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EMPLOYER SPONSORED HEALTH BENEFIT PLANS UNDER ERISA AFTER *PEGRAM v. HERDRICH*: THE FIDUCIARY DUTY ARGUMENT AND MIXED ELIGIBILITY VERSUS TREATMENT DECISIONS

JACK E. KARNS¹

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I. INTRODUCTION AND BACKGROUND

On June 12, 2000, a unanimous Supreme Court quietly rendered what will almost certainly become a landmark decision in healthcare law relative to the interpretation and application of fiduciary duties in an Employer Sponsored Benefit Plan [hereinafter “ESBP”] as regulated by the Employee Retirement Income Security Act of 1974 [hereinafter “ERISA” or the “Act”].² In *Pegram v. Herdrich*³ the Court rejected patient Herdrich’s claim that a cost containment plan whereby annual payments were made to physicians rose to the level of imposing a fiduciary duty on an HMO pursuant to ERISA.⁴ Such a duty would require the providing company to manage the ESBP funds in accordance with the statute and traditional common law principles.⁵ Carle Company, a large Health Maintenance Organization, maintained a policy of making annual kickback payments to physicians who cordoned costs at a

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²29 U.S.C. § 1144a (1988).

³*Pegram v. Herdrich*, 530 U.S. 211 (2000).

⁴Employee Retirement Income Security Act of 1974, 88 Stat. 832 (1974), as amended by Act of 1994, 29 U.S.C. §§ 1001, 1109(a) (1994).

⁵The fiduciary section of the ERISA statute provides:
[a]ny 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.
§ 1109(a).

pre-determined level.⁶ The corporation's rationale was that the payments were an incentive to keep costs down, the very essence of the HMO industry.⁷

Plaintiff Herdrich had been treated by Doctor Pegram who failed to make a referral to a specialist despite patient complaints of severe abdominal pains. Medication was prescribed and the patient sent home.⁸ Eventually, Herdrich suffered a ruptured appendix along with the typical resulting complications.⁹ She sued Carle Company under the theory that the kickback payments violated the ESBP clause of the ERISA statute in that the company stood as a fiduciary of the funds over which it presided.¹⁰ Specifically, Section 1109(a) of ERISA 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.¹¹

The monies in question had been collected from the employer and the worker, and as such, Herdrich claimed that Carle Company had a higher duty to insure their protection and proper use.¹² She also filed a negligence malpractice claim against the individual physician, Dr. Pegram. That suit eventually resulted in a jury verdict in favor of Herdrich with monetary damages.¹³ Carle Company, on the other hand adamantly stood by its position that the ESBP did not impose any fiduciary obligation relative to its handling of employee health care plan premiums.¹⁴ The issue as to whether ERISA preempted the claim against the company was not the focal point of the Circuit level dispute regardless of its growing importance amongst members of the managed care industry to keep states and class litigants from initiating any type of legal action comparable to that seen recently in the tobacco cases.¹⁵

⁶*Pegram*, 530 U.S. at 218-19.

⁷*Id.* at 219.

⁸*Id.* at 216.

⁹*Id.*

¹⁰*Id.* at 217.

¹¹29 U.S.C. § 1109(a); *see also Pegram*, 530 U.S. at 217.

¹²29 U.S.C. § 1109(a).

¹³*See generally Penny Pinching OK*, A.B.A. J., Aug. 2000, at 40.

¹⁴*See generally Pegram*, 530 U.S. 211.

¹⁵*Id.* at 220. The Court stated that Congress did not anticipate that the ERISA fiduciary provision would open the federal courthouse doors for unheard of fiduciary litigation. *Id.*

Previous to the issuance of the Court's opinion in June 2000, the author prepared an article based on the Seventh Circuit's opinion holding in favor of *Herdrich*.¹⁶ That article agreed in every respect that the managed care industry is insufficiently controlled in this country, or in the alternative, is controlling health care costs at the expense of one patient at a time.¹⁷ More specifically, arguments were made supporting the Seventh Circuit's decision as to the fiduciary application of ERISA against the Carle Company.¹⁸ Although accepted for publication prior to the Supreme Court's opinion hand-down date, the article was not available for circulation until subsequent to June 2000.¹⁹

Accordingly, this Article is a rebuttal to the Supreme Court's opinion in *Pegram v. Herdrich* on the strength of two primary arguments. First, the Seventh Circuit's rationale was on-point and extremely sound in concluding that HMOs do stand as trustees as envisioned by the ESBP and cannot offer kickback payments to physicians simply to increase shareholder wealth at the expense of patient health and

¹⁶Jack E. Karns, *Litigating Around ERISA to Quality Managed Healthcare: An HMO Can Breach Fiduciary Duties*, 79 NEB. L. REV. 149 (2000).

¹⁷*Id.* at 153-55.

¹⁸*Id.* at 169-70.

¹⁹The article was published in September 2000, several months after the unanimous decision in *Pegram*. The speed with which the Court dispensed with this case, a total of four months, inevitably emboldened the rationed care industry and its legal spokespersons:

The federal government's General Accounting Office found that every 1% increase in health care insurance premiums causes 300,000 to 400,000 people to lose coverage. There is no free lunch: Either premiums are higher, and fewer people secure coverage, or premiums are lower and less money is spent on health care costs. The inevitable effect of these lawsuits, if successful, would be to make only Cadillac care available, but solely to those who can afford Cadillacs.

Daniel E. Troy, *HMO Ruling Makes Sense*, NAT'L L. J., July 3, 2000, at A18.

The efficacy of the argument set forth by Mr. Troy begins with a questioning of federal governmental agency pronouncements. Mr. Troy can choose to believe whatever he wants, especially since he represents well-heeled HMO clients, but the problem with healthcare delivery in the United States has a venerable and not so glorious past that must be appreciated and then dismantled. As long as the American Medical Association [hereinafter "AMA"] was a major player in the manner in which physicians were educated and permitted to provide services, our system became too heavily skewed toward specialists. The AMA's role in the current debacle can be compared to the free-wheeling corporate takeover days of the 1980's when a corporate board made the company vulnerable to takeover by extravagant decision-making. What resulted was a flurry of activities that were an affront to anything resembling an honest "business" transaction. Michael Milken, junk bonds, paper numbers, and no tangible value. The real unfortunate part was that it was "just business" with no comprehension that the business cycle envisions making or producing services or goods, not paper profits. What finally brought all this chaos to an end was the crash of the market, the demise of junk bonds, the incarceration of a select few (not nearly enough) individuals and a realization that the entire decade had been a charade of greed and waste.

