Doctors, HMOs, ERISA, and the Public Interest After Pegram v. Herdrich

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DOCTORS, HMOS, ERISA, AND THE PUBLIC INTEREST
AFTER PEGRAM V. HERDRICH

Jeffrey W. Stempel and Nadia von Magdenko

I. INTRODUCTION: A QUARTER-CENTURY OF ERISA LIABILITY
DOCTRINE: CONTINUING DEVELOPMENT AND UNCERTAINTY

The Employee Retirement Income Security Act of 1974\(^1\) was enacted in
the wake of highly publicized pension disasters in order to protect
employee pension rights.\(^2\) Born as a piece of pro-worker legislation, it initially
was criticized by business groups as a cause of bureaucratic arteriosclerosis
that was worse than the disease of pension failures. Even worse, it
prompted many employers to consider dispensing with pension plans al-
together rather than struggle with the administrative and financial obliga-
tions of ERISA.\(^3\) Business, labor, and the public all complained about
the law's complexity. It even became something of a national joke as reg-
ulators took years to promulgate regulations for administering the statute.\(^4\)

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1. Hereinafter ERISA.
2. See text and accompanying notes 32–99, infra, regarding purpose of ERISA and legis-
lative history.
3. See, e.g., Another Bear Hug from ERISA: Is ERISA the Pensioner's Friend? Or His Enemy?,
FORBES, Sept. 4, 1979, at 62; Peter Schuck, Regulation: Asking the Right Questions, NAT'L
J. Apr. 28, 1979, at 710, 712–13 ("one ERISA provision elicited more than 220,000 individual
requests for exemption; some taking more than one year to process"); Pension Reform's Ex-
pensive Riscchet, Bus. Wk., Mar. 24, 1975, at 144 ("The new law is a paradigm of complexity,
weighing in at several hundred pages and some 75,000 words, plus a 100-page-plus explana-
tory report . . . . For months, pension officers and consultants have been studying and arguing
about the text like religious scholars seeking the true meaning of Bible passages.").
4. See, e.g., And We Always Thought It Meant Employee Retirement Income Security Act, NAT'L
J., Dec. 30, 1978 ("An employee of the Pension Benefit Guaranty Corp. offers this suggestion

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In short, ERISA seemed to have something to annoy everyone. A silver lining of sorts was that, at least for the first ten years of the law’s existence, most discussions were confined—as was virtually all congressional discussion at the time of ERISA’s enactment—to pensions. At first, no one considered that ERISA related to the delivery of medical services or to the collection of employer-provided insurance benefits. Eventually, alert defense lawyers argued that the broad preemption language in ERISA prevented pension plans from being subject to inconsistent state regulation. Pressing a broad literal reading of the preemption language, they found a willing audience in the U.S. Supreme Court. For example, Pilot Life Insurance Co. v. Dedeaux held that an aggrieved worker attempting to collect disability insurance benefits was unable to make a state law-based claim of

of what ERISA stands for: "‘Everything Ridiculous Invented Since Adam.’”); Nancy L. Ross, Three-Year-Old ERISA Faces Serious Problems, WASH. POST, Sept. 4, 1977, at M1; Daniel Seligman, A Matter of Interpretation, TIME, Jan. 29, 1979 ("There is no good reason to suppose we will ever get to the bottom of ERISA. The act is administered jointly by the Labor and Treasury departments, and both have lots of bureaucrats composing regulations in an effort to invest the law with some operational meaning. Thus far, Labor has produced forty-nine administrative regulations and Treasury forty-four."); David O. Tyson, Labor Dep’t Interpretations of Prudent Man Rule Are Assaulted, AM. BANKER, Aug. 16, 1979, at 8.

5. A search of the LEXIS-NEXIS files for archival news, insurance news, and case law indicates that the argument for ERISA preemption of tort claims against insurers or other fringe benefit providers, although first raised in the late 1970s, was not aggressively litigated until the mid-1980s. See David J. Brummond, Federal Preemption of State Insurance Regulation Under ERISA, 62 IOWA L. REV. 57, 112 (1976) (suggesting that state regulation of insurance was likely to be preempted by courts only for self-insured ERISA plans). After the U.S. Supreme Court gave a broad interpretation to the language of the statute (that in one section states that any state law “relating to” a plan is preempted), the world changed and ERISA preemption defenses became the norm for insurers and health care providers working with an ERISA plan. See, e.g., Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (finding broad preemption of a bad-faith claim against a group disability insurer contracting with a benefit plan came as something of a surprise to the legal community). James D. Hutchinson & David M. Ishin, Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974, 46 U. CHI. L. REV. 23 (1978) (reviewing ERISA preemption case law, expressing concern that courts were not giving preemption language of statute sufficient sweep, but focusing on pension-related preemption with comparatively little concern regarding absence of preemption regarding health care benefits).

