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THE EFFECT OF *PEGRAM* v. *HERDRICH*¹ ON HMO LIABILITY

*Dawn Marie Kelly*²

I. INTRODUCTION

Cynthia Herdrich placed her trust and her life in the hands of her physician and her Health Maintenance Organization (HMO).³ The result of this trust was a ruptured appendix and life threatening peritonitis.⁴ The Supreme Court's decision in the subsequent lawsuit, *Pegram v Herdrich*,⁵ redefined the potential liability of HMOs for their fiduciary obligations and for the negligence of HMO physicians.

In addition to state medical malpractice claims, Herdrich filed claims against the physician, Lori Pegram, and Carle Health Insurance Management Co., (Carle), the HMO for fraud, claiming that the benefit plan's cost saving incentives resulted in diagnostic procedures and treatment being withheld from Herdrich. While Herdrich prevailed in state court on her medical malpractice claims, the defendants used a provision in the Employee Retirement Income Security Act of 1974⁶ (ERISA) to remove the remaining state fraud counts to federal court.⁷ After dismissing one count of fraud, the District Court gave Herdrich leave to amend the remaining fraud count. Herdrich amended her complaint to include breach of fiduciary duty, and sought relief under ERISA, claiming that the HMO's incentive breached a fiduciary duty by creating a conflict of interest between plan participants, or patients, and plan fiduciaries, or physicians and managers of the HMO.⁸

¹ 530 U.S. 211, 215 (2000)

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³ *Pegram*, 530 U.S. at 215.

⁴ *Id.*

⁵ *Id.*

⁶ 29 U.S.C. § 1109 (1994).

⁷ *Pegram*, 530 U.S. at 215.

⁸ *Id.* at 217.

ERISA⁹ was signed by President Ford on Labor Day 1974 with the purpose of creating a uniform method of regulating employee retirement plans nationwide.¹⁰ By federally regulating employee pension plans, Congress sought to cure the mismanagement and underfunding of the plans by eliminating conflict between state and federal regulations.¹¹ In order to accomplish this uniformity, ERISA contained a preemption clause, preempting all state laws that "relate to" an employee health or welfare plan.¹²

In 1973 the Health Maintenance Organization Act of 1973¹³ (HMO Act) was enacted as a response to the rising cost of health care.¹⁴ Prior to this act the states retained exclusive control over HMOs.¹⁵ The HMO Act contained a provision preempting any conflicting state law.¹⁶ The goal of Congress was to encourage the start up of HMOs, which are prepaid medical plans, by providing loan guarantees and grants to HMOs as well as incentives to business to include an HMO option for their employees.¹⁷ By encouraging the growth of HMOs, Congress sought to stem the rising costs of the fee-for-service health care system. Despite the slow growth of HMOs until the 1980's, total HMO enrollments exceeded sixty million by the year 2000.¹⁸

⁹ Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 445 (codified as amended at 29 U.S.C. §§ 1001-1200 (1994)).

¹⁰ Thomas R. McLean, M.D. & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary duty after Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 9 (2001).

¹¹ Justin Goodyear, *What is an Employee Benefit Plan?: ERISA Preemption of "Any Willing Provider" Laws After Pegram*, 101 COLUM. L. REV. 1107, 1110 (2001).

¹² 29 U.S.C. § 1144(a) (1994 & Supp. 2001).

¹³ Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. §§ 300e-300e(17) (1994 & Supp. 2001)).

¹⁴ Jason A. Glodt, *Watch Out HMOs: The Future of Patients' Rights Will Soon Be Determined*, 45 S.D. L. REV. 640 (2000).

¹⁵ *Id.*

¹⁶ 42 U.S.C. § 300e(10) (1994 & Supp. 2001).

¹⁷ Glodt, *supra* note 14, at 641.

¹⁸ *Id.*

HMOs employ a host of cost cutting measures, including limiting diagnostic and treatment tools available to their patients. Many of these tools delay or diminish treatment available to the patients. Although state medical malpractice claims are still available against the physicians themselves, an HMO cannot typically be sued for medical malpractice, and any state fraud claims may be removed to federal court under ERISA, leaving the patient with only the tenuous ERISA claim of breach of fiduciary duty. There is no claim for malpractice or negligence under ERISA. Without a cause of action on which to base a claim, the defendant HMO may never pay for the results of their cost cutting measures. In order to survive a motion for dismissal after a claim has been preempted by ERISA, plaintiffs must make an ERISA based claim.