We are now engaged in an equivalent struggle within the healthcare industry as private firms encroach on what was once the sole domain of tax exempt organizations and the practicing profession. It is regrettable that the AMA and its constituent members did not see this attack forming, but that is understandable since they were too busy guarding private preserves to monitor the state of medical trust in this country. They now reap the whirlwind.

welfare.²⁰ This was a textbook example of breach of fiduciary duty given the medical trust relationship between physician and patient.²¹ Had the HMO offered a hedge fund option using securities from firms other than itself, there is no question that the fiduciary issue would have been much more difficult for Herdrich to establish.²² But by offering cash incentive payments, Carle Company wedged the interest of shareholder wealth maximization between that of physician performance and patient health needs.²³ This created a natural fiduciary tension that cannot be explained away by Justice Souter's comment that, "[t]he pleadings must also be parsed very carefully to understand why acts by physician owners acting on Carle's behalf are alleged to be fiduciary in nature."²⁴ All such decisions are fiduciary in nature.²⁵

Secondly, even though the courts did not deal with the preemption issue, *Pegram* opens the door for the industry to next claim complete preemption from state regulation via ERISA's provisions.²⁶ The managed care industry cannot have it both ways. If the ESBP does not apply to HMOs then neither does the preemption provision of the retirement Act.²⁷ This would then allow state attorneys general to provide at least minimal protection to residents by regulating managed care

²⁰North Carolina House Bill 1537 was passed on June 30, 2000, just ten days after the Supreme Court's decision in *Pegram*. The legislative healthcare package was ultimately ratified by both houses of the legislature as Senate Bill 199. This occurred on October 17, 2001, becoming Session Law 2001-446 following signature by the governor.

²¹*Herdrich v. Pegram*, 154 F.3d 362, 369-70 (7th Cir 1990).

²²WILLIAM F. SHARPE & GORDON J. ALEXANDER, INVESTMENTS, 553, 619-20 (1996). Hedging allows a reduction in sensitivity to the price of options by allowing a position that offsets the value of the investment held. Another investment is purchased that has an opposite price change. When a derivative can be purchased that is interest rate sensitive, an upward or downward movement in interest rates is thwarted. There is no question good hedging positions are difficult to formulate, however, the benefits are geometric.

The application to the HMO in a case such as *Pegram* would permit the company to have the providing physician participate in the "market" rather than in the rationing of healthcare. In effect, by making decisions not to make diagnostic or specialist referrals, the providing physician engages in the same type of risk taking that hedging entails. The difference is that "market hedging" does not involve possible malpractice, federal preemption or ERISA statutory claims. It just involves more work by the HMO to establish the process by which the physician is made a participant in the hedge pool.

²³*Herdrich*, 154 F.3d at 375-76.

²⁴*Pegram*, 530 U.S. 227.

²⁵*Herdrich*, 154 F.3d at 377. The Seventh Circuit stated:

We must remember that doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients. Trained physicians, and them alone, should be allowed to make care-related decisions with, of course, input from the patient. Medical care should not be subject to the whim of the new layer of insurance bureaucracy now dictating the most basic, as well as the important, medical policies and procedures from the boardroom.

Id.

²⁶*Id.* at 378.

²⁷*Id.*

organizations via state consumer protection statutes.²⁸ These are sometimes referred to as “Little FTC Acts,” and could be utilized in conjunction with other specific legislation aimed at curbing abuses in this business.²⁹ For example, North Carolina’s new “Patient Bill of Rights” provides for external review of HMO procedures.³⁰ It also prescribes prompt payment of claims and utilization review.³¹ Predictably, supporters of the *Pegram* decision see managed care organizations as recipients of everything on their wish lists, and then some, by implying too much from Justice Souter’s opinion:

This ruling may not formally end the many class actions filed against HMOs across the country since October [1999]. But the Supreme Court’s recognition that the very nature of an HMO involves cost controls reveals these lawsuits for what they are (but claim not to be) – broad based assaults on the concept of managed care. The court’s decision also shows that the insured are unlikely to benefit if these suits prove successful. Instead, they are likely to encounter higher premiums, less access to health care and health insurance, detailed judicial oversight of health care delivery and massive attorney fees.

...

Yet the HMO class actions attack virtually every incentive and practice managed care entities employ to try to curb medical costs. Accordingly, as Justice Souter implicitly recognized, these suits, if successful, would preclude HMOs.

...

Justice Souter’s commonsense approach undercuts the theory of the class actions. ‘The Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain lawsuits that ‘portend wholesale attacks on existing HMOs solely because of their structure.’ The court thus confirmed what everyone already knew: Managed care necessarily entails financial incentives to control runaway medical inflation.³²

Finally, the clarity of the Court’s position relative to the straightforward question of whether an employer sponsored health plan falls under the purview of ERISA’s fiduciary provision is no longer in issue.³³ However, the significant question is how the decision will affect state efforts to regulate managed care without running afoul of any federal preemption standards established by *Pegram*, implied or expressed?

²⁸*Id.* at 366 n.2 (Herdrich included in Count II of the Complaint an assertion that the Illinois Consumer Fraud Act had been violated due to failure to disclose material information).

²⁹*Herdrich*, 154 F.3d at 366 n.2.

³⁰N.C. GEN. STAT. §§ 58-50-75–95 (2001).

³¹§ 58-50-30.

³²Troy, *supra* note 19, at 4.

³³*See generally Penny Pinching OK*, *supra* note 13, at 40.

This is particularly troublesome since the next obvious step for the managed health care industry would be to argue that this case settles all issues regarding both fiduciary and federal preemption of state regulation.³⁴ *Pegram* did not directly address the preemption question, but the industry could easily look to a corollary situation for support.

In 1992, airline carriers argued that the Texas Attorney General [hereinafter "AG"] did not have the authority to impose advertising regulations given the preemption of any such efforts as set forth in § 1305(a)(1) of the Airline Deregulation Act of 1988 [hereinafter "ADA of 1988"].³⁵ Specifically, the airlines pointed to language in the section that the federal government had the authority to regulate "any law, rule, regulation, standard, or any other standard having the force and effect of law relating to rates, routes, or services of any air carrier."³⁶ In *Morales v. Trans World Airlines, Inc.*,³⁷ the Texas AG sought to impose section 2.5 of Air Travel Industry Enforcement Guidelines [hereinafter "Guidelines"], a document which had been adopted by the National Association of Attorneys General [hereinafter "NAAG"].³⁸ The key issue in this case concerned the manner in which airlines advertised the component parts of total air fares, while § 2.5 of the aforementioned Guidelines related to the handling of surcharges and stated that "[a]ny fuel, tax, or other surcharge to a fare must be included in the total advertised price of the fare."³⁹ The airlines had engaged in the process of "unbundling" fares such that surcharges were not included in the large print prices but were, instead, listed in fine print at the bottom of the advertisement.⁴⁰ Texas, along with six other signatory states, sent a memorandum and copy of the Guidelines to the major airline carriers indicating that failure to heed § 2.5 and that the standing practice of "unbundling" fare prices were violations of the Guidelines.⁴¹ Perhaps more importantly, the signatories added that the actions constituted a clear "violation of our respective state laws on deceptive advertising and trade practices."⁴²

Trans World responded by arguing that the ADA of 1988, as well as the Federal Aviation Act, preempted any such efforts by the states.⁴³ The Court had dealt with this same issue relative to ERISA, and it is these case decisions that the managed care industry is likely to argue are appropriate precedent in regulating HMOs as

³⁴See Steven K. Sanborn, *Supreme Court Clarifies ERISA Fiduciary Liability for HMOs but Muddies the Water on ERISA Preemption*, CAMPBELL L. OBSERVER, Summer 2000, at 4, 9.