6. Again, a search of the LEXIS-NEXIS computer database is revealing. At the time of the law’s passage, there appeared to be no reported news articles or abstracts of any detail discussing ERISA as having any significant impact on the delivery of group employee fringe benefits such as health care or insurance. The media focus on ERISA was one that treated the law as a pension law and not an all-consuming regulation of all aspects of services rendered for employees under group fringe benefit plans. Even industry-related and business publications seem to have regarded ERISA as only a pension law. This is consistent with the legislative history of ERISA that focuses extensively on pensions and investments but literally says nothing about group insurance. See text and notes 32–99, infra. It was only in the aftermath of ERISA that commentators noted the potential legal issues presented by the tension between the strong preemption language and the clear desire of Congress not to supplant state governance of insurance and the insurer-insured relationship. See, e.g., Theodore Paul Manno, ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action, 52 TEMP. L.Q. 51 (1979); Brummond, supra note 5.

insurer bad faith because it was preempted by ERISA. Two years earlier, in *Massachusetts Mutual Life Insurance Co. v. Russell*, the Court held that ERISA, which created a private right of action against ERISA fiduciaries under the statute, entitled the successful claimant only to the benefits owed plus reasonable counsel fees; there was no right of consequential, extra-contractual, or punitive damages arising from the improper or untimely processing of benefit claims.

In the ten years following *Pilot Life*, lower courts in large part continued to take a broad view of ERISA preemption as applied not only to insurers but to managed care organizations such as health maintenance organizations and to physicians working under the auspices of managed care, in many cases insulating them from state law tort claims. In 1993, the U.S. Supreme Court extended ERISA's limited remedy for improper claims handling to suits against nonfiduciaries as well. A covered employee might obtain denied benefits and counsel fees through litigation under ERISA but was barred from consequential and punitive damages. The traditional business-based grumbling about ERISA was replaced by consumer-oriented complaints, as many were stunned to find that a statute ostensibly enacted to protect workers was being used by the courts to strip them of rights that they possessed prior to ERISA.

ERISA's third decade as law began on a more promising note. The U.S. Supreme Court altered its preemption analysis to provide more deference to states' rights. The Court recognized that taking a broad and hyperliteral view of terms like "relate to" was not sound jurisprudence. Although this change in the Court's preemption jurisprudence implicitly cast doubt on the continued vitality of *Pilot Life*, that case's holding, and even a good bit of its rationale, remained undisturbed: insurers providing group prod-
ucts to employers or employers self-insuring were generally immune from bad-faith claims. Uncertainty remained regarding an employee’s ability to seek relief from HMOs or physicians working under the direction of HMOs. Simultaneously during the 1990s, public sentiment showed increasing dissatisfaction with the medical treatment delivered to HMO patients, prompting more focused attempts to impose liability on HMOs and their physicians, notwithstanding the arguably protective shield of ERISA.15

One such aggrieved patient was Cynthia Herdrich, whose efforts to hold an HMO accountable reached the U.S. Supreme Court in Pegram v. Herdrich.16 Suffering from a ruptured appendix allegedly caused in part by her HMO’s financial incentives for undertreatment, she brought suit under a number of legal theories.17 Most significantly, she alleged that the HMO owed her a fiduciary duty under ERISA because the HMO was the administrator of the medical plan of which she was a beneficiary. This legal argument failed with the district court but was successful before a divided Seventh Circuit before ultimately failing again before the U.S. Supreme Court in a June 2000 decision.

Although the HMO was held not to be an ERISA fiduciary, other aspects of the U.S. Supreme Court’s opinion in Pegram strongly suggest that HMOs do not enjoy complete immunity from state-based tort claims.18 Certainly, many commentators reacted to Pegram this way.19 Although one

16. 120 S. Ct. 2143 (2000).
17. Herdrich alleged fraud against the HMO and medical malpractice by the physician. “The original malpractice counts were . . . tried to a jury, and Herdrich prevailed on both, receiving $35,000 in compensation of her injury.” Pegram, 120 S. Ct. at 2148; 154 F.3d 362, 367 (7th Cir. 1998).
19. See, e.g., Bloche, supra note 15, at 228 (“As many have noted, Pegram left open the possibility of plan liability under ERISA for failure to tell subscribers about physicians’ financial incentives to limit care. More importantly, though, the Court said the ‘mixed’ treatment and coverage decision making is actionable under state law, clearing the way for state suits targeting the types of incentives at issue in Pegram—and perhaps opening the door to plan liability for negligent UM. Pegram’s biggest impact, therefore, will be to shift the locus of legal action to the states as conflict over health plans’ efforts to influence clinical decision making continues unabated.”); M. Gregg Bloche & Peter D. Jacobson, The Supreme Court and Bedside Rationing, 284 J.A.M.A. 2776, 2777 (Dec. 6, 2000) (“[I]n Pegram, the Supreme Court put [immunity for HMO’s making health care eligibility decisions] into doubt when it rejected the industry’s portrayal of cost management by treating physicians as distinct from plan administration . . . [t]he Court suggested that mixed treatment and eligibility decisions are beyond the reach of ERISA’s preemptive shield and therefore subject to state lawsuits”); James J. Brudney, The Changing Complexion of Workplace Law: Labor and Employment Decisions of the Supreme Court’s 1999-2000 Term, 16 LAB. L. 151, 195 (2000) (“After Pegram, it seems likely that state malpractice claims are beyond the reach of ERISA preemption. When HMOs
might wonder whether in *Pegram*, HMOs won the metaphorical battle but
lost the proverbial war, the HMO industry's general reaction was one of
relief because a finding of fiduciary liability would have required changes
in basic HMO operations. 20 Although Herdrich's breach of fiduciary duty
fell short, the *Pegram* Court appeared to further reduce ERISA protection
for health care providers, as it and other courts have done since the Court's
shift in ERISA preemption jurisprudence in the mid-1990s. 21