In order to withstand the motion to dismiss her fraud counts, Herdrich amended her claim to include the ERISA based cause of action of breach of fiduciary duty by the administrators of the HMO, Carle. The holding in *Pegram*, barring treatment decisions made by physicians based on covered benefits as breach of fiduciary duty against HMOs, was lauded by HMOs.¹⁹ Essentially, this eliminated any possible claim against the HMO under ERISA. There was, however, another result of the decision in *Pegram*. If a plan is found to control physician decisionmaking, the HMO will be liable for negligence along with the physician, and will not be preempted by ERISA. This opened new doors in state court for plaintiffs denied treatments by their HMO physicians.

Although the cause of action of breach of fiduciary duty under ERISA was eliminated as a claim against HMOs as a result of *Pegram*, not all HMO plans fall into the category of claims that will be preempted by ERISA. Plans that hold physicians out as their agents, or maintain control over physician decisionmaking will be held liable in state court along with the physician.

This note examines the *Pegram* decision and its potential impact on claims against HMOs. The Court's decision in

¹⁹ Goodyear, *supra* note 11, at 10.

Pegram should prove to be an important one in the arena of HMO liability, creating new possibilities for state causes of action for victims of HMO negligence. The elimination of the preemption of some types of negligence claims against HMOs allows the potential for plaintiffs to keep their claims in state court, where the claim may be analyzed in a manner resembling a state malpractice claim against a physician. The plaintiff would now have the same opportunities to seek remedy from the HMO as the plaintiff can now seek against the physician.

Section II of this article discusses the decision in *Pegram v. Herdrich*, and the Court's reasoning behind the holding. Section III explains the incentives for HMO cost cutting, as well as the methods the HMOs use to contain costs. Section IV explains ERISA, including the issues surrounding preemption, fiduciary duties under ERISA, the circumstances that trigger a fiduciary duty, and the remedies that are available. Section V discusses some methods employed to avoid ERISA preemption, and Section VI concludes with a discussion of what the future may hold for claims against HMOs as a result of the *Pegram* decision.

II. *PEGRAM v. HERDRICH*

Cynthia Herdrich visited her doctor, Lori Pegram, a physician-owner of Carle Clinic Association, P.C., Health Alliance Medical Plans, Inc., and Carle Health Insurance Management Co., Inc.²⁰ These organizations cooperatively serve as a for-profit HMO, and are referred to collectively as Carle.²¹ The HMO was a part of Herdrich's health care insurance provided by her husband's employer, State Farm Insurance.²²

Herdrich, complaining of pain in her groin, went to her HMO seeking medical care. Six days later Pegram discovered an "inflamed mass in Herdrich's abdomen."²³ Rather than

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ *Pegram*, 530 U.S. at 215.

recommending an immediate ultrasound examination at a local facility, Pegram scheduled an appointment eight days later in a Carle staffed facility more than fifty miles away.²⁴ Herdrich's appendix ruptured prior to the appointment, causing peritonitis.²⁵

In the lawsuit that followed, Herdrich filed claims in state court against Pegram and Carle for medical malpractice and fraud.²⁶ Claiming that ERISA preempted the fraud counts, the defendants removed the case to federal court, and sought summary judgment on the fraud counts.²⁷ Dismissing one fraud count, the District Court gave Herdrich leave to amend the other.²⁸ She did so by claiming breach of ERISA fiduciary duty, under 29 U.S.C. § 1109(a), based on the incentive program utilized by Carle.²⁹ Herdrich alleged that the cost cutting incentive programs utilized by Carle to encourage its physicians to reduce costs by limiting medical care "entailed an inherent or anticipatory breach of an ERISA fiduciary duty, since these terms created an incentive to make decisions in the physicians' self interest, rather than the exclusive interests of plan participants."³⁰ Although the state malpractice charges were tried and won by the plaintiff, the District Court granted the defendant's motion to dismiss the ERISA fiduciary claim.³¹ The decision to dismiss was later reversed by the Seventh Circuit, and finally brought before the Supreme Court.³²

The Supreme Court analyzed the fiduciary duty claim, ultimately reversing the Seventh Circuit decision.³³ The unanimous decision in *Pegram* held that HMOs are not ERISA plans, and that medical treatment decisions are not governed by

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.* at 216.

²⁹ *Pegram*, 530 U.S. at 216.

³⁰ *Id.*

³¹ *Id.* at 217.

³² *Id.*

³³ *Id.*

ERISA fiduciary duty provisions.³⁴ The results of this decision are twofold. HMOs are no longer liable in federal court under ERISA for medical decisionmaking; however, by holding that ERISA does not preempt all claims against HMOs, the organizations may be held liable under state malpractice and fiduciary duty laws.

