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To Preempt or Not to Preempt: HMO Liability Pre and Post Pegram v. Herdrich

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TO PREEMPT OR NOT TO PREEMPT: HMO LIABILITY PRE
AND POST *PEGRAM V. HERDRICH*

ADAM D. GLASSMAN¹

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I. INTRODUCTION

Should consumers have the right to sue their HMOs (health maintenance organizations) for the way they deliver medical care?

In recent years, the federal courts have focused their attention upon, *inter alia*, the issue of whether HMOs have a duty to reveal financial incentive provisions contained in contracts between the HMO and plan physicians to plan members and beneficiaries under a health plan. In fact, on June 12, 2000, the United States Supreme Court, in *Pegram v. Herdrich*,² pondered whether HMO physicians and administrators are fiduciaries under the Employee Retirement Income Security Act (ERISA)³, and if so, must they exercise their authority solely to benefit the interests of the patient?

Moreover, both houses of Congress recently passed bills, that together, make up the BPPA of 2001.⁴ For either bill to become law, however, “depends largely on its ability to endure House-Senate conference committee discussions, as well as President George W. Bush’s staunch refusal to place his signature on a bill that would ultimately serve as a boon for trial lawyers.”⁵

While the sponsors of the Senate bill appear to favor greater consumer protection, advocates in the House of Representatives are somewhat more restrained in their support of consumers’ rights.⁶ Perhaps it should come as no surprise that the less consumer oriented House bill is favored by President Bush, since it negates advantageous opportunities for trial lawyers.⁷

At this juncture, it is expected that a conference committee will work to develop a compromise bill that can be sent to the President.⁸ Should this compromise bill become law, it will function as the long-awaited Patients’ Bill of Rights.⁹

²*Pegram v. Herdrich*, 530 U.S. 211 (2000).

³29 U.S.C. §§ 1001-1461 (2000).

⁴Urura W. Mayers, *The Bipartisan Patient Protection Act: Greater Liability on Managed Care Plans*, 12 *Annals Health L.* 341, 341 (Summer 2003); *see also* Bipartisan Patient Protection Act of 2001, S. 1052, 107th Cong. (2001); Bipartisan Protection Act of 2001, H.R. 2563, 107th Cong. (2001).

⁵Mayers, *supra* note 4, at 341.

⁶*Id.*

⁷*Id.*

⁸*Id.*

⁹*Id.*

II. BACKGROUND

Historically, medical care in the U.S. has been delivered “on a fee-for-service basis.”¹⁰

Under this type of arrangement, a patient makes a payment to the provider selected for the services provided. Likewise, if the patient had insurance and the provider was willing, the provider submitted the patient's bill to the insurance plan for reimbursement subject to the terms of the insurance agreement. Therefore, under a fee-for-service arrangement, a provider's financial incentive is to provide more care, not less, so long as payment is forthcoming. The check on this incentive is a provider's obligation to exercise reasonable medical skill and judgment in the patient's interest. Beginning in the late 1960's, insurers and others developed new models for health-care delivery, including HMOs. In turn, HMOs developed from managed care, theories of reducing costs and providing the best value for both the provider and the patient. Generally, an HMO is any of a variety of types of health plans that contract with a defined group of providers (usually on a capitated basis) to provide health care to a defined population.

Capitation involves providing a monthly payment per enrollee regardless of what care the individual actually receives. The HMO thus assumes the financial risk of providing the benefits promised: if a participant or enrollee never gets sick, the HMO keeps the money regardless, and if a participant or enrollee becomes expensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant's or enrollee's premiums.¹¹

Accordingly, in an HMO system, less is more, so to speak, and “a [provider's] financial interest lies in providing less care, not more.”¹² However, covered services must be rendered with “a reasonable degree of skill and judgment in the patient's interest.”¹³

Today, HMOs may function both as medical providers and insurers.¹⁴ Moreover, there are two general varieties of HMOs.¹⁵ “The first type, the staff model, hires providers directly to work out of its facilities. The second type, the group model, contracts with provider groups to provide health care at discounted rates.”¹⁶

¹⁰*Id.* at 342.

¹¹*Id.* at 342-343.

¹²*Id.* at 343.

¹³*Id.*

¹⁴*Id.*

¹⁵*Id.*

¹⁶Mayers, *supra* note 4, at 343.

In 1973, the Health Maintenance Organization Act of 1973 (“HMOA”) became law.¹⁷ In an effort to encourage the creation of HMOs, HMOA “offer[ed] loans and loan guarantees to those wishing to establish and operate federally qualified HMOs, and for grants for such things as the training of HMO administrators.”¹⁸

Additionally, and perhaps more crucially, HMOA insulated HMOs from “restrictive state laws” by preempting them.¹⁹

It bears noting that other “managed care entities” were created to serve as “substitutions to conventional systems of health care to reorganize risk assumption and medical decision-making.”²⁰

Two of the managed care models that evolved included preferred provider organizations (“PPOs”) and point-of-service (“POS”) plans. PPOs are health plans that offer full or high coverage for a defined panel of providers (who accept discounted fees) and more limited coverage for care outside of the plan. A POS, on the other hand, is a “hybrid plan with features of managed care and insurance, thereby making it a traditional HMO that also partially reimburses care received outside the plan.”²¹

In an effort to conserve resources, and thus, enhance their bottom line, HMOs and other managed care organizations (MCOs):

primarily use two ways to encourage providers to engage in “cost-conscious decision making.” One way is through capitation. The second way is by salary. Salary exists when an HMO hires a group of providers as employees or contracts with a provider group, and each provider receives a salary for providing health care to a group of individuals in a particular health plan. Both of these payment plans discourage providers from spending more time with their patients, because there is no additional compensation available for doing so. Further, use of ancillary health care services like experimental treatments, diagnostic test, and referrals are not encouraged. This is because there is often a certain amount of money set aside for these services, and anything remaining goes to the provider as a bonus. These payment arrangements have, therefore, either directly or indirectly impacted providers’ decision-making regarding their patients and their patients’ medical care needs.²²

III. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (“ERISA”)

As noted above, the Employee Retirement Income Security Act (“ERISA”) was enacted into law by Congress in 1974. ERISA was enacted primarily to protect employee pension funds from mismanagement and looting by administrators, for the

¹⁷*Id.*

¹⁸*Id.*

¹⁹*Id.*

²⁰Mayers, *supra* note 4, at 343.

²¹*Id.* at 343-344.

²²*Id.* at 344.

ultimate protection of employees reliant upon such plans for retirement benefits.²³ Over time, ERISA has come to insulate most providers of employee benefits under employee benefit plans from lawsuits.

ERISA imposes certain fiduciary responsibilities for the protection of employee benefit rights,²⁴ and it has been held to preclude state law claims for the recovery of benefits or the enforcement or clarification of rights under an ERISA qualified health plan as well as preclude state law claims that “relate to” the statute under the statute’s preemption provisions.²⁵

IV. “FIDUCIARY” AS DEFINED UNDER ERISA

ERISA sets forth the circumstances under which a person is a fiduciary with respect to an employee benefit plan.²⁶ The definition includes one who “exercises any discretionary authority or discretionary control respecting the management of such plan” and one who “has any discretionary authority or discretionary responsibility in the administration of such plan.”²⁷

ERISA also imposes a duty upon plan fiduciaries to “discharge duties with respect to a plan solely in the interest of the participants and beneficiaries,”²⁸ and for the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan with the “care, skill, prudence, and diligence under the circumstances then prevailing that a prudent”²⁹ person would use under similar circumstances.