At a minimum, *Pegram* appears to be the death knell for a line of cases
that had found HMOs virtually immune from litigation so long as they
were providing benefits to workers under an employer-provided benefit
plan. 22 Since most health care in this country is dispensed under the aus-

arrange and provide treatment either directly or through contracts with physicians and hospitals, *Pegram* strongly suggests that they may be sued under state law for negligence or comparable misconduct that pertains to their role as provider or arranger of medical services.


20. The industry regarded the ruling as a boon to HMOs in that it removed the danger that HMOs would be classed as fiduciaries, which would arguably have made the basic organizational structures of HMOs subject to legal attack as inconsistent with fiduciary obligations. See David G. Savage, *Cost-Cutting Consequences: An HMO liability case is being closely watched by the lawyers who targeted tobacco companies*, A.B.A. J., Feb. 2000, at 30 (victory for Herdrich’s fiduciary duty claim would have opened door to class actions against HMOs attacking basic HMO structure); Daniel E. Troy, *HMO Ruling Makes Sense*, Nat’l J., July 3, 2000, at A18 (attorney for firm that represents insurers finds HMOs less adversely affected by *Pegram*’s possibility of medical treatment claims than by alternative of fiduciary claims; U.S. Supreme Court recognized “that the very nature of an HMO involves cost controls”).

The insurance industry, however, criticized the Court’s decision in *Harris Trust & Savings Co. v. Salomon Smith Barney, Inc.*, 120 S. Ct. 2180 (2000), decided the same day as *Pegram*. See, e.g., Steven Brostoff, *Insurers Hit Ruling*, Nat’l Underwriter (Life & Health ed.), July 17, 2000, at 21 (“Insurers are expressing disappointment with a decision by the U.S. Supreme Court ruling that nonfiduciary parties-in-interest can be sued for violations of the prohibited clauses of the Employee Retirement Income Security Act.”). Insurers saw the ruling as increasing their exposure to liability because insurers frequently do business with ERISA plan fiduciaries. Accord, Steven Brostoff, *High Court Ruling Disappoints Insurers*, Nat’l Underwriter (Life & Health ed.), July 17, 2000, at 31; see also Francis A. Cierca & Ann M. Ungarsky, *High Court Rules on HMO Liability, Evidence, Torts, HMOs May Be Liable Through Apparent, Implied Authority, Premises Liability Expanded*, Nat’l J., Nov. 8, 1999, at B11 (noting Illinois Supreme Court decision rejecting HMO immunity as sign of decreasing judicial favor of HMOs).

21. See *Pegram*, 120 S. Ct. at 2146 (decision unanimous).

pieces of employer-funded group plans (HMOs and traditional group health insurance), the bulk of pre-Pegram case law essentially had placed HMO negligence beyond the reach of legal liability. Concurrently, however, public dissatisfaction with HMO-provided health care was increasing, leading to a widespread perception that managed care was benefiting the provider's bottom line at the expense of the patient's health. Throughout the late 1990s, Congress considered legislative intervention to respond to the situation, including House passage (but not Senate approval) of the Norwood-Dingell bill in 1999.

Pegram establishes a standard under which the HMO's liability exposure under ERISA apparently turns on whether it is making eligibility decisions or medical treatment decisions. Under Pegram, the nature of an HMO's activities may determine the applicability of an ERISA-based defense to particular claims. As a practical matter, most of what an HMO does is the administrative practice of medicine rather than anything that can be characterized as ERISA plan administration. However, the drawing of a reliable


24. See Karen A. Jordan, Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution, 65 Mo. L. Rev. 405, 421–32 (2000) (noting dominance in lower courts of view that actions challenging HMO medical treatment decisions are preempted because these "relate to" ERISA plans). Prof. Jordan effectively criticizes this line of cases and argues for an approach similar to that adopted by the Court in Pegram, in which the HMO is not considered part of ERISA for purposes of adjudicating its medical treatment policies and decisions.