The Court in *Pegram* realized that the for-profit HMO would be virtually eliminated by considering mixed eligibility decisions, decisions that combine benefit eligibility with treatment decisions, to be fiduciary decisions.³⁵ Since an HMO's profit is obtained from the residual of fixed membership fees minus costs for salary and care, "no HMO organization could survive without some incentive connecting physician reward with treatment rationing."³⁶ The Court determined that the resulting potential elimination of the for-profit HMO is contrary to congressional intent.³⁷ The Court also noted that to interpret a mixed decision as a breach of fiduciary duty claim would "boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians."³⁸ The Court determined that there was no reason to turn what was traditionally a state malpractice claim into a federal claim. Doing so would only serve to clog the federal courts with malpractice cases, as well as to remove simple negligence claims from the forum most suited to hear them.³⁹

III. FINANCIAL INCENTIVES TO LIMIT CARE

Before the creation of HMOs in the 1960's, medical services were traditionally offered on a "fee-for-service" basis.⁴⁰ The physician provided treatment and then submitted a bill to the patient or the patient's insurance company. The physician set his

³⁴ *Id.* at 236.

³⁵ *Pegram*, 530 U.S. at 233.

³⁶ *Id.* at 220.

³⁷ *Id.*

³⁸ *Id.* at 235.

³⁹ *Id.*

⁴⁰ *Id.* at 218.

own fees, which were paid by the patient or the insurance company, and the physician was reimbursed for care actually provided.⁴¹ Using this method, the financial incentive for the physician is to “provide more care, not less, so long as payment [is] forthcoming.”⁴² Many critics of this model of health care believe that fee-for-service medicine encouraged overutilization of services, and the practice of defensive medicine.⁴³

Alternatively, under an HMO, the physician contracts with the organization and receives a fixed fee for each patient he treats, regardless of the amount of treatment or care provided. The HMO bears the financial risk in this relationship, gambling that the patient will require less medical care than can be covered by the patient’s premiums.⁴⁴ In order to avoid financial loss, the HMOs develop plans to reduce unnecessary treatment and to narrow the scope of treatment covered by the plan. If the patient seeks a treatment not covered by the plan, the patient must bear the cost of the treatment.

HMOs commonly use two types of fee arrangements with physicians, with each arrangement resulting in a different financial incentive for the physician. The two types of fee arrangements commonly used by HMOs are salary plans and capitation plans.⁴⁵

Under a salary plan, the HMO pays the physician a salary, and he is paid the same amount of money regardless of the number of patients he treats or the amount of treatment or care he provides.⁴⁶ Under a salary plan, physicians have a financial incentive to limit the number of patients they see, and the time

⁴¹ David Orentlicher, *Paying Physicians More to do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 156 (1996).

⁴² *Pegram*, 530 U.S. at 218.

⁴³ Defensive medicine is the practice of prescribing tests or treatments that may be unnecessary in order to avoid a later malpractice lawsuit. The practice of defensive medicine was a result of increasing medical malpractice insurance costs and increased damage awards at malpractice trials. This practice is said to cost the healthcare industry millions of dollars of unnecessary costs each year.

⁴⁴ See *Pegram*, 531 U.S. 211.

⁴⁵ Orentlicher, *supra* note 41, at 160.

⁴⁶ *Id.*

and treatment they invest in each patient. There is no incentive to provide excessive care because the physician's salary does not change with the level of care. A capitation plan, however, pays the physician a set fee for each patient.⁴⁷ The physician has a financial incentive under this plan to increase the number of patients he sees in order to increase the number of fees.

In addition to these fee structures, HMOs may employ contractual incentives designed to encourage physicians to limit care. These cost cutting methods may cause physicians to withhold or delay treatment in order to limit costs. Methods used to control costs include utilization review and "scrutinizing requested services against the contractual provisions to make sure that a request for care falls within the scope of covered circumstances . . . or that a given treatment falls within the scope of the care promised."⁴⁸ Among the most questionable cost containment methods utilized by managed care organizations are gag clauses, which prohibit physicians from advising patients of treatment options not covered by the health plan.⁴⁹ In addition to these measures, HMOs also employ bonuses for cost containment, expanded capitation and fee withholding. Fee withholding deducts a portion of the physicians fees to fund certain patient treatments and services, returning any residual fees at the end of the year.⁵⁰ The cost cutting measure utilized in *Pegram* involved a "year-end distribution" of money saved to the HMOs physician owners; this method pays the physician owners annually the profit resulting from their cost cutting measures.⁵¹

⁴⁷ *Id.*

⁴⁸ *Pegram*, 530 U.S. at 219.

⁴⁹ Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity vs. Quality Lead to ERISA's Inequitable Preemption of Claims*, 34 AKRON L. REV. 571, 578 (2001).