ERISA’s provision that fiduciaries shall discharge their duties with respect to a plan “solely in the interest of the participants and beneficiaries”³⁰ is rooted in the common law of agency, but an ERISA fiduciary may also have financial interests adverse to beneficiaries. Thus, in every case charging breach of ERISA fiduciary duty, the threshold question is not whether the actions of some person providing services under the plan adversely affected a beneficiary’s interest, but whether that person was performing a fiduciary function when taking the complained of action.³¹

V. FEDERAL PREEMPTION UNDER ERISA

ERISA imposes certain fiduciary responsibilities for the protection of employee benefit rights³² and has been held to preclude state law claims for the recovery of benefits or the enforcement or clarification of rights under an ERISA qualified health

²³See 29 U.S.C. §§ 1001-1461.

²⁴29 U.S.C. §§ 1001, 1101-14.

²⁵*Id.*

²⁶§ 1002(21).

²⁷§§ 1002(21)(A)(i), (iii).

²⁸§ 1104(a)(1).

²⁹§ 1104(a)(1)(B).

³⁰§ 1104(a)(1).

³¹*Id.*

³²§§ 1001, 1101-14.

plan as well as state law claims that “relate to” ERISA under the statute’s preemption provision.³³ ERISA’s preemption provision is found at 29 U.S.C. § 1144, and it provides that ERISA supersedes state common law affecting employee benefits if the claims “relate to” the plan.³⁴

ERISA was enacted to protect the interests of participants in employee benefit plans and their beneficiaries by, among other things, “establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts.”³⁵ Its regulation “extends to [plans] that provide medical, surgical, or hospital care or benefits for plan participants or their beneficiaries through the purchase of insurance or otherwise.”³⁶

Recognizing “the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans as ERISA’s crowning achievement,”³⁷ the legislation’s sponsors “emphasized both the breadth and importance of the preemption provisions [to] establish pension plan regulation as exclusively a federal concern.”³⁸ Thus, § 514(a) of ERISA provides that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”³⁹ This “broad” and “expansive” preemption clause⁴⁰ thus provides a federal law defense to all common law causes of action that “relate to” an employee benefit plan, unless ERISA expressly excepts the cause of action from ERISA’s preemption provision.⁴¹

Having preempted a field defined by claims relating to an ERISA plan, ERISA precludes the prosecution of preempted state-law claims that are not otherwise saved from preemption under § 514(b)(2)(A) unless they fall within the scope of the exclusive civil enforcement mechanism provided by § 502(a) of ERISA,⁴² in which case they must be treated as federal causes of action under § 502(a).⁴³ Section 502(a) authorizes participants or beneficiaries to file civil actions, among other things, to recover benefits, to enforce rights conferred by an ERISA plan, to remedy breaches of fiduciary duty, to clarify rights to benefits, and to enjoin violations of ERISA.⁴⁴

³³See generally *Miller v. HealthAmerica Pennsylvania Inc.*, 50 Pa. D. & C.4th 1 (Ct. Com. Pl. 2000).

³⁴29 U.S.C. § 1144(a).

³⁵29 U.S.C. § 1001(b).

³⁶*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51, (1995) (quoting ERISA § 3(1), 29 U.S.C. § 1002(1)).

³⁷*Id.*

³⁸*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

³⁹29 U.S.C. § 1144(a).

⁴⁰*Pilot Life*, 481 U.S. at 46.

⁴¹*Id.* at 48.

⁴²29 U.S.C. § 1132(a).

⁴³*Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987).

⁴⁴29 U.S.C. § 1132(a)(1)(B).

Thus, if a state law claim preempted by § 514 is not included within the scope of § 502(a), the claim is susceptible to a § 514 defense, whether it is brought in state or federal court.⁴⁵ However, if a state law claim falls within the scope of § 502(a), it is “completely preempted” and therefore treated as a federal cause of action.⁴⁶

Stated otherwise, under the scheme established by Congress, ERISA § 514 preempts a field defined by claims relating to employee benefit plans regulated by ERISA that are not otherwise subject to ERISA’s saving clause and, once having occupied that field, limits civil enforcement to claims provided in § 502(a).⁴⁷ Any claim falling within the field but not within the scope of § 502(a) is preempted and must be dismissed, and any claim falling within the scope of § 502(a) becomes exclusively a federal cause of action.⁴⁸ Thus, simple preemption under § 514 precludes prosecution of the preempted state law claim, but “complete preemption” exists when the preempted state law claim falls within the scope of the exclusive civil enforcement mechanism of § 502, in which case the state law claim is converted into a federal cause of action removable to federal Court.⁴⁹

Because a state law claim that is completely preempted under § 502(a) becomes a federal cause of action, it may be removed to federal court under 28 U.S.C. §§ 1331 and 1441 even if it is pleaded only as a state law claim. As the Supreme Court explained in *Metropolitan Life*, “[f]ederal pre-emption is ordinarily a federal defense to the plaintiff’s suit”.⁵⁰ As a defense, it does not appear on the face of a well-pleaded complaint, and, therefore, does not authorize removal to a federal court.⁵¹

One corollary of the well-pleaded complaint rule developed in the case law, however, is that Congress may so completely preempt a particular area that any civil complaint raising this select group of claims [within the scope of § 502(a)] is necessarily federal in character.⁵²

VI. THE FIDUCIARY STATUS OF AN HMO UNDER ERISA PRE-*PEGRAM*

Prior to the United States Supreme Court’s decision in *Pegram*, three of the Federal Circuit Courts of Appeal—the Fifth, Seventh and Eighth—heard cases and rendered decisions regarding whether or not HMOs are fiduciaries under ERISA, and thus, subject to liability as such.

⁴⁵*Id.*

⁴⁶*See Metropolitan Life*, 481 U.S. at 66-67.

⁴⁷29 U.S.C. § 1132(a).

⁴⁸*Id.*

⁴⁹*Metropolitan Life*, 481 U.S. at 66-67; *see also* *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 160 (3d Cir. 1999) (“It is important to distinguish complete preemption under § 502(a) of ERISA, which is used in this sense as a jurisdictional concept, from express preemption under § 514(a) of ERISA, which is a substantive concept governing the applicable law”); *Warner v. Ford Motor Co.*, 46 F.3d 531, 535 (6th Cir. 1995) (“Removal and preemption are two distinct concepts”).

⁵⁰*Metropolitan Life*, 481 U.S. at 63.

⁵¹*Gully v. First National Bank*, 299 U.S. 109, 112-13 (1936).

⁵²*Metropolitan Life*, 481 U.S. at 63.

A. The Fifth Circuit's Approach

In *Ehlmann v. Kaiser Foundation Health Plan*,⁵³ the plaintiff HMO plan members, seeking class certification, alleged that the defendant HMO as ERISA fiduciaries had a duty to disclose financial incentive arrangements with plan doctors.⁵⁴ Prior to reaching the class certification issue, the District Court dismissed the action for failure to state a claim, “finding that since ERISA imposed no such duty, Ehlmann could prove no set of facts in which that duty was breached.”⁵⁵

The Court of Appeals affirmed the dismissal on the ground that “ERISA nowhere contains any specific reference to a duty to disclose physician compensation plans.”⁵⁶ The Fifth Circuit refused to interpret ERISA in a broad fashion, opting to defer to the authority of Congress and the strict language of the statute.⁵⁷ The Court also declined to imply a duty to disclose from the general language of ERISA, since the statute has a number of disclosure provisions, none of which require the disclosure of physician incentive plans.⁵⁸

Remedy Sought

Amongst other things, the plaintiff sought an injunction requiring that the defendant “modify its member handbook and/or physicians directories to fully disclose to all plan members the bonus arrangements between the HMO and their contracting physicians.”⁵⁹

B. The Seventh Circuit's Approach

In *Herdrich v. Pegram*,⁶⁰ the District Court dismissed the plaintiff's fiduciary count for failure to state a claim.⁶¹

The Seventh Circuit reversed and remanded the action for trial on the fiduciary issue.⁶² Citing ERISA's conflict preemption provisions, the Court held that:

[i]n order to properly state a claim for breach of fiduciary duty under ERISA, the plaintiff's complaint must allege facts which set forth:

1. that the defendants are plan fiduciaries;

⁵³*Ehlmann v. Kaiser Foundation Health Plan*, 198 F.3d 552 (5th Cir. 2000).