25. See, e.g., George Anders & Laurie McGinley, Actuarial Firm Helps Decide Just How Long You Spend in Hospital, WALL ST. J., June 15, 1998, at A1 (describing complaints as health treatment decisions made by managers rather than physicians in HMOs); Thomas M. Burton, Self-Examination: An HMO Checks Up on Its Doctors' Care and Is Disturbed Itself; United, in an Unusual Study, Finds that Drugs, Tests Are Often Underutilized; Some M.D.'s Are Worried, WALL ST. J., July 8, 1998, at A1 (describing HMO's own findings of undertreatment in situations where organization and physicians have financial incentive to under treat); Rebecca Conklin, HMOs Take Another Big Hit, LAW. WEEKLY USA, Feb. 21, 2000, at B8 ("A Florida jury last month awarded $79.5 million to a girl with cerebral palsy whose health plan cut off her special-care treatment, allegedly causing her condition to deteriorate."); Editorial, HMO's Slight of hand Threatens Patients' Rights, USA TODAY, Mar. 31, 2000, at 16A (attacking HMO public relations campaign and arguing that HMOs should be subject to liability where medical treatment policies cause injury to patients). See also Alissa J. Rubin, Consumers Challenging HMO's Right to Portion of Damages, LAS VEGAS REV.-J., Jan. 9, 2000 (noting consumer complaints about HMO requests for reimbursement from successful tort plaintiffs where HMOs allegedly overestimated the value care at higher prices than cost of care); Jeffrey W. Stempel, Embracing Descent: The Bankruptcy of a Business Paradigm for Conceptualizing and Regulating the Legal Profession, 27 FLA. ST. U. L. REV. 26, 95–100 (1999) (collecting additional articles reflecting criticism of HMOs, discussing litigation challenging HMO care, and noting tendency of HMOs to compromise physicians' professional judgment).


27. See text and accompanying notes 117–41, infra, discussing Pegram.

28. See text and accompanying notes 172–77, infra, discussing proposed modification of Pegram test.
dividing line may prove difficult. It may be more productive to modify Pegram’s test and to focus upon what constitutes the “benefit plan” for purposes of ERISA. Under such a test, courts need only differentiate between ERISA plans themselves and entities that work for ERISA plans, providing or administering benefits established by the plan. As to the former, there is ERISA preemption and remedies are limited to those provided by the statute. As to the latter, disputes between claimants and benefit providers would be subject to the regime of state law that governs non-ERISA disputes of the same type.

Pegram provided a helpful and correct ruling that providing medical care is not the primary activity of an ERISA fiduciary. The decision, however, does not define what constitutes fiduciary and nonfiduciary activities and when HMOs are exposed to or immune from claims of negligence, misrepresentation, or mistreatment. Pegram suggests that ERISA is no longer the shield that it once was for medical or insurance providers. In particular, older case law barring malpractice claims against individual physicians in an ERISA HMO is clearly constructively overruled by Pegram. Pegram also suggests that HMOs and other health insurers may also be sued for their negligent conduct that leads to medical mistreatment or undertreatment, even though they are not fiduciaries under ERISA. Insurance programs tied to an ERISA benefit plan, particularly self-insurance, still seemingly enjoy the immunity conveyed by Pilot Life Insurance Co. v. Dedeaux.29

Pegram remains, to a degree, enigmatic. Under Pegram, purely medical or mixed treatment and eligibility decisions are not fiduciary activities protected by ERISA. But what about the “pure” coverage decisions that an HMO makes in its capacity as an insurer without examining the particular medical situation confronting the patient-insured?30 Outside the ERISA context, insurers making coverage decisions are generally held to have du-

30. Although the area is in some dispute, HMOs clearly constitute insurers according to the traditional definition of insurance that considers insurance to involve (1) risk transfer and (2) risk distribution or pooling and the insured’s acceptance of the certain but small loss (the premium payment) in return for protection against larger but contingent losses (illness and the need for medical treatment). See Stempel, supra note 23, ¶ 1.02. Under the insurer analogy, Pilot Life suggests that HMOs are not subject to state law bad-faith claims—unless the bad-faith law is part of the state’s system of insurance regulation. See UNUM Life Ins. Co. v. Ward, 526 U.S. 358 (1999) (holding that California state law requiring that insurer demonstrate prejudice to avoid coverage on late-notice grounds is law specific to insurers and saved from ERISA preemption even if “relating to” a benefit plan because insurance is provided pursuant to a plan); Hill v. Blue Cross Blue Shield of Alabama, 117 F. Supp. 2d 1209, 1211–12 (N.D. Ala. 2000) (interpreting Ward to permit state law bad-faith actions against ERISA insurers provided that state’s bad-faith cause of action is “limited to insurance industry”); Lewis v. Actma U.S. Healthcare, 78 F. Supp. 2d 1202 (N.D. Okla. 1999) (similar holding regarding Oklahoma bad-faith law); Hall v. UNUM Life Ins. Co., 1999 U.S. Dist. LEXIS, CV-97-M-1828 (Nov. 1, 1999) (similar finding regarding Colorado bad-faith law).
ties to the insureds that are “fiduciary in nature.”31 Thus, holding the HMO’s “pure” eligibility decision to the fiduciary standard would provide a certain symmetry between the status of HMOs connected to an ERISA plan and other health insurers. Logically, it would also mean that group life and disability insurers are governed by ERISA’s fiduciary provisions when making pure eligibility coverage decisions (e.g., was the injured worker a “full-time employee”?) that do not involve medical assessment (e.g., is the treatment sought “medically necessary”?).