³⁵49 U.S.C. § 1305 (1988).

³⁶§ 1305a-(1).

³⁷504 U.S. 374 (1992).

³⁸*Id.* at 379 (NAAG is an organization actively engaged in establishing uniform standards for consumer protection pursuant to state consumer protection statutes).

³⁹*Id.* at 405.

⁴⁰*Id.*

⁴¹*Id.* at 379.

⁴²*Morales*, 504 U.S. at 379.

⁴³*Id.* at 380.

well.⁴⁴ This presents some particular problems for those who support the Seventh Circuit's original decision in *Pegram*, as well as the likely arguments that will be forthcoming that the Court's reversal means in practical terms that a decision was also rendered that ERISA's preemption provision precludes any state regulation of managed health plans whatsoever. In effect, supporters of the *Pegram* decision argue that it settled both the fiduciary and preemption issues together, albeit the latter in an implied fashion.⁴⁵ The result will be one that only a Congressional solution will resolve given the impasse that currently exists with regard to insuring that corporate health care providers are held accountable, or at least held to a due diligence standard.⁴⁶ It is this latter point that produces the most consternation relative to the fallout of *Pegram*.⁴⁷ This Article will explore the actual fiduciary-related holding of *Pegram* and the controversy surrounding the Supreme Court's use of the term "mixed eligibility" decisions in deciding whether an HMO is a fiduciary.⁴⁸ Prior to this discussion the conflicting opinions issued by the Seventh

⁴⁴ERISA preempts state law to the extent that it "relate[s] to any employee benefit plan." 29 U.S.C. § 1144a (1988). The Supreme Court has recognized this particular language to have a "broad scope," *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985), a "broad sweep," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), is "broadly worded," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990), is "broadly worded" *Pilot Life Ins. Co.*, 481 U.S. at 46, and is "conspicuous for its breadth," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

⁴⁵See generally Troy, *supra* note 19.

⁴⁶Even Justice Souter agrees that the resolution of this issue resides with Congress. *Pegram*, 530 U.S. at 233-34.

⁴⁷See Marc I. Machiz, *Hidden Blow to HMOs*, NAT'L L. J., July 3, 2000, at A19.

⁴⁸*Pegram*, 530 U.S. at 227-28. The Court noted and then explained its distinction between "eligibility" versus "treatment" decisions made by HMO physicians:

The pleadings must also be parsed very carefully to understand what acts by physician owners acting on Carle's behalf are alleged to be fiduciary in nature. . . . What we will call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's [sic] condition: given a patient's constellation of symptoms, what is the appropriate medical response? These decisions are often practically inextricable from one another

This is so not merely because, under a scheme like Carle's, treatment and eligibility decisions are made by the same person, the treating physician. It is so because a great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. . . .

Id. (footnotes and citations omitted).

At this point, Justice Souter delivered what would become the foundation for excusing Carle for its providing physician's—Dr. Pegram—liability for mixed eligibility versus treatment decisions:

In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment, and in the case before us, Dr. Pegram's

Circuit and the Supreme Court will be examined as a prelude to a set piece discussion of the fiduciary duty issue.

II. THE SEVENTH CIRCUIT'S OPINION IN *HERDRICH V. PEGRAM*

Cynthia Herdrich was covered by a health insurance program owned by physicians and operated as Carle Company, an HMO.⁴⁹ This plan was provided by her husband's employer, State Farm Insurance, which had a contract with the HMO to cover its employees.⁵⁰ In 1992 she sought treatment from Pegram, a participating physician, for an inflamed abdomen.⁵¹ The physician did not make a referral to a specialist, but rather, sent her home with medicinal treatments.⁵² Eight days later the patient's appendix burst causing her to contract peritonitis.⁵³ An interesting and important aspect of the contract between the HMO and participating physicians was that annual kickback payments would be made if medical costs, especially referral costs, were kept to specified minimums.⁵⁴ Obviously, Carle Company referred to these payments as "cost containment" payments or "year-end bonuses" and argued that they were the very essence of what an HMO was established to do, keep healthcare costs low if not under control.⁵⁵ This particular aspect of the contract would be a particularly contentious one as the case made its way through the appellate process.⁵⁶

decision was one of that sort. She decided (wrongly, as it turned out) that Herdrich's condition did not warrant immediate action; the consequence of that medical determination was that Carle would not cover immediate care, whereas it would have done so if Dr. Pegram had made the proper diagnosis and judgment to treat. The eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical administrative decisions every day.

Id.

The tragedy of the Court's comments is that no allowance for the patient is provided in the case where care is withheld in such fashion that a full diagnosis has been disguised sufficient to claim a lack of negligence, yet still be able to benefit from the HMO's annual kickback scheme. To overlook this as a distinct possibility within the medical field is to disregard a fundamental understanding that not all physicians can be relied upon for superior treatment. Some are in it for the money and will sacrifice patient well-being for personal pecuniary gain, as long as they feel civil and criminal culpability cannot be proven.

⁴⁹*Herdrich*, 154 F.3d at 365.

⁵⁰*Id.* State Farm was an Illinois corporation at the time the plan was in effect. *Id.*

⁵¹*Id.*

⁵²*Id.*

⁵³*Herdrich* 154 F.3d at 365 n.1.

⁵⁴*Id.* at 371-72. Herdrich argued that because the company had the exclusive right to determine all "disputed and non-routine claims" the firm was a fiduciary. *Id.* at 371. Judge Coffey did not debate this conclusion: "We can reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims." *Id.* See also *Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 613 (7th Cir. 1995).

⁵⁵*Herdrich*, 154 F.3d at 372.

⁵⁶*Id.* In a very simple paragraph the Court set forth the self-serving nature of the kickback payments received by plan physicians to withhold critical care for personal pecuniary gain:

Herdrich sued both Doctor Pegram and Carle Company in state court alleging fraud on the part of the HMO and negligence on the part of the physician.⁵⁷ While Carle Company filed a motion to remove the case to federal court which was granted, Herdrich won a jury verdict in the amount of \$35,000 as to Doctor Pegram on the negligence claim.⁵⁸ The HMO refused to settle; in federal district court the HMO argued that ERISA preempted the fraud claims and was successful in having one of the fraud counts dismissed via summary judgment.⁵⁹ However, plaintiff Herdrich was given leave to amend the remaining fraud count which she did by artfully including the argument that the healthcare plan fell under ERISA's fiduciary rules since the physicians made decisions in the provision of medical services that were directly in their self interest.⁶⁰

The Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrator's year-end bonuses were based on the difference between total plan costs (i.e., the costs of providing medical services) and revenues (i.e., payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. With a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the Plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership.