⁵⁴*Id.* at 554.

⁵⁵*Id.*

⁵⁶*Id.* at 555.

⁵⁷*Id.*

⁵⁸*Id.* at 555-556.

⁵⁹*Id.* at 554

⁶⁰*Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), *reh'g en banc*, 170 F.3d 683 (7th Cir. 1999), *cert. granted*, 527 U.S. 1068 (1999), *rev'd*, 530 U.S. 211 (2000).

⁶¹*Id.* at 367.

⁶²*Id.* at 380.

2. that the defendants breached their fiduciary duties; and
3. that a cognizable loss resulted.⁶³

The Circuit Court, in noting that Congress intended the definition of fiduciary be broadly construed under ERISA, found that the defendant was an ERISA fiduciary.⁶⁴ The Court also found that the HMO's failure to disclose its physician incentive scheme was tainted with self-interest.⁶⁵ As for cognizable loss, the Court notes that since the plan was deprived of funds due to the incentive plan in question, loss was, in fact, suffered.⁶⁶ The 7th Circuit remanded the case to District Court for a trial on the fiduciary duty issue.⁶⁷

Remedy Sought

The plaintiff in *Herdrich* sought a prohibition against the alleged drainage of funds from the plan through enforcement of ERISA's fiduciary provisions.⁶⁸ Prior to the appeal, the plaintiff had received a \$35,000 verdict arising out of Dr. Pegram's medical malpractice.⁶⁹

C. The Eighth Circuit's Approach

In *Esensten v. Shea*,⁷⁰ the District Court dismissed the action for failure to state a claim on the ground that ERISA does not require disclosure of doctor compensation agreements since they are not "material facts affecting a beneficiary's interests."⁷¹ The Eighth Circuit reversed, finding that the HMO had a duty to disclose its "referral-discouraging approach to health care."⁷² The Eighth Circuit noted that the HMO in question was a fiduciary under ERISA and must comply with the common law duty of loyalty, which includes the obligation to deal fairly and honestly with all plan members.⁷³

Contrary to the District Court, the Eighth Circuit found that the financial incentive plan in question was a material piece of information to the patient, and that the duty of loyalty requires an ERISA fiduciary to communicate any material facts

⁶³*Id.* at 369.

⁶⁴*Id.* at 370.

⁶⁵*Id.* at 371.

⁶⁶*Id.*

⁶⁷*Id.*

⁶⁸*Id.* at 367.

⁶⁹*Id.*

⁷⁰*Esensten v. Shea*, 107 F.3d 625, *cert denied*, 522 U.S. 914, (1997), *aff'd on reh'g*, 208 F.3d 712 (8th Cir. 2000), *cert denied*, 531 U.S. 871 (2000).

⁷¹*Id.* at 627; *see also Pegram*, 530 U.S. at 228.

⁷²*Id.* at 628.

⁷³*Id.* at 628-629.

which could adversely affect a plan member's interests.⁷⁴ The Supreme Court denied *certiorari*.⁷⁵

Remedy Sought

While the remedy issue was not reached by the Court in *Esensten*, counsel for the plaintiff sought the value of the care her decedent spouse should have received. Additionally, plaintiff sought equitable relief, namely restitution to be paid to the HMO plan members from that portion of the HMOs profits which went toward unjustly enriching the administrator-physicians.⁷⁶

VII. THE SUPREME COURT RECTIFIES A CIRCUIT SPLIT: *PEGRAM V. HERDRICH*⁷⁷

A. The Facts

In *Pegram v. Herdrich*, the Petitioner was an HMO owned by physicians providing prepaid medical services to participants whose employers contract with Carle for coverage.⁷⁸ Respondent Herdrich "was covered by Carle through her husband's employer, State Farm Insurance Company." After petitioner Pegram, a Carle physician, required Herdrich to wait eight days for an ultrasound of her inflamed abdomen, Herdrich's appendix ruptured, causing peritonitis. She sued Carle in state Court for, fraud, *inter alia*.⁷⁹

Carle responded that the Employee Retirement Income Security Act of 1974 (ERISA) preempted the fraud counts and removed the case to federal court.⁸⁰

The District Court granted Carle summary judgment on one fraud count but granted Herdrich leave to amend the other.⁸¹ Her amended count alleged that the provision of medical services under terms rewarding "physician owners for limiting medical care entailed an inherent or anticipatory breach of an ERISA fiduciary duty," since the terms created an incentive to make decisions in the physicians' self-interest, rather than the plan participants' exclusive interests.⁸²

The District Court granted Carle's motion to dismiss on the ground that Carle was not acting as an ERISA fiduciary.⁸³ The Seventh Circuit reversed the dismissal.⁸⁴

⁷⁴*Id.* at 629.

⁷⁵*Esensten v. Shea*, 531 U.S. 871 (2000).

⁷⁶*Esensten*, 208 F.3d at 716.

⁷⁷*Pegram v. Herdrich*, 530 U.S. 211 (2000).

⁷⁸*Id.* at 215.

⁷⁹*Id.*

⁸⁰*Id.*

⁸¹*Id.* at 216.

⁸²*Id.*

⁸³*Id.* at 217.

⁸⁴*Id.* at 217-18.

B. *The Issue Presented*

The question presented in *Pegram* was “whether treatment decisions made by a[n] [HMO], acting through its physician employees, are fiduciary acts within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA).”⁸⁵ Despite the significance of *Pegram* to post-*Pegram* HMO liability preemption cases under ERISA, *infra*, the issue of federal preemption, pursuant to ERISA, was not addressed by the *Pegram* Court.

C. *The Court’s Holding*

The United States Supreme Court held that because mixed treatment and eligibility decisions by HMO physicians are not fiduciary decisions under ERISA, Herdrich did not state an ERISA claim.⁸⁶

D. *The Court’s Rationale*

Herdrich sought relief under 29 U.S.C. § 1109(a), which provides that:

any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the Court may deem appropriate, including removal of such fiduciary.⁸⁷

According to the Court, Congress did not intend an HMO “to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians,”⁸⁸ and, in fact, Congress is unlikely to have thought of such decisions as fiduciary.⁸⁹ The common law trustee’s most defining concern is the payment of money in the beneficiary’s interest, and mixed eligibility decisions have only a limited resemblance to that concern.⁹⁰ Consideration of the consequences of Herdrich’s contrary view leaves no doubt as to Congress’s intent.⁹¹ Recovery against for-profit HMOs for their mixed decisions “would be warranted simply upon a showing that the profit incentive to ration care would generally affect [such] decisions, in derogation of the fiduciary standard to act [in the patient’s interest] without possibility of conflict.”⁹² And since the provision for profits is what makes a for-profit HMO a proprietary organization, Herdrich’s remedy – return of profit to

⁸⁵*Id.* at 214.

⁸⁶*Id.* at 237.

⁸⁷29 U.S.C. § 1109(a).

⁸⁸*Pegram*, 530 U.S. 231.

⁸⁹*Id.*

⁹⁰*Id.*

⁹¹*Id.* at 232.