The courts, ERISA, patients, and public policy would be better served by taking one further step in ERISA analysis: simple differentiation between the core administration of the ERISA plan itself and the provision of services on behalf of an ERISA plan. Part II of this article summarizes the history and background of ERISA and of ERISA preemption litigation in the 1980s and 1990s as well as the rising controversy that has attended the ascendency of HMOs. Part III describes the Pegram litigation and the U.S. Supreme Court’s decision. Part IV applies Pegram to ascertain the current status of HMO and physician liability today, providing a template for assessing the viability of such claims. Part V develops the suggested alternative means of determining the status of HMOs vis-à-vis federal and state claims made by aggrieved patients.

II. HISTORY AND BACKGROUND

A. ERISA’s Structure, Content, and Purpose

ERISA’s passage was prompted by complaints about what many regarded as unconscionable treatment of American workers.32 Beginning in the late 1960s, stories surfaced about companies that had failed to properly fund pension plans, resulting in workers having essentially no pension benefits despite having been promised the “guaranteed” benefits of a “defined plan.”33 In addition, it was discovered that many pension plans had rather

31. See Stem, supra note 23, § 10.4.
32. See Barry R. Furrow et al., Health Law 419 (2d ed. 2000) (“ERISA was adopted in 1974 in response to highly publicized instances of fraud and mismanagement in employee pension funds, which had resulted in [many] workers losing retirement benefits accumulated over a lifetime of work.”).

A succession of witnesses coming before the Pension Study Subcommittee—mostly union workers in their late forties and fifties—told of losing their pension rights, because of plant shutdowns, transfers, store closings, and pension fund terminations. One witness, who had worked for 32 years for one company, was laid off 3 years before he was eligible for his pension. Other workers have lost their pensions when a company has shut down. Perhaps the most famous case involved the Studebaker Division of Studebaker Packard. More than
restrictive barriers to full pension eligibility. Thus, it was possible (indeed, it was the case) that workers at even large and respected companies were working for years, only to find themselves bereft of promised pensions when the company laid off, lost revenues, or otherwise changed operations. Where a solvent company had an underfunded plan, workers might have recourse but only if they successfully prosecuted claims for breach of contract. Successful prosecution was of course no guarantee of successful collection of a judgment against an impoverished or defunct company.

The situation was sufficiently scandalous that Congress felt compelled to act. ERISA was passed, with some of its provisions taking effect immediately and others phased in over time. The overall purpose of the legislation was to require that employee pensions be funded and fairly administered. ERISA required that employers support established plans, set forth standards for employee vesting of rights, and established the Pension Benefit Guarantee Corporation as a safety net for insolvent plans.

As its title suggests, ERISA was intended primarily as an instrument for regulating pension plans. ERISA also, however, applies to employee welfare benefit plans, and thus covers employer-provided health insurance, the dominant vehicle for privately financed health care in the United States. Although ERISA's influence upon the financing of health care in the

4,000 Studebaker workers aged 40 to 60 got only 15 percent of what the company owed them. Other workers lost benefits when their companies moved or when they changed jobs. See also id., Vol. II at 1599 (remarks of Sen. Harrison Williams (D.-N.J.) during floor discussion) ("when a Raybestos Corp. plant in New Jersey closed, up to 900 employees lost not only their jobs but were foreclosed from any future pension benefits, since their plan afforded no vested rights until retirement").

34. See id., Vol. II at 1601–35 (Senate floor discussion of legislation).
36. See ERISA Legislative History, supra note 24, Vol. II at pp. 1597–1600 (discussion on Senate floor between Senators Harrison Williams (D.-N.J.), Robert Byrd (D.-W. Va.), Lloyd Bentsen (D.-Tex.), and Gaylord Nelson (D.-Wis.) (noting that ERISA emerged after three-year study of private pension plans; clear focus of colloquy is on pensions with no mention of group insurance or other employee fringe benefits).
37. See id., Vol. II at 1633 (remarks of Sen. Lloyd Bentsen (D.-Tex.):

The objectives of the pension legislation we are considering today are twofold: first, to eliminate inequitable aberrations in our private pension system; and second, to prevent an unprincipled employer from taking advantage of his workers.

The purpose of this pension legislation is not to establish an ideal pension plan, but rather, to set up certain minimum standards to assure that all workers receive the pension benefits that they have earned.

38. See, e.g., 29 U.S.C. § 1052 (1994) (prohibiting ERISA pension plans from imposing lengthy requirements for vesting); 29 U.S.C. § 1054 (1994) (setting benefit accrual requirements, essentially establishing employee rights to vesting and benefits); 29 U.S.C. § 1054(g) (1994) ("accrued benefit of a participant under a plan may not be decreased by an amendment of the plan, other than an amendment of the type set forth in § 1082(c) of the law.
39. See Furrow et al., supra note 32, at 419.
United States is undisputed, Congress apparently did not foresee the effect that ERISA might have on health care. ERISA’s preemption clause was added as a last-minute conference committee compromise.\textsuperscript{40}

When enacting ERISA, Congress’s focus was not on health care and preemption but on retirement benefits. In the legislation itself, Congress declared that

despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable . . . that minimum standards be provided assuring the equitable character of such plans and their financial soundness.\textsuperscript{41}