Id.

It is difficult to see how Justice Souter could conveniently "parse" the pleadings this way as to overlook such a blatant "self-dealing" being perpetrated by Dr. Pegram. *Pegram*, 530 U.S. at 226. First, she examined Herdrich on March 1, 1991, and according to the Court, "acknowledged that she (Herdrich) was experiencing pain in the midline area of her groin." *Herdrich*, 154 F.3d at 365 n.1. Six days later, March 7, Dr. Pegram discovered an inflamed mass in the patient's abdomen. *Id.* Pegram then required the patient to suffer an additional eight days before she would accede to an ultrasound treatment. *Id.* Of course, that latter treatment had to be administered at a Carle Company facility fifty miles distant simply to save costs. *Id.* Altogether, Dr. Pegram required the patient to unnecessarily suffer fifteen days and face a company edict that she travel to an HMO owned facility for further treatment before her appendix ruptured. *Id.* This is not a medical condition generally considered to be minor in nature, and the unmitigated complication rests with Carle Company's callous disregard of patient pain and suffering at the expense of profit and care rationing. Then the company chose to reward this conduct by plan participants, if not require it at the risk of individual physician deselection, and hid behind the ERISA liability shield. The foregoing is the first illustration that the Supreme Court improperly overlooked critical Circuit Court rationale and conclusions that render suspect its four month leap to justice.

Judge Coffey cast a "jaundiced eye" toward the kickback arrangement vis a vis the fiduciary question while Justice Souter did not similarly view the arrangement. This is hardly the "commonsense approach" advocated by Mr. Daniel E. Troy in his observations of the final Court ruling. See *supra* note 32 and accompanying text.

⁵⁷*Herdrich*, 154 F.3d at 365.

⁵⁸See *Penny Pinching OK*, *supra* note 13, at 40.

⁵⁹*Herdrich*, 154 F.3d at 365.

⁶⁰*Id.*

Stated differently, by keeping medical costs down and refusing expensive referrals, the physicians received larger annual kickback payments. This created a personal incentive that rendered any decision to underprescribe treatment and procedures to be of direct pecuniary interest to plan participants.⁶¹ Assuming *arguendo*, the correctness of plaintiff's position, this would make Carle Company a fiduciary of the monies, both employer and employee contributed, used to fund the healthcare program and the HMO's liability for violating ERISA's fiduciary standards.⁶² The Seventh Circuit's affirmation of the district court's decision established the landscape for an epic healthcare legal battle that is likely to have repercussions for years.⁶³

The amended complaint was quite explicit regarding this heretofore unseen application of ERISA.⁶⁴ Bolstering the argument was the fact that if ERISA was determined to be applicable in this case, then the legislative history of the Act was very much in play.⁶⁵ Plaintiff most likely would have preferred to argue the preemption issue on other grounds, but given the Supreme Court's track record for applying ERISA in a "very broad" manner the situation dictated a novel approach to the question.⁶⁶ Accordingly, if Carle Company chose to protect itself under the ERISA umbrella, plaintiff should at least be heard on the broadest of applications as far as the statute was concerned.⁶⁷ This meant that Carle Company was portrayed as

⁶¹*Id.* at 372.

⁶²*Id.* at 372-73.

⁶³*Id.* at 379-80.

⁶⁴*Herdrich*, 154 F.3d at 366-67.

⁶⁵*Pegram*, 530 U.S. at 231-32. The United States Supreme Court in its reversal of the Seventh Circuit relied heavily on the assumption that Congress did not intend to include HMOs within the reach of ERISA:

Based on our understanding of the matters just discussed, we think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians. . . . Indeed, when Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits. . . . Its focus was far from the subject of *Herdrich*'s claim. Our doubt that Congress intended the category of fiduciary administrative functions to encompass that would follow from *Herdrich*'s contrary view.

Id. citing S. REP. NO. 93-127, at 5 (1973); S. REP. NO. 93-383, at 17, 95 (1973).

The irony of the position taken by the Supreme Court rests with the fact that a health benefit plan has all the comparable aspects of a pension plan, and employees view the two as critical benefits in any job selection process. Further, even if Congress passed ERISA to focus mainly on pensions, the provisions of the statute are written broadly and nothing cited by the Court as legislative history would have precluded a contrary decision.

⁶⁶*Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 439-43 (1999) (holding that ERISA's Exclusive Benefit Rule does not preclude the conferral of benefits by a plan sponsor on others, the sponsors may promote business interests unrelated to the pension plan, and sponsors may enhance existing plan benefits for current employees).

⁶⁷*Id.*

a significant trustee-like player and the healthcare plan was clearly an employer sponsored benefit plan that triggered ERISA's fiduciary responsibilities.⁶⁸ The crucible was the kickback payment scheme set in alignment with a healthcare plan where plan participants made self serving treatment decisions.

From a policy perspective, after ruling that the fiduciary rules of ERISA applied, the Seventh Circuit looked at the critical issue of duty breach.⁶⁹ The Circuit Court, Judge John L. Coffey presiding, was not led astray by Carle Company's extended effort to obfuscate the kickback scheme as it applied to the fiduciary issue in a smoke cloud of weak issues and arguments.⁷⁰ Judge Coffey believed that Carle Company's kickback payment arrangement cast a grave shadow over the entire healthcare program raising questions in the minds of patients as to whose interests were first and foremost on the minds of the participating physicians.⁷¹ Although not stated specifically in the opinion, the issue of medical trust has become a major concern as HMOs increase in number and total patient coverage. Yet, the managed care firms hold the trump cards as they can enter a market and self-determine just how aggressively to pursue market objectives. The result for covered patients is no or limited choices in medical care providers at the individual practitioner and hospital levels, since the HMOs can choose to qualify participants at both levels.

As to the breach of duty question the Seventh Circuit took all of the foregoing into consideration in rendering its opinion that Herdrich's claim merited consideration by a trial court.⁷² The circuit court also considered the overall effect

⁶⁸*Herdrich*, 154 F.3d at 371.

⁶⁹*Id.* at 372-73.

⁷⁰*Id.* at 376. Judge Coffey noted the interplay of the kickback scheme used by Carle Company and the flat fee or "capitation" payment system used by many HMOs:

In order to minimize health care costs and fatten corporate profits for HMOs, primary care physicians face severe restrictions on referrals and diagnostic tests, and at the same time, must contend with ever-shrinking incomes. Sixty percent of all managed-care plans, including HMOs and preferred-provider organizations, now pay their primary-care doctors through some sort of 'capitation' system, according to the Physician Payment Review Commission in Washington, D.C. That is, rather than simply pay any bill presented to them by your doctor, most HMOs pay their physicians a set amount every month--a fee for including you among their patients.

Id.