⁹²*Id.* at 232-33.

the plan for the participants' benefit – “would be nothing less than elimination of the for-profit HMO. [T]he Judiciary has no warrant to precipitate the upheaval that would follow a refusal to dismiss Herdrich's . . . claim.”⁹³

The Court, in shielding HMOs from such “breach of fiduciary obligation” causes of action under ERISA, acknowledged that Congress, which has promoted the formation of HMOs for 27 years, may choose to restrict its approval to certain preferred forms, “[b]ut the . . . Judiciary would be acting contrary to . . . congressional policy . . . if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure.”⁹⁴

Furthermore, the Court noted that the Seventh Circuit's attempt to limit fiduciary breach cases to instances in which the sole purpose of delaying or withholding treatment is to increase the physician's financial reward, would also lead to fatal difficulties.⁹⁵ The HMO's defense would be that its physician acted for good medical reasons.⁹⁶ For all practical purposes, every claim would boil down to a malpractice claim, and the fiduciary standard would be nothing but the traditional medical malpractice standard.⁹⁷ The only value to plan participants of such an ERISA fiduciary action would be eligibility for attorney's fees if they won.⁹⁸ A physician “would [also] be subject to suit in federal Court applying an ERISA standard of reasonable medical skill.”⁹⁹ This would, in turn, seem to preempt a state malpractice claim, even though ERISA does not preempt such claims absent a clear manifestation of congressional purpose.¹⁰⁰

E. Justice Souter's Footnote

Justice Souter, at footnote 8, leaves the door open to the imposition of liability upon an HMO.¹⁰¹ More specifically, Souter notes that an HMO may be considered a fiduciary under ERISA, “insofar as it has discretionary authority to administer the plan, and so it is obligated to disclose characteristics of the plan and those who provide services to the plan, if that information affects beneficiaries' material interests.”¹⁰²

⁹³*Id.* at 233.

⁹⁴*Id.* at 233-234.

⁹⁵*Id.* at 235.

⁹⁶*Id.*

⁹⁷*Id.*

⁹⁸*Id.* at 236.

⁹⁹*Id.* at 236.

¹⁰⁰*Id.*

¹⁰¹*Id.* at 228.

¹⁰²*Id.*

VIII. THE IMPACT OF PEGRAM

A. *Miller v. HealthAmerica Pennsylvania Inc.*¹⁰³

“What is a ‘mixed eligibility decision,’ and what is the significance (as to ERISA preemption) that such is not a (fiduciary) decision?”¹⁰⁴ These questions were addressed in *Miller v. HealthAmerica Pennsylvania Inc.*

The *Miller* Court dissected the holding in *Pegram*, and in so doing, it analyzed a number of matters important for any Court addressing ERISA preemption issues as they relate to the acts of an HMO.¹⁰⁵ According to the Court:

the Supreme Court took up the matter of an HMO playing various roles: sometimes making medical treatment decisions and sometimes making administrative decisions. That discussion arose in the following context. Ms. Herdrich claimed that the HMO breached a fiduciary duty in making certain decisions. Under ERISA, in order for a person to be considered a fiduciary, he or she “must be someone acting in the capacity of manager, administrator, or financial adviser” to a plan. (citation omitted). The statute “defines an administrator, for example, as a fiduciary only ‘to the extent’ that he acts in such a capacity in relation to the plan.” (citation omitted). Thus, it was important for the Supreme Court to determine whether the acts in question by the HMO were administrative: because, if so, the HMO was acting as a fiduciary at that time. It was in this context, then, that the Court discussed the various sorts of decisions that an HMO may make, and whether such decisions are “administrative” acts within the meaning of ERISA.¹⁰⁶

The *Miller* court further commented that “[t]he Supreme Court acknowledged that an HMO will sometimes make “pure” eligibility decisions (which are clearly administrative decisions) and sometimes pure medical treatment decisions (which are not administrative). The Court expanded this concept in a new way, however, by pointing out that, in many cases, these decisions are “practically inextricable from one another.”¹⁰⁷

The court went on to state that:

Eligibility decisions cannot be untangled from physicians’ judgments about reasonable medical treatment.¹⁰⁸ The Supreme Court concluded that in the case before it: [the HMO physician’s] decision was one of that sort. She [the HMO physician] decided (wrongly, as it turned out) that Herdrich’s condition did not warrant immediate action; the consequence of that medical determination was that [the HMO] would not cover

¹⁰³*Miller*, 50 Pa. D. & C.4th 1 (Ct. Com. Pl. 2000).

¹⁰⁴*Id.* at 22.

¹⁰⁵*See generally Miller*, 50 Pa. D. & C.4th 1 (Ct. Com. Pl. 2000).

¹⁰⁶*Miller*, 50 Pa. D & C.4th at 22.

¹⁰⁷*Id.* at 23.

¹⁰⁸*See Pegram*, 530 U.S. 211 (2000).

immediate care, whereas it would have done so if Dr. Pegram [the HMO physician] had made the proper diagnosis and judgment to treat. The eligibility decision [that Ms. Herdrich was not covered for the diagnostic test at the local hospital] and the treatment decision [that Ms. Herdrich did not require immediate medical attention] were inextricably mixed, as they are in countless medical administrative decisions every day.¹⁰⁹

Next, the *Miller* court noted that the Supreme Court “distinguished such ‘mixed’ eligibility decisions from ‘pure’ eligibility decisions ‘such as whether a plan covers an undisputed case of appendicitis.’”¹¹⁰ These “pure” eligibility decisions are “administrative” for purposes of ERISA. Where, however, there is an element of medical judgment involved, such decisions by an HMO are not made in an administrative capacity, and therefore not in a fiduciary capacity.¹¹¹

In an effort to clarify the Supreme Court’s concept of “mixed eligibility determinations,” the *Miller* court examined the following hypothetical:

assume that an ERISA plan provides that a plan participant is covered for treatment received at a hospital outside the HMO network only where such treatment is for emergency care. In Pegram, the Supreme Court pointed out that “an HMO’s refusal to pay for emergency care on the ground that the situation giving rise to the need for care was not an emergency” is just such a mixed determination. Such an eligibility determination, mixed as it is with medical judgment, does not constitute “administering” the plan, and is therefore not made by the HMO in a fiduciary capacity.

The significance of this analysis toward ERISA preemption analysis now becomes apparent. In both circumstances, the key inquiry is whether the decisions under consideration were made by the HMO in its capacity as “administrator” to the plan. In the Pegram case before the United States Supreme Court, such a finding would lead to the conclusion that the HMO was acting as a fiduciary with regard to that particular decision. In ERISA preemption cases, such a finding would lead to the conclusion that the claim is preempted under section 514 of ERISA. Accordingly, because the United States Supreme Court has concluded that such mixed eligibility decisions are not administrative acts under ERISA, a state Court tort claim against an HMO based upon such a mixed eligibility decision would likewise not be preempted by ERISA. The net effect of all of this, of course, is to reduce the opportunity for preemption. A decision by an HMO that might otherwise be thought to be administrative (and therefore give rise to preemption) is deemed not to be so where it is mixed with medical judgment.

¹⁰⁹*Miller*, 50 Pa. D. & C.4th at 23.

¹¹⁰*Id.*

¹¹¹*Id.* at 24.