The statute further states:

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries . . . by 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.\textsuperscript{42}

Despite the preemption language later in the statute,\textsuperscript{43} ERISA’s language and legislative history stress substantive remedies for workers more than the need for uniformity. Where uniformity is discussed, the implication is that uniformity and protection against state regulation are desired to pre-

\textsuperscript{40} Furrow et al., supra note 32, at 418–49. The assessment of the Furrow treatise is, if anything, understated. A review of the three-volume legislative history of ERISA shows that in neither house of Congress was there any apparent significant discussion of ERISA’s impact on employer insurance and health care. The legislative history strongly suggests that the preemption provisions of ERISA were intended—as was the rest of the law—to govern pensions, and not all employer-provided benefits. Indeed, it is highly doubtful that Congress had any notion that its preemption provisions would have the impact they achieved when interpreted by the U.S. Supreme Court. A reading of the background of ERISA suggests that Congress never intended any displacement of state tort or health care law when enacting ERISA. See generally ERISA Legislative History, supra note 33; Fisk, supra note 14, at 46–60.

\textsuperscript{41} 29 U.S.C. § 1001(a).

\textsuperscript{42} 29 U.S.C. § 1001(b). Congress further stated that it was the policy of the statute to protect interstate commerce, the federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service and to meet minimum standards of funding and by requiring plan termination insurance. 29 U.S.C. § 1001(c).

\textsuperscript{43} See 29 U.S.C. § 1144 (c)(2) (ERISA “shall supersed any and all state laws insofar as they may now or hereafter relate to any employee benefit plan”).
prevent dilution of retirement benefits. No mention occurs of the possibility of preempts- ing large blocks of state common law, an unsurprising absence in light of the statute’s overall purpose: protection of workers, primarily their retirement benefits.44 ERISA was classically remedial legislation designed to correct a social problem largely affecting the less fortunate.45 The news stories that spurred passage of ERISA were not tales of CEOs left without severance pay, stock options, or bonuses; they were tales of lunch- bucket-toting blue-collar workers left with almost nothing after years of loyal, backbreaking service to the company.

As previously mentioned, in addition to its primary goal of pension security for workers, ERISA also sought to improve the security of other job-related benefits, such as the group health, disability, and life insurance programs. However, this part of ERISA appears to have been something “tacked on” to what was basically a pension reform statute. Although ERISA contains substantial codification of congressional findings regarding retirement benefits, the statute and legislative history are almost completely silent on the intent of Congress regarding other employer-provided fringe benefits.46

For both pensions and other benefits, ERISA was designed to preclude employers from obtaining tax deductions for such plans unless certain criteria were met regarding solvency, operation, and nondiscrimination in favor of managerial employees. The statute also sought to limit self-dealing and opportunism by employers and employer plan administrators, barring ERISA fiduciaries from engaging in transactions with interested parties so as to protect plan assets.47 The statute provides that fiduciary breach makes the plan fiduciary “personally liable to make good to such plan any losses


46. See ERISA LEGISLATIVE HISTORY, supra note 34.

47. See 29 U.S.C. § 1106 (1994) (outlining prohibited transactions between plan fiduciaries and parties in interest); see also 29 U.S.C. §§ 1106(b)(1), (3) (1994) (ERISA fiduciary shall not “deal with the assets of the plan in his own interest or for his own account” and shall not “receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets for the plan.”)
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."

Any ERISA plan's attempt to relieve fiduciaries of this responsibility is "void as against public policy." Plans must provide participants with a reasonable opportunity for review of an adverse benefits decision.

In addition, ERISA established a mechanism for civil actions against the plan and its fiduciaries, authorizing federal regulation, civil penalties, injunctive relief, and counsel fees (in the discretion of the court) to a participant, beneficiary, or fiduciary enforcing the statute. For certain breaches of fiduciary duty, the secretary of labor is empowered (arguably required) to assess a civil penalty against a breaching fiduciary in an amount of 20 percent of the amount recovered.

Under ERISA, the claimant must prove that the plan administrator or other fiduciary committed an "abuse of discretion." Extracontractual damages against plan administrators and fiduciaries are prohibited in view of the statute's explication of civil remedies that does not mention punitive or other extracontractual damages. "ERISA therefore restricts substantially the amount of recovery possible in what would otherwise be an ordinary malpractice case."

To promote uniformity and avoid inconsistent state regulation of pension benefits, Congress also included strong preemption language providing that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

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49. See 29 U.S.C. § 1110 (1994). However, ERISA fiduciaries are not barred from procuring liability insurance for such breaches. Id.


