given the power that 502 preemption has previously exercised, this note may bode ill

for those who would pursue state malpractice claims against HMOs. Further, a week after deciding *Pegram*, the Court vacated and remanded, for reconsideration in light of *Pegram*, a Pennsylvania Supreme Court case that had recognized expansive liability against an ERISA HMO under state malpractice law and significantly narrowed the scope of § 514 preemption. *United States Healthcare Sys. of Pa. v. Pennsylvania Hosp. Ins.*, 530 U.S. 1241 (2000).

39. *Pegram*, 530 U.S. at 228.

40. See William M Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701 (1999) (analyzing arguments for and against incentive disclosure).