⁵⁰ Orentlicher, *supra* note 41, at 160.

⁵¹ *Id.*

IV. ERISA

In 1974, Congress enacted ERISA⁵² to combat “underfunding and mismanagement of employee pension plans.”⁵³ By enacting ERISA, and including a broad preemption clause, Congress intended to eliminate conflict between local and state regulation of benefit plan administration.⁵⁴ The act gives the federal government control over the regulation of employee benefit plans by superceding all state laws that “relate to” employee benefit plans.⁵⁵ This effort to protect employee pension plans, however, not only resulted in changes in the way pension funds were administered, but also produced far-reaching effects on the accountability of HMOs. The broad language of ERISA allowed HMOs to neatly fall into the category covered by laws that “relate to” employee benefit plans, resulting in any state claims against HMOs being preempted under ERISA. Preemption could occur regardless of whether or not there was a cause of action available to the plaintiff under ERISA. Utilizing these loopholes allowed HMOs to escape virtually all liability for their actions. With no malpractice or negligence causes of actions available under ERISA, breach of fiduciary duty remained the only option for plaintiffs.

A. *Preemption of State Claims*

ERISA preempts any state law relating to an employee benefit plan⁵⁶ if that plan is maintained or established by an employer engaged in commerce, or an organization representing employees engaged in commerce, or in an industry or activity affecting commerce.⁵⁷ This means that any state law, including a

⁵² Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 445 (codified as amended at 29 U.S.C. §§ 1001-1200 (1994)).

⁵³ Goodyear, *supra* note 11, at 1110.

⁵⁴ Ochmann, *supra* note 49, at 581.

⁵⁵ ERISA § 514(a), codified in 29 U.S.C. § 1144.

⁵⁶ 29 U.S.C. § 1144 (1994 & Supp. 2001).

⁵⁷ 29 U.S.C. § 1003 (1994 & Supp. 2001).

state claim of medical malpractice, can be preempted if it “relates to” an ERISA plan.

The Act defines employee benefit plans to include plans that provide “medical, surgical, or hospital care of benefits...through the purchase of insurance or otherwise.”⁵⁸ This preemption is effective even if the plaintiff is left with no remedy under ERISA.⁵⁹ “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.”⁶⁰ State laws aimed at correcting the lack of remedy are preempted if they refer or relate to an ERISA plan.

1) *Qualifying as a Plan Under ERISA*

In order to determine if a law is “related to” a plan, and therefore preempted by ERISA, it is necessary to determine what a “plan” is. ERISA defines a plan as “any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits”⁶¹ Prior to *Pegram*, this definition encompassed HMO plans, as HMOs provide the medical benefits described to the plan beneficiaries. The decision in *Pegram*, however, restricts the definition of a plan to the contract between the HMO and the employer, rather than the “provisions of documents that set up the HMO.”⁶² The plan, therefore, is the contract between the employer and the HMO, and the relationship between the HMO and the patient falls outside the boundaries of the “plan.”

⁵⁸ 29 U.S.C. § 1002(1) (1994 & Supp. 2001).

⁵⁹ McLean, *supra* note 10, at 9.

⁶⁰ Timothy S. Jost, *Pegram v. Herdrich: The Supreme Court Confronts Managed Care*, 1 YALE J. HEALTH POL'Y L. & ETHICS 187 (2001).

⁶¹ 29 U.S.C. § 1002(1) (1994 & Supp. 2001).

⁶² *Pegram*, 530 U.S. at 223.

By defining “plan” in this manner, the Court restricts who can be considered a fiduciary under the plan. “[F]iduciary obligations can apply to managing, advising, and administering an ERISA plan.”⁶³ As a result of this decision, a fiduciary obligation can only be applied to those involved in the contract between the HMO and the employer, not between the HMO and the patient. The result is that, under some circumstances, a physician who is part owner of the HMO may have a fiduciary duty, whereas a physician who is an employee of the HMO may not.

2) *The “Related to” Problem*

ERISA section 514(a)⁶⁴ states “[t]he provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”⁶⁵ By using the broad language “related to” in ERISA, Congress used language that can be interpreted to connect almost any law to an employee benefit plan. The broad language has allowed even tenuously connected laws to be preempted and claims to be removed to federal court. However, in 1995, in *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,⁶⁶ the Supreme Court eliminated the preemption of tenuously connected laws by looking to the objectives of ERISA and interpreting the scope of the statute that was intended by Congress.⁶⁷ The *Travelers* Court “worked on the ‘assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.’”⁶⁸

⁶³ *Id.*

⁶⁴ Codified as 29 U.S.C. § 1144 (a).

⁶⁵ 29 U.S.C. § 1144(a) (1994 & Supp. 2001).