In fact, the “emergency care” example used by the United States Supreme Court in *Pegram* not only illustrates that concept well, it also parallels the factual pattern before the Pennsylvania Supreme Court in *Pappas*. In *Pappas*, as set forth above, plan participants were generally required under the plan to receive their medical care only from doctors and hospitals within the HMO network-i.e., from doctors and hospitals having contracts with the HMO. Emergency care, however, was an exception. In an emergency, participants were covered under the plan no matter where they received their medical care. In the *Pappas* case, as noted above, the emergency room physician determined that the situation before him was a neurological emergency. The physician requested the HMO, therefore, to approve Mr. Pappas’s transfer to Jefferson Hospital, a facility outside the HMO network, but equipped and ready to treat Mr. Pappas. The HMO refused this request for authorization.

Such an eligibility determination by the HMO (that, under the plan, Mr. Pappas was not eligible for treatment at Jefferson) is clearly premised upon a medical determination (that Mr. Pappas’s condition did not warrant emergency care). The United States Supreme Court concluded in *Pegram* that such a mixed determination does not involve the “administration” of a benefit plan. It follows that a state Court medical malpractice claim challenging this mixed determination is not expressly preempted under section 514 of ERISA. Accordingly, the Pennsylvania Supreme Court’s holding in *Pappas* is still good law.¹¹²

Such a conclusion is also suggested by another section of the United States Supreme Court’s analysis in *Pegram*.¹¹³ In discussing the practical consequences of allowing mixed eligibility decisions by an HMO to form the basis of a fiduciary claim under ERISA, the Court concluded that such a claim would simply duplicate remedies already available in a state court malpractice action:

Thus, for 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. What would be the value to the plan participant of having this kind of ERISA fiduciary action? It would simply apply the law already available in the state Court.¹¹⁴

In short, the Supreme Court of the United States acknowledged that, in connection with certain claims against an HMO (such as those made in *Pappas*), a state Court remedy is “already available.”¹¹⁵ However, “such a remedy is (available), in state court, of course, only if it is not subject to preemption by ERISA.”¹¹⁶ The

¹¹²*Id.*

¹¹³*See Pegram*, 530 U.S. 211 (2000).

¹¹⁴*Miller*, 50 Pa. D. & C.4th at 26.

¹¹⁵*Id.*

¹¹⁶*Id.*

logical conclusion, then, is that the Supreme Court does not intend such “mixed” claims against an HMO to be preempted by ERISA.¹¹⁷

*B. The Second Circuit’s First Look Post-Pegram: Cicio v. Does*¹¹⁸

Cicio v. Does was the first case in the Second Circuit, subsequent to *Pegram*, to consider whether ERISA preempted medical malpractice claims.¹¹⁹ The *Cicio* case involved a claim in which an HMO denied a patient, who had been diagnosed with multiple myeloma, a treatment involving high dose chemotherapy, as well as peripheral blood stem cell transplantation in a tandem double transplant. The medical director of the HMO denied the treating physician’s request to authorize this treatment on the ground that it was an “experimental/investigatory procedure” not covered by the plan.¹²⁰ In response to the treating physician’s request for reconsideration, the medical director replied that “[b]ased on the clinical peer review of the additional material, a single stem cell transplant has been approved [but] the original request for tandem stem cell transplant remains denied.”¹²¹

The court dismissed the plaintiff’s malpractice claim on the ground that it was preempted by ERISA. In so doing, the Second Circuit concluded that “a state law malpractice action, if based on a ‘mixed eligibility and treatment decision,’ is not subject to ERISA preemption when that state law cause of action challenges an allegedly flawed medical judgment as applied to a particular patient’s symptoms.”¹²²

*C. Drawing Distinctions: Rubin-Schneiderman v. Merit Behavioral Care Corp.*¹²³

In *Rubin-Schneiderman v. Merit Behavioral Care Corp.*,

[p]laintiff brought a state court action against Empire Blue Cross, Merit, and Dr. Ahluwalia based on Merit’s refusal to authorize coverage for inpatient care for plaintiff’s psychiatric illness. The plaintiff claim[ed] that Merit and Dr. Ahluwalia were negligent in refusing coverage, and that Empire Blue Cross [was] vicariously liable for their acts. The plaintiff also charged both Merit and Empire Blue Cross with negligent hiring, training, and supervision.¹²⁴

Following removal of the action to federal court, the plaintiff moved to remand the matter back to state court.¹²⁵ The motion to remand was denied by the District

¹¹⁷*Id.*

¹¹⁸*Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *vacated by* *Vytra Healthcare v. Cicio*, 542 U.S. 933 (2004).

¹¹⁹*Id.*

¹²⁰*Id.* at 88.

¹²¹*Id.* at 88.

¹²²*Id.* at 102.

¹²³*Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 163 F. Supp. 2d 227 (S.D.N.Y. 2001).

¹²⁴*Id.* at 228.

¹²⁵*Id.*

Court on the grounds that the plaintiff's cause of action had been preempted by ERISA.¹²⁶

The District Court noted that “[i]n attempting to define the scope of claims subject to complete preemption, Courts have drawn a distinction between claims that relate to plan administration, which are completely preempted, and claims for medical malpractice, which remain governed by state law.”¹²⁷ The rationale behind this distinction lies in the fact “that malpractice claims involve individual cases of negligence for which ERISA provides no standards of review, and in which lack of uniformity does not subvert Congress’s purpose in regulating employer insurance plans.”¹²⁸

Ultimately, the plaintiff was unsuccessful in arguing that his claim should not be subject to complete preemption, since such claims should be construed as claims for negligence in providing medical treatment, as opposed to claims for the recovery of a benefit under the plan.¹²⁹

In denying the plaintiff’s remand request, the court acknowledged that prospective utilization review (“UR”) is a cost-containment mechanism commonly used by medical insurance providers. It further acknowledged that Merit’s job in performing UR for Empire Blue Cross was to determine whether plaintiff’s requested mental health treatment would be covered by plaintiff’s policy.¹³⁰

The plaintiff maintained that, by concluding that in-patient treatment was not medically necessary, “Merit exercised medical judgment and essentially dictated the course of plaintiff’s treatment. Plaintiff reasoned that his negligence claims did not involve enforcement of plan benefits *per se*, but rather related to the quality of medical care he received.”¹³¹

In denying the plaintiff relief, the District Court recognized that other courts have rejected claims such as the plaintiff’s on numerous occasions and concluded that decisions by UR agents to disapprove requested treatment relate to administration of plan benefits, not to provisions of medical care.¹³² In so doing, the Court recognized that claims for negligence in improperly failing to approve treatment more closely resemble claims for denial of a plan benefit than claims for medical malpractice.¹³³

The plaintiff further sought to overcome the weight of this authority by extending the reasoning of the Supreme Court’s recent decision in *Pegram*. In *Pegram*, the Court held that mixed eligibility/treatment decisions by HMOs and their physicians are not fiduciary decisions giving rise to a claim under ERISA.¹³⁴

¹²⁶*Id.* at 232.

¹²⁷*Id.* at 229-230.

¹²⁸*Id.* at 230.

¹²⁹*Id.*

¹³⁰*Id.*

¹³¹*Id.* at 230.

¹³²*Id.*

¹³³*Id.*

¹³⁴*Id.* at 230-231.

