



2001

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Louis Saccoccio

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### Recommended Citation

Louis Saccoccio, *Pegram's Significance for Managed Health Care*, 1 *YALE J. HEALTH POL'Y L. & ETHICS* (2001).

Available at: <https://digitalcommons.law.yale.edu/yjhple/vol1/iss1/12>

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## ***Pegram's Significance for Managed Health Care***

**Louis Saccoccio, J.D.\***

On June 12, 2000, in a unanimous opinion written by Justice Souter, the U.S. Supreme Court, reversing a decision of the U.S. Court of Appeals for the Seventh Circuit, held in *Pegram v. Herdrich*<sup>1</sup> that “mixed eligibility” decisions made by HMO physicians are not fiduciary decisions under ERISA.<sup>2</sup> In so ruling, the Court upheld the concept that the reasonable sharing of financial risk with HMO<sup>3</sup> network physicians for providing health care to a given patient population does not run afoul of ERISA’s fiduciary requirements. This result is a significant victory for managed health care plans, their network physicians, and their members.

Although the decision’s impact on the viability of physician risk sharing is clearly positive, the decision’s impact on the question of HMO liability under ERISA remains less clear. Some, including the U.S. Department of Labor, argue that this case represents a shift in ERISA preemption law. They argue that *Pegram* now precludes ERISA preemption of state law causes of action aimed at HMO coverage determinations that involve questions of medical-necessity or experimental or investigational treatments. A more reasonable reading of the case, consistent with its facts, however, leads to the conclusion that *Pegram* represents nothing more than a common sense answer to a simple question. What law should apply when a treating physician makes a treatment decision that may arguably raise issues of eligibility for coverage? *Pegram*’s answer does not represent a shift in the law regarding ERISA preemption of HMO coverage decisions.

The importance of *Pegram* does not end, however, with its resolution of the question of the scope of ERISA’s fiduciary requirements in the realm of a physician’s practice of medicine. The greater impact of the *Pegram* decision may lie in its language addressing the proper role of the courts in addressing the social and policy questions that arise from managed health care. In this regard, the Court in *Pegram* unambiguously stated that the debate about managed care belongs not in the courts, but in the legislature. This clear message already is having an impact in class action

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\* Louis Saccoccio is General Counsel to the American Association of Health Plans (AAHP). AAHP is a national trade association representing HMOs, PPOs, and other network based health plans.

litigation filed against health plans where broad allegations under ERISA and the Racketeer Influenced and Corrupt Organizations Act (RICO)<sup>4</sup> seek to challenge (some would say destroy) managed health care practices.

Cynthia Herdrich originally brought medical negligence claims against Dr. Lori Pegram, and Carle Clinic Association (Carle), as well as state law fraud claims against Carle and its HMO, Health Alliance Medical Plans, in Illinois state court.<sup>5</sup> The medical negligence counts went to trial in state court resulting in a \$35,000 verdict for Herdrich. Carle and Health Alliance Medical Plans removed the state fraud claims to federal court alleging that they were preempted by ERISA. The federal district court dismissed the state fraud complaint, but allowed Herdrich to amend her claims to state a claim under ERISA. Herdrich's amended claim alleged a breach of ERISA fiduciary duty on the part of the defendants. The claim was premised on the fact that the physician owners of the HMO potentially were entitled to year-end bonuses based on the difference between the cost of providing medical care and HMO revenues. Herdrich argued that this created an improper incentive to limit treatment. The federal district court subsequently granted the defendants' motion to dismiss the amended ERISA claim for a failure to state a proper claim, and Herdrich appealed.

The U.S. Court of Appeals for the Seventh Circuit reversed the decision, finding that Herdrich had alleged sufficient facts to make a claim for breach of fiduciary duty under ERISA.<sup>6</sup>

The issue before the Supreme Court in *Pegram* was the application of ERISA's fiduciary duty principles to HMO treating physicians who make "mixed eligibility decisions."<sup>7</sup> The Court had no occasion to address the issue of whether HMO coverage decisions involving medical-necessity issues fall outside the scope of ERISA's preemption of state law. Nevertheless, the issues are closely enough related to pose the question of whether *Pegram* has brought a shift in the law that narrows the application of ERISA preemption with respect to HMO coverage decisions involving medical necessity.

Any application of the *Pegram* decision to the question of ERISA preemption of state law for liability arising from HMO coverage determinations must be made in light of the facts before the Court. The heart of the case before the Supreme Court was simply a treating physician's misdiagnosis of appendicitis. As a result, Herdrich was able to convince an Illinois state court jury that Pegram failed to properly diagnose her condition, and was awarded \$35,000 in damages for her injuries. However, because it was alleged that Pegram's year-end compensation was based in part on the financial health of the HMO, Herdrich argued that Pegram's misdiagnosis, coupled with her ostensible

interest in the financial health of the HMO, raised the issue of breach of fiduciary duty under ERISA.