52. See 29 U.S.C. § 1132(b)(1)(B) ("Secretary shall assess a civil penalty . . . .").


55. See Furrow et al., supra note 32, at 436.

56. See 29 U.S.C. § 1144(a) (emphasis added); 29 U.S.C. § 1003(a), which is referred to in the statutory excerpt in text, is the general definition of employee benefit plan. Section 1003(b) exempts from ERISA's reach government plans, church plans, plans maintained solely to comply with workers' compensation laws, excess benefit plans, and plans maintained outside the United States for nonresident aliens.
This preemption is often referred to as section 514 preemption after the number of the section of the original act, now codified at 29 U.S.C. § 1144. In addition, state laws may be considered preempted if inconsistent with the relief and operation of ERISA’s provision for a private right of action to enforce benefit rights under a plan (originally in section 502 of the Act and now codified at 29 U.S.C. § 1132(a)(1)(B)). This type of preemption is often referred to as section 502 preemption to distinguish it from the section 514 “relate to” preemption. An “employee benefit plan” is defined in the statute as either a pension plan, a benefit plan, or a combination pension and benefit plan.

Exempted from this broad preemption clause is “any law of any State which regulates insurance, banking or securities.” However, an employee benefit plan shall not be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

For litigants dissatisfied with some aspect of their benefit plans or delivery of services connected to a plan, the nature of the claim and entity sued take on supreme importance. If an aggrieved party’s dispute is with the ERISA plan itself, a plan administrator, or other fiduciary, the action must be brought pursuant to the statute’s private right of action in section 502. Although ERISA was designed to aid workers, its liability provisions are quite favorable to employers, the most likely targets of such claims. As noted above, damages are restricted to performance of the obligation of the benefit plan, payment of accrued benefits, and an injunction against future wrongful denial; extracontractual or punitive damages are prohibited. Attorneys’ fees are available to the prevailing party only where the defendant’s position was not “substantially justified” and in good faith. The section 502 remedy may include disgorgement of profits as well as the undoing of past adverse plan action.

57. See Furrow et al., supra note 32, at 423–35.
61. See text and accompanying notes 7–9, supra.
62. See Molasky v. Principal Mut. Life Ins. Co., 149 F.3d 881 (8th Cir. 1998); Quinn v. Blue Cross & Blue Shield Ass’n, 161 F.3d 472 (7th Cir. 1998); Furrow et al., supra note 32, at 453.
63. See 29 U.S.C. §§ 1109, 1132; Furrow et al., supra note 32, at 436; see also Durham v. Health Net, 108 F.3d 337 (1997) (table), No. 95-16585, 1997 WL 66558 (9th Cir. 1997) (affirming district court view that section 502 claim does not allow recovery of value of medical treatment that was wrongfully withheld in past).
an individual section 502 suit is unlikely to create significant liability exposure for the employer.

ERISA cases resemble administrative review cases more than traditional contract or tort cases. ERISA plan administrators and fiduciaries make initial-claim determinations, which are reviewable by the courts under ERISA’s remedial provisions. The court, however, does not generally reach its own decision as to the propriety of coverage; it merely reviews the plan’s own determination, almost invariably under highly deferential standards of review.64

For example, if the ERISA plan vests the plan administrator with discretion in determining availability of benefits in individual situations, a decision denying benefits will be upheld in court so long as it was not an “abuse of discretion.”65 Most courts have held that a jury is not available in such claims due to the equitable nature of the action.66

A party seeking greater remedies will undoubtedly prefer not to style the action as one arising under section 502 and will prefer to make a claim pursuant to other statutes or state common law if the suit can be characterized as something other than a claim directly against an ERISA plan. However, even where this is easily done, as when the claim is against an insurer or physician rather than the employer, there remains the issue of section 514 preemption. If that preemption applies, the non-ERISA claim is barred. Consequently, the judicial definition of a “benefit plan” and what activities relate to the plan are important for preemption and liability purposes.

Similar legal and strategic concerns govern the issue of liability of ERISA fiduciaries. The statute imposes certain requirements on ERISA fiduciaries67 but these are only “limited fiduciary obligations” that “provide little protection at all in the health benefit plan context.”68 Like section 502 claims for benefits, a section 404 action to enforce fiduciary obligations provides for injunctive relief and other equitable remedies such as restitution as well as the possible recovery of counsel fees. But, like the section

64. See Furrow et al., supra note 32, at 445.
65. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) (arbitrary and capricious standard of review applies where “benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan”). As might be expected, “ERISA plan administrators almost invariably draft plan documents so as to bring their decisions under the ‘arbitrary and capricious’ review standard. The courts are quite generous in reading plan documents to confer discretion.” Furrow et al., supra note 32, at 448. In addition, courts have generally deferred to limitations periods, claims procedures, and alternate dispute resolution provisions contained in ERISA plans. See id. at 446–48.
66. See, e.g., Tischmann v. ITT/Sheraton Corp., 145 F.3d 561 (2d Cir. 1998); Sprague v. General Motors Corp., 133 F.3d 388 (6th Cir. 1998); see also Furrow et al., supra note 32, at 452–53.
68. See Furrow et al., supra note 32, at 454.
502 benefits action, the section 404 fiduciary action has been held generally not to provide for damages, particularly punitive damages.69

In addition, an ERISA fiduciary is something less than a traditional fiduciary such as an attorney or banker administering a trust fund.70 The ERISA fiduciary has duties to the individual employees as well as to the employer to conserve plan resources and to administer the plan pursuant to the statute. The general fiduciary obligations of ERISA are usually viewed by courts as subordinate to other specific portions of the statute. Thus, if the ERISA fiduciary has complied with the statute's other provisions, an employee cannot generally complain that the fiduciary has breached its duty by failing to act in the employee's best interests.71

B. ERISA Preemption Jurisprudence and Pre-Pegram Case Law Concerning Medical Provider and Insurer Liability

Against this backdrop of ERISA and the employer-provided group health care that dominates American medicine, the last quarter of the twentieth century saw significant development of the law, most notably concerning the important question of liability for health care that is denied or poorly delivered.