Judge Coffey continues with some payment examples. The Chicago GIA Primary Care Network pays \$8.43 monthly for every male patient and \$10.09 for every female patient. *Id.* He also cites the "withhold" system as yet another mechanism for rationing primary provider care. *Herdrich*, 154 F.3d at 376. Under this latter system "a percentage of the doctor's monthly fees are withheld and then reimbursed if they keep their referral rates low enough." *Id.*

⁷¹*Id.* In referring this "bottom line mentality," the business aspect of managed care is now indicated by what is referred to as the "medical-loss ratio," or the proportion of total revenues that have to actually be paid for patient care. *Id.* "The Association of Medical Colleges reported last November that medical-loss ratios of for-profit HMOs paying a flat fee to doctors for treatment averaged only 70% of their premium revenue. The remaining 30% went for administrative expenses--and profit." *Id.*

⁷²*Herdrich*, 154 F.3d at 380.

on the plan corpus⁷³ in light of the carefully crafted fiduciary argument so as to minimize the scope of the overall claim and the preemption issue.⁷⁴ This goal was achieved and is evidenced by the statement in the opinion that Herdrich alleged a fundamental and unconscionable overstepping that “springs from the authority of physician/owners of Carle to simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals.”⁷⁵ With this pronouncement the stage was set for Carle Company's expenditure of significant corporate resources to seek review by the highest court and for a disappointing result from the perspective of patients trapped by similarly situated HMO plans.⁷⁶

III. SUPREME COURT REVERSAL

The Supreme Court acted swiftly on this case by hearing oral argument in February and issuing its unanimous decision on June 12, 2000.⁷⁷ Justice Souter wrote for the Court and summed the salient issue as follows: “The question in this case is whether 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). . . . We hold that they are not.”⁷⁸ Following a recitation of the facts in *Pegram*, Justice Souter turned briefly to “some background of fact and law about HMO organizations, medical benefit plans, fiduciary obligation, and the meaning of Herdrich's allegations.”⁷⁹ Prior to the 1960's, fee-for-service was the accepted method for receiving medical assistance in this country.⁸⁰ A physician could establish set prices for defined procedures such as a physical exam or vaccination with the patient receiving a bill for payment.⁸¹ The physician might have been willing during this period to file the claim with the patient's insurance company, or as was more often the case, the individual had to do it himself.⁸²

In this fee-for-service system the check and balance as to the provision of medical services was the trust obligation between doctor and patient that reasonable skill and diligence would be exercised despite the fact that there was a definite

⁷³*Id.* (“On the surface, it does not appear to us that it was in the interest of plan participants for the defendants to deplete the Plan's funds by way of year-end bonus payouts.”).

⁷⁴*Id.* at 366. Herdrich had received judicial leave to amend Count III of the Complaint which provided the basis for moving forward on the ERISA claim. *Id.*

⁷⁵*Id.* at 373.

⁷⁶*Herdrich*, 154 F.3d at 372-73.

⁷⁷*Pegram*, 530 U.S. at 214.

⁷⁸*Id.* at 218.

⁷⁹*Id.*

⁸⁰*Id.*

⁸¹*Id.*

⁸²*Pegram*, 530 U.S. at 218.

incentive to provide excess care.⁸³ Perhaps more importantly, patients were free to choose their preferred physician and could rely on a variety of factors in doing so, a choice allowance not necessarily afforded with the introduction of HMOs. Starting in the 1960's new models for providing medical services sprouted up as non-medically trained individuals got involved with alternative healthcare delivery systems. HMOs were the logical outgrowth of this evolution and had as their defining feature one set fee for each patient enrolled in the program with the services to be provided established in a contract, typically with the employer.⁸⁴ Assumption of financial costs in excess of premiums paid were absorbed by the HMO which resulted in steps that any risk bearing organization would take.⁸⁵ Certain procedures would be permitted, or covered, while others were excluded.⁸⁶

It was also typical for the company to issue a general set of guidelines to be followed in the decision making process regarding additional medical procedures.⁸⁷ Requested services were scrutinized to insure that they fell well within the guidelines of covered procedures, and participating physicians were often provided financial incentives for keeping total general medical costs, as well as specialist referrals, to a minimum.⁸⁸ With the HMO the physician's personal pecuniary interest rested with providing less care, the patient protected only by the provider's professional obligation and medical trust.⁸⁹ After all, the reason that HMOs began to displace fee-for-service providers was that excessive and unnecessary services were being requested.⁹⁰ This natural tension resulted in the type of situation posed by the *Pegram* case since the provider received the type of annual payment discussed above.⁹¹ Further, Doctor Pegram decided to wait before referring her patient for an ultrasound, and she insisted that Herdrich travel a long distance to have this procedure done at a facility owned by Carle Company, another cost cutting move dictated by the HMO.⁹² Health care observers and commentators can easily argue that this is a clear violation of the medical trust and the professional obligation owed to a patient in immediate need of specialist care, constituting a complete disregard for the individual's needs in favor of self interest and HMO bottom lines.⁹³

The Supreme Court then discussed the bona fides of annual incentive payments to providers concluding that they were the essence of any healthcare delivery system

⁸³*Id.*

⁸⁴*Id.* This payment system is often referred to as capitation.

⁸⁵*Id.* at 219.

⁸⁶*Id.*

⁸⁷*Pegram*, 530 U.S. at 219.

⁸⁸*Id.*

⁸⁹*Id.*

⁹⁰*Id.*

⁹¹*Id.* at 220.

⁹²*Pegram*, 530 U.S. at 215.

⁹³*Id.*

designed with cost control in mind.⁹⁴ The Court stated that it was not suggesting “that the Carle provisions are as socially desirable as some other HMO organizational schemes; they may not be. . . . But whatever the HMO, there must be rationing and inducement to ration.”⁹⁵ No court could determine whether the decision-making of an HMO was good or bad in a particular case with additional information not likely to be readily accessible, such as correlation between malpractice rates and HMO models or fee-for-service programs.⁹⁶ In summation on this point, the Court quoted case precedent: “Congress is far, better equipped than the judiciary to ‘amass and evaluate the vast amounts of data’ bearing upon an issue as complex and dynamic as that presented here.”⁹⁷ The conclusion was that “courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs.”⁹⁸

Plaintiff Herdrich’s fiduciary claims were next addressed in the context as applied via ERISA. The statute requires that to be a fiduciary an individual must be acting as a manager or financial advisor to a “plan.”⁹⁹ The complaint alleged that Carle had breached its fiduciary duty by failing to properly execute its duties as to the health care plan.¹⁰⁰ ERISA includes a rather convoluted definition of the term “plan,” or “circular” as the Court put it.¹⁰¹ As to the term “fiduciary,” Carle is not a fiduciary under ERISA “merely because it administers or exercises discretionary authority over its own HMO business, it may still be a fiduciary if it administers the plan.”¹⁰²

Applying the common law of trusts necessitates a different approach, and does not adequately cover the healthcare issues presented in *Pegram*.¹⁰³ The most critical duty owed by a common law fiduciary is that of loyalty to the interests of the beneficiary(ies) with no self interest or third party promotion.¹⁰⁴ The Court referred to *Meinhard v. Salmon*¹⁰⁵ where Justice Cardozo stated:

Many forms of conduct permissible in a workaday world for those acting at arm’s length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not

⁹⁴*Id.*

⁹⁵*Id.* at 221.