⁶⁶ 514 U.S. 645 (1995).

⁶⁷ *Id.* at 655 (a unanimous Court held that a New York statute requiring hospitals to collect surcharges from certain commercial insurers did not “relate to” employee benefit plans within the meaning of 29 U.S.C. § 1144(a), and was therefore not preempted).

⁶⁸ *Id.* (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947))

The Court determined that the objective of the ERISA preemption clause was “to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . and to prevent the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.”⁶⁹ So, the congressional intent, and the goal of the Court, is to avoid repetition or conflict of regulation “in order to permit the nationally uniform administration of employee benefit plans.”⁷⁰ Using this interpretation, the Court held that laws of general applicability, that only indirectly affect an ERISA plan, were not intended to be preempted by ERISA.⁷¹

In 1997, the Supreme Court utilized a two-part test to determine whether a state law was intended to be preempted by ERISA.⁷²

- A law “relates to” a covered employee benefit plan if it has a connection with, or reference to, such a plan.⁷³

- Even if a law does not refer to ERISA plans, it may still be pre-empted if it has a “connection with” ERISA plans.⁷⁴

The Supreme Court also reiterated that state law would not be superseded unless this was the clear intent of Congress.⁷⁵ After *Travelers*, a state law claim might avoid preemption if the law “does not impede a ‘nationally uniform administration of employee benefit plans.’”⁷⁶

⁶⁹ *Id.* at 657.

⁷⁰ *Id.* at 657.

⁷¹ *Id.* at 668.

⁷² *California Div. of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316, 324 (1997).

⁷³ *Id.* (quoting *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992)).

⁷⁴ *Id.* (clarifying this statement by utilizing the holding in *Travelers*, looking to the objectives of ERISA to determine the scope of state law intended to be preempted by Congress).

⁷⁵ *Id.* at 325.

⁷⁶ Ochmann, *supra* note 49, at 585.

B. Fiduciary Duty

Section 409 of ERISA⁷⁷ states that any fiduciary who breaches any of the duties under ERISA is personally liable for any loss to the plan resulting from the breach.⁷⁸ A fiduciary is defined by ERISA as someone acting in the capacity of manager, administrator, or financial advisor to a plan.⁷⁹ The fiduciary conflict claimed in *Pegram* was a result of the potential conflict between the physician-owner of the plan and the plan beneficiary.

The Court noted that a fiduciary “may have financial interests adverse to beneficiaries,”⁸⁰ such as when an administrator wears more than one hat at a time by acting as administrator, employer or plan sponsor. However, the Court made it clear that when acting as both fiduciary and as plan administrator, the “fiduciary with two hats wear[s] only one at a time, and wear[s] the fiduciary hat when making fiduciary decisions.”⁸¹ In order to determine if a fiduciary has breached his duty, it is first necessary to determine whether the function he was performing was fiduciary in nature.⁸² The physicians in Carle owed duties not only to the patient, but to “Carle Clinic, and to the ERISA plan itself.”⁸³ The prospect of receiving a large bonus at the end of the year, a bonus that increased as patient care costs are cut, may easily act as an incentive to limit care to the patient. This effect on medical decisionmaking may impair a fiduciary relationship with the patient. Therefore, the financial incentive structure of a plan may imply or cause a conflict of fiduciary duty under ERISA.

⁷⁷ Codified in 29 U.S.C. § 1109.

⁷⁸ 29 U.S.C. § 1109 (1994).

⁷⁹ 29 U.S.C. § 1102 (1994).

⁸⁰ *Pegram*, 530 U.S. at 225.

⁸¹ *Id.*

⁸² *Id.* at 226.

⁸³ McLean, *supra* note 10, at 18.

C. TYPES OF DECISIONS

In order to evaluate whether a claim for a decision made by an HMO or physician is preempted under ERISA, it must be determined what kind of decision it is. Decisions may involve: the quantity of care, or the denial of benefits; the quality of care, or the actual treatment provided by the physician; or a combination of quality and quantity of care, treatment decisions made by the physicians based on what benefits are covered by the HMO.

Quantity decisions, decisions involving denial of benefits or eligibility for benefits are typically preempted by ERISA.⁸⁴ These claims are based on the assertion that the welfare plan withheld a plan benefit due the plaintiff. ERISA § 502 provides redress for plaintiffs when promised benefits are not provided to them. Section 502 makes available a claim against an HMO, allowing plaintiffs seeking a remedy for a health care benefit that was covered by the HMO, yet was refused to the plaintiff.⁸⁵ Therefore, claims seeking remedy for denial of promised benefits would be preempted under ERISA.