The Court rejected Herdrich's claim that the HMO, acting through its physician owners, breached its duty to act solely in the interest of beneficiaries by making decisions affecting medical treatment while allegedly being influenced by the terms of the HMO physician compensation structure. In doing so, the Court expressed doubt that Congress intended physicians to be treated as ERISA fiduciaries to the extent that they make "mixed eligibility decisions" during the course of treating their patients.<sup>8</sup>

The Court correctly recognized that when examining the question of whether a treating physician acted for good medical cause, as opposed to his or her own financial interest, the answer to that question "would require reference to standards of reasonable and customary medical practice in like circumstances."<sup>9</sup> The Court noted however, that this is the very standard used in medical malpractice cases: "[F]or all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians."<sup>10</sup> As a result, the Court saw no reason to turn traditional medical malpractice cases into ERISA fiduciary cases simply because the treating physician assumed some of the financial risk for the treatment of the patient.

Thus, *Pegram* is a case about treating physicians, medical malpractice, and ERISA fiduciary implications of malpractice in light of physician risk sharing. The Court rightly recognized that it would be folly to convert standard malpractice actions, involving treating physicians that take place within the HMO context, into ERISA fiduciary actions. However, this conclusion is a far cry from the position taken by some in the trial bar and by the Department of Labor (see below) that *Pegram* stands for the proposition that HMO coverage decisions involving questions of medical necessity are now subject to state tort actions.

In September 2000, the Department of Labor filed an *amicus curiae* brief before the Supreme Court of Pennsylvania in *Pappas v. Asbel*.<sup>11</sup> This case is again before the Pennsylvania Supreme Court after the U.S. Supreme Court, on June 19, 2000, vacated the Pennsylvania court's earlier decision and remanded the case for reconsideration in light of *Pegram*.<sup>12</sup> The Department of Labor's brief in *Pappas* sets out its interpretation of how it believes *Pegram* narrows ERISA preemption of state tort claims for negligence. As discussed below, the Department of Labor's interpretation ranges far beyond the holding in *Pegram*.

The issue before the Pennsylvania Supreme Court in its initial decision in *Pappas* was whether state law negligence claims against an HMO, U.S. Healthcare, were preempted by ERISA.<sup>13</sup> The claim arose from an alleged delay in the HMO's authorization to transfer the plaintiff to a hospital capable of treating his condition. The Pennsylvania Supreme Court held in this initial decision that negligence claims against HMOs do not "relate to" ERISA plans, and are therefore not preempted.<sup>14</sup>

Interestingly, the Department of Labor previously had filed an *amicus curiae* brief with the U.S. Supreme Court supporting U.S. Healthcare's petition for *certiorari* in *Pappas*.<sup>15</sup> In that earlier brief, the Department of Labor argued that the Supreme Court of Pennsylvania's decision was overbroad and incorrect. The Department of Labor stated that ERISA's fiduciary standards preempt state law because an HMO's coverage decision is considered an act of health care plan administration even when medical judgment about how to treat a patient is involved.<sup>16</sup>

In the brief filed before the Supreme Court of Pennsylvania in *Pappas* on remand from the U.S. Supreme Court, the Department of Labor now argues that the case should be remanded to the Court of Common Pleas to decide whether U.S. Healthcare made a "mixed eligibility decision."<sup>17</sup> The Department of Labor claims that "*Pegram* holds that treatment decisions and mixed treatment and eligibility decisions by physician employees of an HMO are governed by state malpractice standards and not by ERISA fiduciary standards."<sup>18</sup> According to the Department of Labor, if the Court of Common Pleas finds that U.S. Healthcare made a "mixed eligibility decision," as used by the U.S. Supreme Court in *Pegram*, then there is no preemption, and the state law claims may proceed against U.S. Healthcare.<sup>19</sup>

The Department of Labor's interpretation of *Pegram*, as set out in its recent *amicus* brief, attempts to expand the holding of *Pegram* far beyond what the plain language of the decision supports. It extends the concept of "mixed eligibility decisions" beyond the HMO treating physician addressed in *Pegram* to the HMO itself, with no support or basis.

The foundation for the *Pegram* decision was a clear reluctance by the Court to expand the concept of ERISA fiduciary principles to physicians treating patients, with its resulting interference with traditional state medical malpractice law. In contrast, HMO coverage decisions within the context of ERISA employee benefit plans, even when involving medical necessity, have traditionally been recognized as benefit determinations within the purview of ERISA preemption.<sup>20</sup> Contrary to the position taken by the Department of Labor, *Pegram*, dealing as it does with the decisions of treating physicians, does little to change the landscape of ERISA

preemption for HMO coverage decisions.

Maybe more significant than the holding of *Pegram*, is Justice Souter's discussion of managed care and the respective roles of the federal judiciary and Congress as it pertains to addressing the debate about managed care. After all, the holding that "mixed eligibility decisions" made by HMO treating physicians should be left to state medical malpractice law does little more than confirm what is probably already common practice. As a direct example, Herdrich proceeded with and won a judgment in a state malpractice action in her case. However, with the filing in the last eighteen months of multiple class action lawsuits against several large health plans alleging general violations of ERISA and RICO,<sup>21</sup> *Pegram* gives the lower federal courts clear direction as to how they should react to these cases and their attempts to set health care policy through litigation.