⁹⁶*Id.*

⁹⁷*Pegram*, 530 U.S. at 221 (quoting *Walters v. National Ass’n of Radiation Survivors*, 473 U.S. 305, 331 n.12 (1985)).

⁹⁸*Id.* at 222.

⁹⁹*Id.*

¹⁰⁰*Id.*

¹⁰¹*Id.*

¹⁰²*Pegram*, 530 U.S. at 222.

¹⁰³*Id.* at 224.

¹⁰⁴*Id.*

¹⁰⁵164 N.E. 545, 546 (N.Y. 1928).

honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.¹⁰⁶

Beyond the initial requirement of “responsibility” owed to the beneficiary, fiduciaries under ERISA and the common law part ways markedly.¹⁰⁷

A common law fiduciary only acts in this capacity when he or she takes direct action that impacts on the beneficiary.¹⁰⁸ Typically, he owes no additional responsibilities in any other capacity to the beneficiary.¹⁰⁹ On the other hand, an ERISA fiduciary may at one moment be the manager of a healthcare plan benefiting employees, and then take on additional employer responsibilities owed to the beneficiary or where interaction with the beneficiary is required.¹¹⁰ In either case, there is absolutely no connection with his duties as the healthcare plan fiduciary.¹¹¹ Looking at the Herdrich complaint, the Court stated that:

In every case charging breach of ERISA fiduciary duty, then the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary’s interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to the complaint.¹¹²

More simply stated, Herdrich’s complaint did not sufficiently detail a breach of the ERISA fiduciary duty relative to Carle’s cost containment program adequate to maintain a cause of action under the statute.¹¹³

The Court analyzed the plaintiff’s claims as meaning that once Carle, as fiduciary administrator, was immediately “subject to such influence from the year-end payout provision that its fiduciary capacity was necessarily compromised, and its readiness to act amounted to anticipatory breach of fiduciary obligation.”¹¹⁴ This is the point at which the Court made clear its direct opposition to the fiduciary duty argument as framed in this case.¹¹⁵ The Court insisted that the pleadings be read carefully to determine exactly what actions by the physician owners could be construed as fiduciary in nature when undertaken on Carle’s behalf.¹¹⁶ At this point issues of “eligibility” were segregated from those regarding “treatment.”¹¹⁷ The former

¹⁰⁶*Id.* quoted in *Pegram*, 530 U.S. at 224-25.

¹⁰⁷*Pegram*, 530 U.S. at 225.

¹⁰⁸*Id.*

¹⁰⁹*Id.*

¹¹⁰*Id.*

¹¹¹*Id.*

¹¹²*Pegram*, 530 U.S. at 226.

¹¹³*Id.*

¹¹⁴*Id.* at 227.

¹¹⁵*Id.*

¹¹⁶*Id.* at 227-28.

¹¹⁷*Pegram*, 530 U.S. at 228.

decisions are those that go to the extent which the health plan provides coverage to a particular health problem or malady or the “medical procedure for its treatment.”¹¹⁸ In contrast, a treatment decision revolved around choices as to how to diagnose and treat a patient’s medical condition.¹¹⁹ This latter point is an extremely important one from the perspective of the Court and Carle Company as they both argue that the failure to refer or pursue a more vigorous plan of treatment is not, in and of itself, a breach of ERISA’s fiduciary duty.¹²⁰ But then, the Court made clear just how critical it was to “parse” the pleadings in order to render the appropriate decision.¹²¹

In a case like the one involving Herdrich, both eligibility and treatment decisions are rendered by the same individual with no recourse to a second opinion or double check method.¹²² The Supreme Court dismisses this argument since most coverage questions are simple yes or no questions:

Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO’s obligation to provide or pay for that particular procedure at that time in that case.¹²³

Dr. Pegram faced this type of decision and made an incorrect choice, as even the highest Court acknowledged.¹²⁴ This resulted in the patient’s eligibility and treatment decisions becoming “inextricably mixed, as they are in countless medical administrative decisions everyday.”¹²⁵ Perhaps Cynthia Herdrich disagreed, as the author does, with the characterization by the Court of the decision to deny her treatment as an “administrative decision” that simply went wrong.¹²⁶ This particular “administrative decision” had disastrous consequences and cannot simply be explained away as a “mixed eligibility” decision. To do so would rip whatever fabric remains of the medical trust between patient and doctor subsequent to the introduction of cost conscious HMOs.

For now, suffice it to say that the Court found no way that the eligibility and treatment decisions in Cynthia Herdrich’s case could be “untangled from the physician’s judgments about reasonable medical treatment.”¹²⁷ Doctor Pegram’s

¹¹⁸*Id.*

¹¹⁹*Id.*

¹²⁰*Id.* at 226.

¹²¹*Id.* at 227.

¹²²*Pegram*, 530 U.S. at 227.

¹²³*Id.* at 228-29.

¹²⁴*Id.* at 229.

¹²⁵*Id.*

¹²⁶*Id.*

¹²⁷*Pegram*, 530 U.S. at 229.

determination, as wrong as it was, made it possible for Carle to claim the “mixed eligibility” defense and avoid responsibility for the actions of one of its providers.¹²⁸ This amounts to a most convoluted legal rationale since virtually every decision rendered daily by HMO providers falls into this category.¹²⁹ The practical effect of this ruling is to render HMOs virtually judgment proof as long as the “mixed eligibility” factor is retained in the treatment process analysis.¹³⁰ This is hardly what Americans bargained for when managed care organizations burst onto the scene as the much heralded answer to medical inflation.¹³¹ How should a blatantly incorrect diagnosis be treated when the sum total of all medical decisions affect the physician's annual kickback payment?¹³² Does ERISA strip patients of all protection against HMO negligence, perhaps not in the “mixed eligibility” issue?¹³³ These are questions that now lay open as a result of *Pegram*. The Supreme Court has definitely provided the managed care industry with a shield that, when combined with a favorable preemption decision yet to come, will render HMOs more difficult to pursue in litigation.¹³⁴

IV. CONCLUSION

The most contradictory portion of the Court's rationale is the legalistic leap made regarding Congressional intent, “we think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians.”¹³⁵ The Court continues, “We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature.”¹³⁶ It is difficult to accord this speculation to be a fair reading of legislative history. Court speculation is not to be substituted for true legislative intent, and yet here, there appears to be no difficulty in doing so. Furthermore, the Court cites *Lockheed v. Spink*¹³⁷ to support the proposition that Carle was free to establish the kickback scheme since its “decisions about the content of a plan are not themselves fiduciary acts.”¹³⁸ *Lockheed* spoke to the issue of whether an employer had to adopt a plan or establish employee benefits at all. This rationale has been improperly intertwined and compared with the decision-making power handed over by Carle to its providing physicians to increase pecuniary gain at the expense of patient care. Mixed eligibility aside, this is not what underpinned the *Lockheed*

¹²⁸*Id.*

¹²⁹*Id.*

¹³⁰*Id.*

¹³¹*Id.*

¹³²*See, e.g., Michiz, supra note 47.*

¹³³*Id.*

¹³⁴*Id.*

¹³⁵*Id.*

¹³⁶*Id.*

¹³⁷517 U.S. 882 (1996).