Claims involving treatment decisions by physicians are not preempted, and thus may be litigated in state court.⁸⁶ ERISA § 502 does not provide a remedy for claims involving the quality of care the plaintiff received under the plan. Quality of health care benefits are a "field traditionally occupied by state regulation,"⁸⁷ and courts have interpreted the silence of Congress

⁸⁴ *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995); *Corcoran v. U.S. Healthcare*, 965 F.2d 1321, 1331 (5th Cir. 1992) (holding that a plaintiff's claim against her HMO for denial of complete bed rest during her pregnancy, resulting in the death of her fetus, was preempted by ERISA, because it was a denial of benefits claim).

⁸⁵ *Id.* at 357.

⁸⁶ *Dukes*, 57 F.3d at 350 (holding that the plaintiffs claim for the death of her newborn due to the negligence of the physician could go forward in state court).

⁸⁷ *Id.* at 357.

on the issue of preemption of claims involving treatment decisions “as reflecting an intent that it remain as such.”⁸⁸

It is the combination of treatment and benefit decisions, where physicians make treatment decisions based on benefits that are available in the HMO that was the basis of the dispute in *Pegram*. There are no distinct lines drawn in determining whether a decision is a benefit eligibility, treatment or mixed eligibility treatment decision and this subjective determination has led to frequently conflicting court decisions regarding whether a particular claim should be preempted by ERISA.

1) *Mixed Eligibility Treatment Decisions*⁸⁹

The decisions at issue in *Pegram* were termed by the Court as mixed eligibility treatment decisions. Mixed decisions are those that combine eligibility decisions and treatment decisions. Pure eligibility decisions are defined by the Court as decisions that “turn on the plan’s coverage of a particular condition or medical procedure for its treatment.”⁹⁰ Alternatively, treatment decisions “are choices about how to go about diagnosing and treating a patient’s condition.”⁹¹ These two types of decisions, however, are often not easily separated from one another.⁹² Mixed eligibility treatment decisions combine the questions of coverage with the best route for diagnosing and treating a patient. This type of decisionmaking combines both administrative and medical considerations. The decision in *Pegram* was just this type of mixed decision: diagnosing Herdrich’s abdominal mass, utilizing a facility staffed by Carle, and determining the necessity for treating the illness as an emergency were all combined into one decision.⁹³

⁸⁸ *Id.*; see also *Travelers*, 514 U.S. at 645.

⁸⁹ “Mixed eligibility treatment decision” is the phrase used by the Supreme Court in *Pegram* to refer to decisions combining eligibility for benefit decisions with treatment decisions.

⁹⁰ *Pegram*, 530 U.S. at 228.

⁹¹ *Id.*

⁹² *Id.* at 229.

⁹³ *Id.*

2) *Mixed Decisions as Fiduciary in Nature*

Pegram held that mixed eligibility treatment decisions made by a health maintenance organization were not fiduciary acts and, therefore, there was no federal claim for breach of fiduciary duty.⁹⁴ The Court determined that Congress did not intend HMOs, acting through their physicians, to be treated as fiduciaries when making mixed decisions.⁹⁵ The Court distinguished between an HMO and a traditional trustee, noting that “[t]rustees buy, sell, and lease investment property, lend and borrow, and do other things to conserve and nurture assets”⁹⁶ These duties revolve around financial decisions and protecting assets, with only a distant resemblance to the mixed eligibility decisions made by HMOs. The Court determined that it was financial decisions, not these mixed decisions that Congress intended to label as fiduciary in nature.⁹⁷

The Court also realized another potential result of holding HMOs to a fiduciary responsibility when making mixed decisions: the virtual elimination of the for-profit HMO. The remedy for breach of fiduciary duty is return of profits realized by the breach. This would mean the return of all profits of any incentive program, or other profit enhancing method utilized by the HMO. Since HMOs operate for profit, elimination of the profit would mean elimination of the HMOs. This potential result, coupled with Congress’s history of encouraging the formation of HMOs, led the Court to infer that Congress did not intend for ERISA to include a cause of action for breach of fiduciary duty against HMOs.⁹⁸

“[T]he 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

⁹⁴ *Id.* at 215.

⁹⁵ *Id.* at 231.

⁹⁶ *Pegram*, 530 U.S. at 231.