The Court recognized that for more than twenty-seven years, Congress has promoted the formation of HMO practices, and stated that:

If Congress wishes to restrict its approval of HMO practice to certain preferred forms, it may choose to do so. But the Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations [sic] if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm.<sup>22</sup>

The impact of this message already has been felt in a recent decision that should directly influence the outcome in the numerous class action lawsuits mentioned above. The case, *Maio v. Aetna*, was decided by the U.S. Court of Appeals for the Third Circuit on August 11, 2000.<sup>23</sup> It affirmed the dismissal of a class action lawsuit filed against Aetna and its regional subsidiaries that was based on alleged violations of RICO. Significantly, the Third Circuit relied in part upon the Supreme Court's analysis in *Pegram* when finding that the plaintiffs failed to state a claim under RICO.

In its opinion, the Third Circuit examined the plaintiffs' damage theory in light of *Pegram*. The court indicated that absent specific allegations by the plaintiffs that the quality or quantity of their benefits under the health plans had been diminished, the "only theoretical basis for appellants' claim that they received an 'inferior health care product' is their subjective belief that Aetna's policies and practices are so unfavorable to enrollees that their very existence . . . demonstrates that they overpaid for the coverage they received."<sup>24</sup>

Looking to *Pegram*, the Third Circuit rejected this theoretical basis for recovery. The court stressed that under this theory the plaintiffs would be asking the court to pass judgment on Aetna's policies and practices leading

to a “myriad of practical problems, which undoubtedly arise in a situation in which the federal courts are asked to determine the social utility of one particular HMO structure as compared to another.”<sup>25</sup> The court refused to accept the plaintiffs’ notion implied by their complaint that it should evaluate the social utility of Aetna’s health plans. To stress this point, the court indicated that this theory would require the trier of fact to “inappropriately act as a state regulatory commission and determine the value of Aetna’s product.”<sup>26</sup>

The Third Circuit’s refusal to pass judgment on a health plan’s otherwise legal policies and practices with its “myriad of practical problems” gives a clear signal that *Pegram*’s most significant impact may come from its clear message of restraint to the federal judiciary in the debate about managed care.

The Court’s decision in *Pegram* has given the federal courts direction when addressing physician compensation arrangements and risk sharing in the context of ERISA. It has validated the concept that the treatment decisions of physicians, even if mixed with ERISA eligibility questions, are to be left to the purview of state medical malpractice law. Moreover, the Court’s resolution of these issues does not mean a shift in how the federal courts should analyze ERISA preemption questions relating to HMO medical-necessity decisions. Contrary to the views of the Department of Labor, *Pegram* did not hold that HMO coverage decisions involving medical-necessity issues are subject to state medical malpractice law.

*Pegram*’s most significant impact, however, may be in its call for judicial restraint when federal courts are faced with broad challenges to managed health care practices. The Court’s clear message was that the courts were not the appropriate venue for making health care policy; that responsibility remains with Congress.

## References

1. *Pegram*, 530 U.S. 211.
2. 29 U.S.C. § 1001 (1994).
3. Although the form of managed health care plan in *Pegram* was an HMO, the analysis in this paper equally applies to other managed health care plans to the extent that they share the financial risk for the delivery of health care services with their network providers.
4. The Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961-68 (1994).
5. For a summary of the procedural background of *Pegram* in the lower courts, see *Herdrich v. Pegram*, 154 F.3d 362, 365-67 (7th Cir. 1998).
6. *Id.*
7. The term “mixed eligibility decision” is one created by the Court. It arises from the Court’s view that Pegram’s treatment decision that Herdrich’s condition did not warrant immediate attention resulted in the HMO’s not covering immediate care, while it would have done so had Pegram made the proper diagnosis and judgment to treat. *Pegram*, 530 U.S. at 229-30. The Court’s use of the term “eligibility” appears to be interchangeable with the concept of coverage.
8. *Pegram*, 530 U.S. at 236.
9. *Id.* at 235.
10. *Id.*
11. *Amicus Curiae Brief for the Department of Labor, Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889 (Pa. 1998) (No. 00098).
12. *Amicus Curiae Brief for the Department of Labor, United States Healthcare Sys. Of Pa., Inc. v. Pennsylvania Hosp. Ins. Co.*, 530 U.S. 1241 (2000) (No. 98-1836).
13. *Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889, 890 (Pa. 1998).
14. *Id.* at 893-94.
15. *Amicus Curiae Brief for the Department of Labor, supra* note 12.
16. *Id.* at 6-10.
17. *Amicus Curiae Brief for the Department of Labor, supra* note 11, at 17.
18. *Id.* at 10-11.
19. *Id.* at 11-12.
20. *E.g.*, *Cannon v. Group Health Serv. of Ok., Inc.*, 77 F.3d 1270 (10th Cir. 1996); *Kuhl v. Lincoln Nat’l Health Plan of Kan. City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).
21. MDL-1334, MDL-1364, MDL-1366, and MDL-1367 pending before the U.S. District Court for the Southern District of Florida (on file with the author).
22. *Pegram*, 530 U.S. at 234.
23. 221 F.3d 472 (3d Cir. 2000).
24. *Id.* at 496.
25. *Id.* at 499.
26. *Id.*