¹³⁸*Id.* at 887.

holding. There it simply was a question of plan establishment, and it did not have the employer-created conflict of interest issues present in *Pegram*.

Then the Court turns to the common law fiduciary which is also a comparative stretch since the statute contains a fiduciary provision within. Even if the Court is afforded a favorable interpretation with respect to the applicability of common law fiduciaries, its conclusions are compelling, “[T]hus, the common law trustee’s most defining concern historically has been the payment of money in the interest of the beneficiary.”¹³⁹ Is this also not the case with health plans that are governed by ERISA?¹⁴⁰ Even if the Court believes that actions by Carle Company did not rise to a level sufficient to impose liability under this theory, the language of the opinion leaves the reader with the distinct impression that fiduciary law has no applicability to an HMO’s handling of an ESBP.¹⁴¹ But the Court states further that, “Mixed eligibility decisions by an HMO acting through its physicians have, however, only a limited resemblance to the usual business of traditional trustees.”¹⁴²

It is at this point that the Court pens the most controversial paragraph in the opinion:

To be sure, the physicians (like regular trustees) draw on resources held for others and make decisions to distribute them in accordance with entitlements expressed in a written instrument (embodying terms of an ERISA plan). It is also true that the objects of many traditional private and public trusts are ultimately the same as the ERISA plans that contract with HMOs. Private trusts provide medical care to the poor; thousands of independent hospitals are privately held and publicly accountable trusts, and charitable foundations make grants to stimulate the provision of health services.¹⁴³

The foregoing preamble to the paragraph could just as easily be an introduction to a decision upholding Herdrich’s claim.¹⁴⁴ What then, makes the difference?¹⁴⁵ The Court continues:

But beyond this point the resemblance rapidly wanes. Traditional trustees administer a medical trust by paying out money to buy medical care, whereas physicians making mixed eligibility decisions consume the money as well. Private trustees do not make treatment judgments, whereas treatment judgments are what physicians reaching mixed decisions do make, by definition. Indeed, the physicians through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day, in every possible medical

¹³⁹*Pegram*, 530 U.S. at 231.

¹⁴⁰*Id.*

¹⁴¹*Id.*

¹⁴²*Id.*

¹⁴³*Id.*

¹⁴⁴*Pegram*, 530 U.S. at 231.

¹⁴⁵*Id.* at 233 n.11 (opining the death of the HMO if Herdrich were to prevail on her claim).

setting: HMOs, fee-for-service proprietorships, public and private hospitals, military field hospitals, and so on. The settings bear no more resemblance to trust departments than a decision to operate turns on the factors controlling the amount of a quarterly income distribution.¹⁴⁶

Although it is true that private trustees may not make mixed eligibility decisions, this conduct does not, as the Court suggests, differentiate HMO provider decisions from the common law trustee.¹⁴⁷ They are both very much trustees, and the term “mixed eligibility” is a misnomer as the Court uses it in this opinion.¹⁴⁸ A “mixed eligibility” choice is not a decision as to whether a patient needs operative care, it is a conscious decision to forego medical care that the provider believes is not essential, and therefore, justified in its denial.¹⁴⁹ Further, this decision is reached with full knowledge that significant pecuniary benefit is accorded to the provider.¹⁵⁰

The Court would have us believe that “mixed eligibility” decisions are to be looked at from the view that medical practitioners can be trusted to do the right thing in the face of a plan that rewards them handsomely for denying care, specifically specialist services.¹⁵¹ Worse yet, the Court supports the notion that rationing of care is an absolute key component of managed care, otherwise it will not work.¹⁵² Without a substantial remedy that undertreated patients can seek against these managed care organizations, a mockery is made of the very essence of common law negligence and malpractice causes of action.

Further, the author is not so naive as to believe that the physicians of today, who are feeling the pinch of managed care as it changes the level of autonomy they once enjoyed, are as altruistic as the Court portrays them.¹⁵³ But the Court's final

¹⁴⁶*Id.* at 231-32.

¹⁴⁷*Id.*

¹⁴⁸*Id.*

¹⁴⁹*Pegram*, 530 U.S. at 232.

¹⁵⁰*Id.*

¹⁵¹*Id.* at 234. The Court stated: “The fiduciary is, of course, obliged to act exclusively in the interest of the beneficiary, but this translates into no rule readily applicable to HMO decisions or those of any other variety of medical practice.” *Id.* According to this rationale ERISA does not apply to employer sponsored health benefit plans at all, thereby begging the question as to exactly how the Court views the statutory fiduciary provision. *Id.*

¹⁵²*Pegram*, 530 U.S. at 233. “Since the provision for profit is what makes the HMO a proprietary organization, her [Herdrich] remedy in effect, would be nothing less than elimination of the for-profit HMO.” *Id.* The Court speculates as to the ultimate effect of a decision in favor of the patient in this case, “Recovery [according to Herdrich] would be warranted simply upon showing that the profit incentive to ration care would generally affect mixed decisions, in derogation of the fiduciary standard to act solely in the interest of the patient without possibility of conflict.” *Id.* at 232-33.

¹⁵³*Id.* at 233. Of equal concern to the Court was not just the immediate outcome of Herdrich's remedy request but speculation as to whether the managed care business would survive such a victory. “Her remedy might entail even more than that, although we are in no position to tell whether and to what extent nonprofit HMO schemes would ultimately survive the recognition of Herdrich's theory.” *Id.* The Court's mere speculation on this point is totally unwarranted, unnecessary to the decision at hand and makes clear its predisposition to

pronouncement is one that can be readily accepted, “Thus, it is at least questionable whether Congress would have had mixed eligibility decisions in mind when it provided that decisions administering a plan were fiduciary in nature.”¹⁵⁴ This conclusion is critical to buttressing the weak rationale afforded by *Pegram v. Herdrich*, but then, the Court ought not be in the business of fabricating legislative histories.¹⁵⁵ Finally, the Court expresses the view that Congress is the correct forum for a resolution to this interpretative problem.¹⁵⁶ The reticence with which this argument is espoused is astounding since the Court has never seen fit to curtail its interpretative powers over ERISA in the past.¹⁵⁷ What remains at the end of *Pegram* is a clarion call for Congress to pass legislation that clearly delineates the applicability of ERISA to pensions and deferred compensation, or in the alternative, clearly prohibiting its application to employer sponsored health care plans under

support the managed care industry by offering support to its financial viability. This is not the job of the Court but serves better to provide HMOs with exactly the type of “I told you so” justification that has proliferated the industry for the past decade.