Although the issue of preemption was not before it, the *Pegram* Court expressed the concern that allowing preemption of claims relating to determinations about medical necessity would necessarily federalize malpractice litigation.¹³⁵ The Court also justified its finding on the basis that the health plan, a fee-for-service based plan, was not a covered plan under ERISA.¹³⁶

Ultimately, the Southern District, in a subsequent decision,¹³⁷ granted the defendant's motion to dismiss the action on the grounds of preemption.¹³⁸ Thereafter, the Second Circuit Court of Appeals¹³⁹ ordered the District Court to reconsider its dismissal of the underlying action in light of its decision in *Cicio*¹⁴⁰ Despite so reconsidering, the District Court adhered to its prior decision.¹⁴¹

*D. The Third Circuit Has a Look at HMO Liability Under ERISA Post-Pegram: Lazorko v. Pennsylvania Hospital*¹⁴²

The Third Circuit had an opportunity to examine the *Pegram* decision in *Lazorko v. Pennsylvania Hospital*. The decedent, Patricia Norlie-Lazorko,

committed suicide in July 1993, allegedly as a consequence of her untreated mental illness. Her husband, Jonathan Lazorko, brought suit in state Court against Dr. David Nicklin, Patricia's doctor; University City Family Medicine, Nicklin's employer; Pennsylvania Hospital; the Institute of Pennsylvania; and U.S. Healthcare, Inc., the health maintenance organization (HMO) administering Lazorko's health benefits. After a series of removals of the case to the U.S. District Court and remands to state Court, Lazorko appeals the dismissal of his direct claims against U.S. Healthcare and the District Court's award of sanctions against him for including two purportedly frivolous allegations in his complaint. U.S. Healthcare cross-appeals the District Court's remand to state Court of the vicarious liability claims against it.¹⁴³

The *Lazorko* court, following the Third Circuit's pre-*Pegram* decision in *In re U.S. Healthcare, Inc.*,¹⁴⁴ affirmed the remand to state court of the vicarious liability claims against U.S. Healthcare. However, it reversed the judgment of the district

¹³⁵*Id.* at 230.

¹³⁶*Id.* at 231-232.

¹³⁷*Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 2001 WL 1415165, 26 Employee Benefits Cas. 2872 (S.D.N.Y. 2001), *vacated by*, 60 Fed.Appx. 887, 2003 WL 1913131 (2d Cir. 2003), *aff'd in part and remained in part*, 121 Fed.Appx. 414 (2005).

¹³⁸*Id.*

¹³⁹*See Cicio*, 321 F.3d at 230.

¹⁴⁰*See id.*

¹⁴¹*Rubin-Schneiderman*, 2003 WL 22019833 (S.D.N.Y. 2003).

¹⁴²*Lazorko v. Pennsylvania Hospital*, 237 F.3d 242 (3d Cir. 1999), *cert. denied by Aetna U.S. Healthcare v. Lazorko*, 533 U.S. 930, 121 S.Ct. 2552, 150 L.Ed.2d 719 (2001).

¹⁴³*Id.* at 245.

¹⁴⁴*In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999).

court, dismissing the direct claims against U.S. Healthcare (Count I of the Complaint), and remanded these claims to the District Court for remand to the state court.¹⁴⁵

In examining the District Court's prior decision, the Third Circuit focused its attention on the scope of § 514(a).¹⁴⁶ The court maintained that its intervening decision in *In re U.S. Healthcare*¹⁴⁷ convinced it that plaintiff's direct claims against U.S. Healthcare are not completely preempted.¹⁴⁸ Of significance to the court was the fact that these direct claims "challenged the soundness of a medical decision by a health care provider rather than the administration of benefits under an ERISA plan."¹⁴⁹ Thus, the Third Circuit concluded that the plaintiff was not seeking a remedy for "the administrative denial of a benefit under § 502(a)(1)(B). For that reason, the removal of Lazorko's action to the federal court on the basis of complete preemption was improper."¹⁵⁰

The *Lazorko* court went on to hold that such a conclusion adhered to its holding in *In re U.S. Healthcare*,¹⁵¹ where the plaintiffs, like the plaintiff in *Lazorko*, "challenged U.S. Healthcare's financial incentive structure. They claimed it contributed to their newborn daughter's death because she was prematurely discharged from the hospital in order that the hospital might avoid monetary penalties. Thus, the infant was denied essential post-natal care."¹⁵²

Moreover, the Third Circuit noted that the plaintiffs brought their suit against the HMO in New Jersey state court, "alleging a variety of state law claims aimed at the influence which U.S. Healthcare's financial incentive system had on medical decisions."¹⁵³ The court noted that "[a]s in the case before us, U.S. Healthcare removed the case to federal court, claiming that the failure to provide adequate post-natal care constituted a denial of benefits that was completely preempted by ERISA."¹⁵⁴

Relying upon its additional pre-*Pegram* precedent, *Dukes v. U.S. Healthcare, Inc.*,¹⁵⁵ the court in *Lazorko* notes:

the refusal to offer additional care, whether couched in terms of direct or vicarious liability, could be a question of the quality of care provided. As such, it did not amount to a claim that benefits to which the plaintiffs were otherwise entitled had been denied by U.S. Healthcare when

¹⁴⁵*Lazorko*, 237 F.3d at 245.

¹⁴⁶*Id.* at 248.

¹⁴⁷*Id.* at 249; *see also U.S. Healthcare*, 193 F.3d at 161-62, 164.

¹⁴⁸*Lazorko*, 237 F.3d at 248-249.

¹⁴⁹*Id.* at 249.

¹⁵⁰*Id.*

¹⁵¹*See U.S. Healthcare*, 193 F.3d at 156.

¹⁵²*Id.*

¹⁵³*Id.*

¹⁵⁴*Id.*

¹⁵⁵*Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

administering a plan. Instead, the claim concerned decisions of treatment that were akin to claims for medical malpractice.¹⁵⁶ We had concluded in *Dukes* that a claim for vicarious liability against an HMO for a doctor's malpractice fell outside the scope of ERISA's complete preemption clause. In *In re U.S. Healthcare*, we extended that ruling to encompass claims that an HMO was directly liable for arranging inadequate care. In doing so, we reasoned that financial incentives that discouraged care did not deny plan benefits, but instead, affected the quality of the care provided. (citation omitted). Thus, we held that decisions to deny a particular request in the course of providing treatment could be a claim about the quality — and not the quantity — of benefits provided. In all but the details, Lazorko's claims against U.S. Healthcare fall squarely within this rubric. On appeal, Lazorko argues that his liability claims amount to ones of quality because U.S. Healthcare implicitly caused Dr. Nicklin to misdiagnose and/or mistreat the severity of Ms. Norlie-Lazorko's illness. Thus, such a claim does not fall within the complete preemption scope of § 502(a)(1)(B).¹⁵⁷

*E. Pappas v. Asbel*¹⁵⁸

The facts involved in *Pappas* were as follows:

On May 21, 1991, Basile Pappas ("Pappas") was admitted to Haverford Community Hospital ("Haverford") through its emergency room complaining of paralysis and numbness in his extremities. At the time of his admission, Pappas was an insured of HMO-PA, a health maintenance organization operated by U.S. Healthcare.

Dr. Stephen Dickter, the emergency room physician, concluded that Pappas was suffering from an epidural abscess which was pressing on Pappas' spinal column. Dr. Dickter consulted with a neurologist and a neurosurgeon; the physicians concurred that Pappas' condition constituted a neurological emergency. Given the circumstances, Dr. Dickter felt that it was in Pappas' best interests to receive treatment at a university hospital.

Dr. Dickter made arrangements to transfer Pappas to Jefferson University Hospital ("Jefferson") for further treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that U.S. Healthcare was denying authorization for treatment at Jefferson. Ten minutes later, Dr. Dickter contacted U.S. Healthcare to obtain authorization for the transfer to Jefferson. At 1:[05]p.m., U.S. Healthcare

¹⁵⁶*Lazorko*, 237 F.3d at 249 (citing *U.S. Healthcare*, 193 F.3d at 161-62, 164).

¹⁵⁷*Lazorko*, 237 F.3d at 249.