⁹⁷ *Id.*

⁹⁸ *Id.* at 234.

treatment of the patient.”⁹⁹ Although the Court found that there was no ERISA claim for breach of fiduciary duty, the Court did not discount a state breach of fiduciary duty claim, noting that the standard used to determine breach would resemble the medical malpractice standard.¹⁰⁰ Although a state breach of fiduciary duty claim would have previously opened the door for ERISA preemption, as a result of the Court’s holding in *Pegram*, the claim will not be preempted without clear congressional intent to do so. Therefore, if physicians are held liable under a state cause of action for either malpractice or fiduciary duty, “the HMO [will] be held vicariously liable for the physician’s conduct if it employed the physicians or represents to the public that the physicians are the HMOs agent.”¹⁰¹

D. Remedies under ERISA

Plaintiffs struggle to avoid ERISA preemption because of the limited remedies available under ERISA. Remedies available under ERISA §1132 are limited to equitable relief.¹⁰² Unlike state tort claims, actions brought under ERISA do not result in punitive damages; rather, ERISA remedies are limited to declaratory or injunctive relief. And, although trust law typically provides for “make whole” remedies that put the plaintiff “in the position in which he would have been if the trustee had not committed the breach of trust,”¹⁰³ courts have not fully embraced this remedy as applied to ERISA. Five circuits have held that plaintiffs are precluded from recovering punitive or compensatory damages under ERISA’s § 1132.¹⁰⁴ Even though ERISA

⁹⁹ Louis Saccoia, *Pegram’s Significance for Managed Health Care*, 1 YALE J. HEALTH POL’Y L. & ETHICS 195, 197 (2001).

¹⁰⁰ *Pegram*, 530 U.S. at 235.

¹⁰¹ McLean, *supra* note 10, at 30.

¹⁰² 29 U.S.C. § 1132 (1994 & Supp. 2001).

¹⁰³ *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 157 (1985) (Brennan, J., concurring) (citing Restatement 2d of Trusts §205).

¹⁰⁴ *Corcoran*, 965 F.2d at 1336; *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir. 1992); *Novak v. Anderson*, 962 F.2d 757 (8th Cir. 1992); *Bishop v.*

provides only for equitable remedy, the plaintiff still faces preemption of state law claims.¹⁰⁵ If the plan participant dies, even the limited remedies available under ERISA are no longer enforceable. The survivors cannot seek to enforce the deceased participant's rights.¹⁰⁶

V. *Avoiding ERISA Preemption and Removal*

HMOs seek to use ERISA to preempt all state claims against the HMO into federal court, where causes of action and remedies are extremely limited, and where there will be little financial redressibility for any wrongdoing on their part. Plaintiffs strive to maintain their claims in state court, where punitive and compensatory damages are available, and their negligence and other tort claims can go forward. So how does a plaintiff avoid preemption? There are no absolutes, but several tactics are available to plaintiffs.

A. *Basis for claim*

Following *Pegram*, mixed eligibility-treatment decisions, as well as treatment decisions, are not preempted by ERISA. The resemblance of claims involving treatment or mixed eligibility decisions to state negligence claims, and the silence of Congress on the issue of preemption of state claims against HMOs, cause the courts be reluctant to preempt these claims into federal court. Negligence claims are historically tried in state court, and federal courts are reluctant to clog up the federal system with claims that strongly resemble those traditionally tried in state court. If a plaintiff can demonstrate that the decision is not a mere benefit denial, he may be able to avoid preemption.

Osborn Transp., 838 F.2d 1173 (11th Cir. 1988); Sokol v. Bernstein, 803 F.2d 532 (9th Cir. 1986).

¹⁰⁵ *Corcoran*, 965 F.2d at 1336.

¹⁰⁶ Jane M. Mulcahy, *The ERISA Preemption Question: Why Some HMO Members are Dying for Congress to Amend ERISA*, 82 MARQ. L. REV. 877, 883 (1999).

B. *Well-Pleaded Complaints*

According to 28 U.S.C. § 1441, a claim must raise an issue of federal law on its face.¹⁰⁷ In order to be removed, a complaint must assert a federal claim.¹⁰⁸ The defendant cannot remove a state claim to federal court solely by using a federal law based defense. If a complaint contains only state claims, it may withstand preemption unless that area of law has been completely preempted by federal law.¹⁰⁸ Under 29 U.S.C. § 1144, ERISA preempts claims involving laws “related to” an employee benefit plan.¹⁰⁹ The Supreme Court in *Travelers* held that state laws that have only a “tenuous, remote, or peripheral connection”¹¹⁰ will not be preempted by ERISA. However, under § 1132, when “a plan participant brings a claim against an HMO which seeks to recover benefits due, to enforce his rights, or to clarify his rights, the claim is completely preempted by ERISA and automatically presents a federal question which must be addressed in federal court.”¹¹¹ A claim is only completely preempted if it falls within the civil enforcement provisions of § 502¹¹² of ERISA. “State law claims which fall outside of the scope of § 502, even if preempted by § 514(a), are still governed by the well-pleaded complaint rule and, therefore, are not removable under the complete-preemption principles . . . ”¹¹³ ERISA preemption under § 514(a) does not justify removal on its own, unless it falls within ERISA’s enforcement provisions.¹¹⁴ Without a § 502 claim, the well pleaded complaint rule can prevent preemption by the defendant.