¹⁵⁴*Pegram*, 530 U.S. at 232.

¹⁵⁵*Id.* at 236. One primary concern the Court has is the creation and promotion of a federal fiduciary malpractice claim should *Herdrich* prevail: “[w]hat would be gained by opening the federal courthouse doors for a fiduciary malpractice claim, save for possibly random fortuities such as more favorable scheduling, or the ancillary opportunity to seek attorney’s fees.” *Id.* at 237.

¹⁵⁶*Id.* at 233. The Court relies exclusively on the right of Congress to promote and govern the practices of HMOs. *Id.* (citing Health Maintenance Organization Act of 1973, 87 Stat. 914, 42 U.S.C. § 300e *et. seq.*, as amended by, 110 Stat. 1976 (1994 ed., Supp. III)).

¹⁵⁷*See Hughes Aircraft Co.*, 525 U.S. 432 (The “Exclusive Benefit” rule contained in ERISA does not preclude a decision by the plan sponsor to confer benefits on others, nor does it prevent the sponsor from promoting business related interests not related to current pension benefits. The Supreme Court also held that plan benefits could be enhanced for current employees without violation of this rule.). *See generally* J. KARNs, *Deferred Compensation Planning, The ‘Exclusive Benefit’ Rule, and The Hughes Aircraft Case: Has the Employer Benefit Restriction Been Altered With Respect to ERISA Qualified Pension Plans?*, 33 CREIGHTON L. REV. 507 (2000). *See also supra* note 44.

ERISA.¹⁵⁸ This is the reason that the statute was passed, and it should not be used by managed care organizations to conveniently avoid malpractice liability.¹⁵⁹

But the real devastation of the *Pegram* decision rests in the judicially sanctioned shield placed around the healthcare industry, and the damage that it will have in denying treatment resulting in life and death consequences. The only hope that consumer patients have at present is the case of *Pappas v. Asbell*,¹⁶⁰ decided by the Pennsylvania Supreme Court prior to the February 12, 2000, decision in *Pegram v. Herdrich*.¹⁶¹ In *Pappas*, the Pennsylvania High Court followed structured case precedent in holding that HMOs were liable to patients under the ERISA statute. Interestingly, in that case the United States Department of Labor [hereinafter "USDOL"] filed an initial amicus brief that supported the HMO position.¹⁶² Following remand by the United States Supreme Court to reconsider the decision in light of *Pegram*, the USDOL has filed a second brief repudiating the position it took in the previous pleading.¹⁶³ Proponents of HMOs spell doom if the Pennsylvania Supreme Court is persuaded by the reversal in positions, even if it is a change by an executive agency rather than a higher court.

One commentator, a member of the bar who represents HMOs, went so far as to say that the revised USDOL position would threaten HMOs with infinite liability:

¹⁵⁸*Pegram*, 530 U.S. at 233. If the Supreme Court selectively adopts a broad interpretation of ERISA when convenient then the following dicta in *Pegram* has no basis:

Indeed, when Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits. Its focus was far from the subject of Herdrich's claim. Our doubt that Congress intended the category of fiduciary administrative functions to encompass the mixed determinations at issue here hardens into conviction when we consider the consequences that would follow from Herdrich's contrary view.

Id. at 232 (citations omitted). See also *supra* note 65.

This judicial observation is emboldened by the comment that "[T]he mischief of Herdrich's position . . .," would portend serious consequences for federal jurisdictional purposes. *Pegram*, 530 U.S. at 236.

¹⁵⁹*Id.* at 235-36. Perhaps the most telling aspect of the Court's bias in favor of HMOs is the less than slightly veiled prognostication of the dangers to follow a Herdrich victory. Again, the federal fiduciary malpractice claim has the justices concerned more about judicial workload than uncorroborated legislative history. ("[W]e know that Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary, nor such a risk to the efficiency of federal courts as a new fiduciary-malpractice jurisdiction would pose in welcoming such unheard-of fiduciary litigation." *Id.* at 237.) For the final time, Justice Souter demonstrates histrionically exactly what Congress intended in the ERISA fiduciary provision and the opinion that it would lead to another federal jurisdiction basis. These conclusions are not warranted but do serve to neatly contain the Herdrich claim before it is permitted to open the way for more litigation against the managed care industry. Or does it? See *infra* notes 159-61 and accompanying text.

¹⁶⁰724 A.2d 889 (Pa. 1998), *cert. granted, vacated by* 530 U.S. 1241 (2000).

¹⁶¹530 U.S. 211.

¹⁶²Deirdre Davidson, *HMOs Face Attacks on Two Fronts*, NAT'L L.J. at B1, B3.

¹⁶³*Id.*

“HMOs are going to be sued for everything they do and everything they don’t do. What the Department of Labor opinion would do, if adopted by the court, is undermine every single element of managed care.”¹⁶⁴ In the interest of equity and justice this opinion is barely defensible as it will place an impenetrable barricade around managed care organizations. Patient consumers would like to settle for HMOs being liable for at least something rather than nothing, since clearly, the industry oriented bar is not looking to protect the fate of the citizenry. As for HMO liability under ERISA, the final word has not been formulated, yet alone articulated in law and policy. It is time for Congress to erase the legalese quagmire of “mixed eligibility versus treatment” decisions created by the Court and to stop “ERISA creep” from destroying every conceivable legal recourse open to patients injured as a result of corporate business judgment rather than professional and ethical standards left to practicing providers. The paycheck of a providing physician ought not depend on whether minimal and questionable treatment decisions are made. Given the Supreme Court’s position as to HMO status as a fiduciary under ERISA, only with the swift and decisive intervention of Congress can the provision of healthcare in the United States retain its standing as a national priority and not just a business. However, this will not happen without an immediate recognition of the fact that “managed care” is not synonymous with “rationed care.”¹⁶⁵

¹⁶⁴*Id.*

¹⁶⁵The Court openly sanctions the proposition that rationing care and the basic premise behind an HMO’s approach to managed care via annual kickback payments are compatible and to be expected despite possible malpractice negligence:

Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others (ruptured appendixes are more likely; unnecessary appendectomies are less so), any legal principle purporting to draw a line between good and bad HMOs would embody, in effect a judgment about socially acceptable medical risk.

Pegram, 530 U.S. at 221.

Courts engage in decision-making that has immense social implications on a regular basis. Even ERISA has been so interpreted in the past, so why the espoused denial of the right to do so in this case? *See supra* note 43. In addition, state legislatures are evidencing a willingness to enter this contentious area. North Carolina has enacted a law that would severely limit, if not eliminate, the cost containment payments at issue in *Pegram*. *See* N.C. GEN. STAT. § 58-3-265 (2001).