¹⁵⁸*Pappas v. Asbel*, 564 Pa. 407, 768 A.2d 1089 (2001), *cert denied* by U.S. Healthcare Systems of Pennsylvania, Inc. v. Pennsylvania Hosp. Ins. Co., 536 U.S. 938, 122 S. Ct. 2618, 153 L. Ed.2d 802 (2002).

responded to Dr. Dickter's inquiry and advised him that authorization for treatment at Jefferson was still being denied, but that Pappas could be transferred to either Hahnemann University ("Hahnemann"), Temple University or Medical College of Pennsylvania ("MCP").

Dr. Dickter immediately contacted Hahnemann. That facility advised Haverford at approximately 2:20 p.m. that it would not have information on its ability to receive Pappas for at least another half hour. MCP was then reached and within minutes it agreed to accept Pappas; Pappas was ultimately transported there at 3:30 p.m. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.¹⁵⁹

Plaintiff filed suit against his primary care physician, as well as the above hospital. He alleged that the physician had committed medical malpractice and that the hospital was negligent in causing "an inordinate delay in transferring him to a facility equipped and immediately available to handle his neurological emergency."¹⁶⁰

A subsequent third party action was commenced against U.S. Healthcare, which claimed that U.S. Health Care's liability hinged upon its failure and "refusal to authorize the plaintiff's transfer to a hospital selected by the Haverford physicians." In addition, the primary care physician asserted cross-claims against U.S. Healthcare seeking contribution and indemnity.¹⁶¹

Thereafter, U.S. Healthcare brought a motion for summary judgment with respect to the third party action, and maintained "that the third party claims are preempted by § 1144(a) of ERISA."¹⁶² While the lower court granted the motion, the superior court on appeal "determined that ERISA did not preempt the state law claims."¹⁶³ This Court subsequently granted U.S. Healthcare's Petition for Allowance of Appeal in order to determine whether these third party claims fall within the scope of those state actions which are preempted by ERISA."¹⁶⁴

Pursuant to the U.S. Healthcare Plan at issue, plan participants were generally required to receive their medical care only from doctors and hospitals within the HMO network, that is, from doctors and hospitals having contracts with the HMO. Emergency care, however, was an exception. In an emergency, participants were covered under the plan no matter where they received their medical care.¹⁶⁵

In the *Pappas* case, as noted above, the emergency room physician determined that the situation before him was a neurological emergency. The physician requested the HMO, therefore, to approve Mr. Pappas transfer to Jefferson Hospital, a facility

¹⁵⁹*Id.* at 410-411.

¹⁶⁰*Id.* at 411

¹⁶¹*Id.*

¹⁶²*Id.*

¹⁶³*Id.*

¹⁶⁴*Id.*

¹⁶⁵*Id.* at 419.

outside the HMO network, but equipped and ready to treat Mr. Pappas. The HMO refused this request for authorization.¹⁶⁶

Upon remand, pursuant to the direction of The United States Supreme Court, the *Pappas* court concluded that the HMO's refusal to permit referral to non-network hospitals was a "mixed eligibility and treatment decision" best addressed by state medical malpractice laws, and further, that ERISA did not preempt the claim against the HMO.¹⁶⁷

*F. One Court's Refusal to Apply the Principles Set Forth in
Pegram: Rosenkrans v. Wetzel*¹⁶⁸

In *Rosenkrans*, the "plaintiffs brought a state Court action against, *inter alia*, a medical center and health plan, seeking damages for patient's death allegedly resulting from defendants' tortious and negligent conduct."¹⁶⁹ The health plan sought removal to federal court on the grounds of federal preemption, while the plaintiffs made a motion to remand the matter to state court. The District Court maintained that the plaintiff's medical malpractice claim "was not subject to complete preemption, necessitating remand."¹⁷⁰ The basis for the court's holding was that the medical malpractice claim asserted against health plan was based upon alleged delivery of poor quality health care, and, thus, it fell outside scope of ERISA's civil enforcement provision and was not subject to complete preemption.¹⁷¹

Interestingly, the Court distinguished the matter before it from *Pegram*, which was relied upon by one of the defendants in the action. According to the Court:

We find that reliance, however, is misplaced and does not justify Defendant's argument.

In *Pegram* the Plaintiff, Herdrich, instituted a lawsuit in State Court for medical malpractice and subsequently added two counts charging state-law fraud. Several of the Defendants responded that ERISA preempted the new counts and removed the case to Federal Court. After certain proceedings in the Federal Court, Plaintiff was allowed to amend the complaint and she did so by alleging that the "provision of medical services under the terms of the Carle HMO Organization rewarding its physician owners for limiting medical care, entailed an inherent or anticipatory breach of an ERISA fiduciary duty.

¹⁶⁶*Id.*

¹⁶⁷*Id.*

¹⁶⁸*Rosenkrans v. Wetzel*, 131 F. Supp. 2d 609 (M.D. Pa. 2001).

¹⁶⁹*Id.* at 611.

¹⁷⁰*Id.*

¹⁷¹Employee Retirement Income Security Act of 1974, §§ 502(a)(1)(B), 514, 29 U.S.C.A. §§ 1132(a)(1)(B), 1144.

There was no contest in the *Pegram* case concerning the propriety of the removal of the matter from State to Federal Court and the Supreme Court took no position on whether the case was properly removed.

The question which the Supreme Court addressed in the *Pegram* case was “whether treatment decisions made by a health maintenance organization, acting through its physician employees, are fiduciary acts within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA) (citation omitted). The Supreme Court held that such conduct did not amount to “fiduciary acts within the meaning of ERISA.”

This is a different question than the one we face in the matter before us. The Complaint in this case is a straightforward medical malpractice action. All of the authorities we have cited herein instruct that such actions are not completely preempted and should be remanded to the State Court.

The Defendant would have us extend some of the commentary in the *Pegram* case and conclude that the commentary indicates the Supreme Court is moving in a direction which would find the preemption doctrine applies to a case such we consider in this opinion. We find no reason to accept the invitation to find within the *Pegram* case any indication of such a directional movement. Rather, we find the *Pegram* is confined to its own particular factual background and it provides us with no authority to accept the Defendant’s argument.¹⁷²

*G. Pryzbowski v. U.S. Healthcare, Inc.*¹⁷³

In *Pryzbowski v. U.S. Healthcare, Inc.*:

[t]he beneficiary of an employee benefit plan brought state Court action against an HMO, the beneficiary’s primary health-care provider, and the provider’s physicians, alleging injury from delays in approving requested referrals, and asserting claims for negligence and other torts. The HMO removed action. The United States District Court for the District of New Jersey dismissed the claim against the HMO and granted summary judgment in favor of the remaining defendants, all on the grounds of preemption by Employee Retirement Income Security Act (ERISA). The beneficiary appealed. The Court of Appeals, held that: (1) the state law claims against the HMO were completely preempted under ERISA’s civil enforcement provision; (2) the District Court had discretion to exercise pendent jurisdiction over the claims against the provider and physicians after the dismissal of the claims against the HMO; and (3) the negligence

¹⁷²*Rosenkrans*, 131 F. Supp. 2d at 611.