¹⁰⁷ 28 U.S.C. § 1441 (1994).

¹⁰⁸ Mulcahy, *supra* note 106, at 883.

¹⁰⁹ 29 U.S.C. § 1144 (1994 & Supp. 2001).

¹¹⁰ *Travelers*, 514 U.S. at 655.

¹¹¹ Mulcahy, *supra* note 106, at 886 (referring to *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987)).

¹¹² Codified as 29 U.S.C. § 1132.

¹¹³ *Dukes*, 57 F.3d at 355.

¹¹⁴ *Id.*

C. *New State Laws*

Some states are revamping their state laws in an attempt to avoid ERISA preemption. In 1997, Texas enacted a law giving plaintiffs injured by an HMO the statutory right to sue the HMO for malpractice.¹¹⁵ This law provides: "A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care."¹¹⁶ The statute defines a health care treatment decision as "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees."¹¹⁷ This statute essentially provides a state cause of action for medical treatment provided by the HMO that has harmed a beneficiary, as well as a vicarious liability claim against the health plan.¹¹⁸ In *Corporate Health Insurance v. Texas Department of Insurance*,¹¹⁹ the Fifth Circuit concluded that the liability provisions of the law, as applied to services actually provided, was not preempted by ERISA.¹²⁰ A petition for a writ of *certiorari* is pending before the Supreme Court in the Texas case.

VI. CONCLUSION

The protection enjoyed by HMOs against state claims was eliminated by the Supreme Court in *Pegram*. As a result of this decision, plaintiffs may now seek redress in state court against HMOs for injuries they received as a result of inappropriate

¹¹⁵ Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-88.003 (2002).

¹¹⁶ *Id.* at § 88.002(a).

¹¹⁷ *Id.* at § 88.001(5).

¹¹⁸ *Corporate Health Ins. v. Texas Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000).

¹¹⁹ *Id.*

¹²⁰ *Id.*

mixed eligibility treatment decisions. HMOs may not continue to escape liability for their cost cutting measures now that plaintiffs have the opportunity to seek remedy in state court for negligence, breach of fiduciary duty, and vicarious liability against the HMOs. HMOs may have to review their procedures for containing costs and their treatment decisions in order to avoid breach of fiduciary duty claims against physicians and HMO administrators and physicians held out to be agents of the HMO.

The plaintiff has been given a new opportunity to seek compensation for injuries under state law, as opposed to merely obtaining equitable remedies under ERISA. While the HMO community lauded the *Pegram* decision as a victory, barring a cause of action for breach of fiduciary duty under ERISA for mixed eligibility decisions, they may find that they must answer in state courts, at a much higher price. A direct decision by the Court on the preemption of state statutes imposing liability on HMOs would further clarify the issue. Perhaps the Texas case will further illuminate this controversial issue.

A better method for imposing negligence or fiduciary liability on HMOs would be for Congress to enact new legislation. Such legislation could establish a uniform means for providing redressibility for plaintiffs who suffer from the negligence of their HMOs, and this uniformity would only further the purposes of the HMO Act and ERISA. Legislation to limit financial incentives to cut costs would also serve to protect plan beneficiaries. Until such legislation is established, however, the results will be left in the hands of the courts.

In the meantime, some cases have been remanded by the Supreme Court in light of the *Pegram* decision. For example, *Pappas v. Asbel*¹²¹ was remanded by the Supreme Court to the Pennsylvania Supreme Court, to be reheard in light of *Pegram*.¹²² Using the *Pegram* analysis, the Pennsylvania court affirmed its

¹²¹ 724 A.2d 889 (Pa. 1998), *vacated sub nom.* U.S. Healthcare Systems of Pa. v. Pennsylvania Hosp. Ins., 530 U.S. 1241 (2000), *and aff'd sub nom.* Pappas v. Asbel 768 A.2d 1089 (2001).

¹²² *Pappas*, 768 A.2d at 1090.

opinion that the medical negligence claim against the HMO was not preempted by ERISA.¹²³

If courts begin to consider the preemption issue in the manner demonstrated by the Court in *Pegram*, HMOs will have to accept liability for the decisions they make, and the decisions their physicians make in order to conform with HMO guidelines. If the state cause of action is not preempted, the HMO is susceptible to more extensive remedies than are available under ERISA, which may prove to be far more costly than revamping cost cutting measures.

¹²³ *Id.*