¹⁷³*Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001).

claims against the provider and the physicians were not preempted under ERISA's express preemption provision.¹⁷⁴

One of the "benefits" that HMOs provide is the doctors who render the medical services. Thus, claims of malpractice against HMOs arising from denial of authorization for treatment readily implicate the quality of care received by the patient, and courts rely on the fact that the HMO was acting as "medical provider" rather than "administrator" in finding that negligence claims are not completely preempted.¹⁷⁵

According to the *Pryzbowski* Court:

Pegram suggests preferable terminology. Although that case concerned fiduciary acts under ERISA and not preemption, the distinction made there between "eligibility decisions," which "turn on the plan's coverage of a particular condition or medical procedure for its treatment," and "treatment decisions," which are choices in "diagnosing and treating a patient's [sic] condition," is equally applicable for complete preemption analysis. Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.¹⁷⁶

The court further noted that it had not:

had occasion to consider how a claim that the HMO or plan administrator delayed in the approval of benefits should be treated under ERISA. It is evident that a claim alleging that a physician knowingly delayed in performing urgent surgery on a patient whose appendix was about to rupture would relate to the quality of care, and not be subject to removal on the basis of complete preemption. On the other hand, a claim alleging that an HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits. Such a claim, no matter how couched, is completely preempted and removable on that basis.¹⁷⁷

In determining whether a claim "falling between these poles is completely preempted . . . , [the Court maintained that] . . . it is necessary to refer to § 502(a)."¹⁷⁸ According to the Court, "Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable

¹⁷⁴*Id.*

¹⁷⁵*Id.* at 274.

¹⁷⁶*Id.* at 273.

¹⁷⁷*Id.*

¹⁷⁸*Id.*

to federal Court.”¹⁷⁹ Accordingly, the court concluded that it must examine the plaintiff’s claims against U.S. Healthcare to determine whether they could have been the subject of a civil enforcement action under § 502(a).¹⁸⁰

In essence, the Third Circuit distinguished its quality-of-care cases in holding that a plaintiff’s claim that her HMO delayed approving treatment by an out-of-network doctor was preempted.¹⁸¹ The *Pryzbowski* court reaffirmed the principle that determinations of whether requested treatment is covered under a policy relate to plan administration, and noted that because ERISA provided a remedy for this type of complaint, Congress intended that such claims be preempted.¹⁸²

IX. CONCLUSION

It is widely believed that the U.S. Supreme Court struck a “body blow” against the recent flood of lawsuits against managed care organizations in Federal courts.¹⁸³ *Pegram* arose from a rather “garden variety” medical malpractice case in which the plaintiff alleged that doctors at her HMO waited too long to order an ultrasound when they detected a mass in her abdomen, resulting in a ruptured appendix leading to peritonitis.¹⁸⁴ But the case had an additional twist. Pegram also claimed that her HMO violated the ERISA requirement, that plan trustees act in her best interests, by failing to disclose to her that the HMO paid a year-end bonus to its physicians for holding down the number of out-of-plan referrals and diagnostic tests. Pegram argued that this disincentive to refer was the reason her doctor waited so long to order her ultrasound.¹⁸⁵

The Supreme Court ruled unanimously that ERISA does not require such a disclosure and that, therefore, a federal court is not an appropriate forum for such a “garden variety” medical malpractice claim. Justice Souter’s opinion acknowledged that for HMOs to survive there must be both rationing of services and an inducement to ration.¹⁸⁶ The Court rejected the notion that ERISA provides a route for federal courts to be drawn into questions of malpractice that are traditionally decided by state courts.¹⁸⁷ Requiring such disclosures, and imposing liability for failing to make them, would mean the end of HMOs.¹⁸⁸ The court justified its ruling by noting that the system necessarily increased some risks, such as the risk of a ruptured appendix,

¹⁷⁹*Id.*

¹⁸⁰*Id.* at 273

¹⁸¹*Id.* at 272.

¹⁸²*Id.* at 274.

¹⁸³Healthcare Practice Newsletter, Vol. 3, Iss. 1, *Supreme Court Rules ERISA Bars Federal Suits Against HMOs*, available at <http://www.bkslegal.com/html/newsletters/healthcare/Vol3Iss1.html> (July 2000).

¹⁸⁴*Id.*

¹⁸⁵*Id.*

¹⁸⁶*Id.*

¹⁸⁷*Id.*

¹⁸⁸*Id.*

but reduced other risks, such as the performance of an unnecessary appendectomy.¹⁸⁹ The check on the incentive to provide less service, not more, is the physician's professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest.¹⁹⁰

While *Pegram* is widely viewed as a resounding victory for the managed care industry,¹⁹¹ such victory may prove to be a short-lived one.¹⁹² As noted at the outset of this article, the *Pegram* decision has, to some extent, increased the momentum in Congress for enactment of a patients' "bill of rights" legislation.¹⁹³ Some states, such as Texas and Illinois, already allow HMOs to be sued under certain circumstances.¹⁹⁴ However, to what extent Congress and our current President will water down the Bipartisan Patient Protection Act of 2001 remains to be seen.¹⁹⁵ For now, it is this author's belief that *Pegram* represents the resounding industry victory it is portrayed to be.

The flip side of *Pegram* is the Court's basic holding in the case that doctors do not act in a "fiduciary capacity,"¹⁹⁶ for ERISA purposes, when they make "mixed eligibility" decisions, i.e., decisions about which plan services are appropriate in a particular case.¹⁹⁷ This means that ERISA is not implicated in the medical judgments that managed care physicians make in parceling out healthcare resources.¹⁹⁸ Since ERISA does not apply to these decisions, HMOs and other providers will no longer be able to remove suits based on such decisions to federal court, and argue that ERISA's very limited damages provisions apply to them.¹⁹⁹ In that sense, the Supreme Court's opinion in *Pegram* may prove to be as much of a victory for "patient's rights" advocates as it is for the managed care industry.²⁰⁰

Certainly, it is incumbent upon a plaintiff seeking to maintain a state court action for malpractice against an HMO to plead very cautiously. As noted by the *Miller* Court, *supra*, the complaint "must be parsed very carefully."²⁰¹ Ultimately, those actions that strictly attack the quality of the health care provided by the HMO, and/or address mixed eligibility decisions,²⁰² as opposed to those actions involving purely

¹⁸⁹*Id.*

¹⁹⁰*Id.*

¹⁹¹*Id.*

¹⁹²*Id.*

¹⁹³*Id.*

¹⁹⁴*Id.*

¹⁹⁵*Id.*

¹⁹⁶*Id.*

¹⁹⁷*Id.*

¹⁹⁸*Id.*

¹⁹⁹*Id.*

²⁰⁰*Id.*

²⁰¹*Id.*

administrative decisions of the HMO, will remain unmolested by ERISA and accordingly will not be preempted by ERISA.²⁰³

In sum, state laws having general application and relating to areas traditionally subject to state regulation are more likely to survive preemption challenges.²⁰⁴

Ultimately, there is still uncertainty as to how far-reaching the *Pegram* decision is with respect to the issue of federal preemption. In fact, at least one jurist has commented:

I am not . . . certain . . . that the Supreme Court would confine the possibility of preemption solely to those cases involving pure eligibility determinations, and I believe that the reasoning of *Pegram* contains at least inferential evidence to the contrary. In my view, *Travelers*'²⁰⁵ alteration in the course of ERISA preemption jurisprudence, which was emphasized by this Court in *Pappas I*, may evidence more than the fact of a stricter preemption construct. It may also demonstrate that the preemption inquiry may not be presently capable of distillation into questions answerable in a simple "yes" and "no" fashion. Rather, in absence of an appropriate legislative solution, the inquiry may have to endure a degree of further evolution in the law, perhaps substantial, at both the state and federal levels, particularly as it applies to an industry which occupies a societal role that touches the citizenry at large and is itself rapidly evolving.²⁰⁶

²⁰²*I.e.*, where the decision to treat and the decision to ration care are inextricably intertwined.

²⁰³*See Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003).

²⁰⁴*See Pappas*, 564 Pa. 407 (2001).

²⁰⁵*New York State Conf. of Blue Cross & Blue Shield, Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995).

²⁰⁶*Pappas v. Asbel*, 564 Pa. 407, 432 (2001) (Saylor, J., dissenting).