Early cases construing ERISA gave a broad, almost hyperliteral reading to the section 514 “relate to” preemption clause.72 Perhaps the most no-

70. “ERISA's fiduciary obligations do have some content, however. An ERISA fiduciary, for example, is obligated to process a claim submitted by a beneficiary. It may even be liable for paying out a claim for a person not entitled to beneficiary status. Finally, under separate provisions of ERISA, an employer may not fire an employee to avoid obligations for the cost of health insurance benefits.” Furrrow et al., supra note 32, at 455 (footnotes omitted).
71. See Furrrow et al., supra note 32, at 454–55. The ERISA fiduciary has obligations not only to just a particular individual participant or beneficiary claiming benefits from the plan, but also to all other beneficiaries as well. Paying out questionable benefits to one beneficiary depletes the plan of resources that might be needed to fund benefits for other beneficiaries . . . . Courts are quite sensitive to the multiple obligations of ERISA fiduciaries, and thus the notion of fiduciary obligation rarely dictates a result urged by an individual claimant in a particular case . . . . [F]iduciary obligations only extend to the issue of plan administration, not to questions of plan scope and design. An employer is not obligated under ERISA to provide any particular coverage. Thus, for example, the Fifth Circuit in McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991), cert. denied, 981 U.S. 506 (1992) upheld an employer’s dramatic reduction of nonvested coverage for AIDS after an employee contracted the disease and the U.S. Supreme Court denied certiorari. At least one court [Jones v. Kodak Med. Assistance Plan, 169 F.3d 1287 (10th Cir. 1999)] has gone further, holding that utilization review guidelines and criteria are completely discretionary and not subject to judicial review.

table is *Pilot Life Insurance Co. v. Dedeaux*;\textsuperscript{73} which held that state common law bad-faith claims against a disability insurer operating under a benefit plan were preempted under the section 514 “relate to” language and were not saved by the provision in section 514 that avoids preemption of state laws regulating insurance. The U.S. Supreme Court reasoned that under the applicable state law (Louisiana), a bad-faith claim was at least in theory available against both insurers and other contract parties.\textsuperscript{74} Hence, the bad-faith action was not an insurance regulation even if, as a practical matter, almost all successful bad-faith claims are prosecuted against insurers\textsuperscript{75} that under prevailing law have a relationship with the policyholder that is fiduciary in nature even if something short of a full fiduciary status.\textsuperscript{76}

*Pilot Life* has been criticized as an overbroad reading of the statute,\textsuperscript{77} but attempts at legislative revision have never progressed far “[b]ecause the preemption clause has served the interests of powerful employer and insurer interests.”\textsuperscript{78} For the U.S. Supreme Court, however, the hyperliteralism of *Pilot Life* has proven awkward since “as the Court eventually came to understand,” the term “relates to” is one that “is not self-limiting—everything in a sense ‘relates to’ everything else.”\textsuperscript{79} The Court employed a different approach to address preemption in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*\textsuperscript{80} and appears to have solidified this approach in subsequent cases, particularly *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*,\textsuperscript{81} and *DeBuono v. NYS-ILA Medical & Clinical Services Fund.*\textsuperscript{82} Although not a preemption case as such, *Pegram* is consistent with this more mature approach to ERISA preemption.

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The word “early” is used advisedly. ERISA was enacted in 1974 and for some provisions had effective dates as late as 1975. However, it took nearly a decade for cases to percolate to the U.S. Supreme Court level for any commentary or construction regarding the statute’s preemption language. Some of this delay took place because counsel for employer and plan-related defendants were slow to recognize the defense potential of the broad preemption language, a factor that supports the view that the preemption provision was never intended to have the broad scope accorded it in the “early” ERISA cases.

\textsuperscript{73} 481 U.S. 41 (1987).
\textsuperscript{74} See *Pilot Life*, 481 U.S. at 46–51.
\textsuperscript{75} See *Stempel*, *supra* note 23, § 10.4.
\textsuperscript{76} See *Stempel*, *supra* note 23, § 10.4.
\textsuperscript{78} See *Furrow et al.*, *supra* note 32, at 424.
\textsuperscript{79} See *Furrow et al.*, *supra* note 32, at 424–25.
\textsuperscript{80} 514 U.S. 645 (1995).
\textsuperscript{81} 519 U.S. 316 (1997).
\textsuperscript{82} 520 U.S. 806 (1997).
Under the post-*Travelers* approach to preemption, the Court begins with the traditional presumption that Congress does not intend to preempt state law and that such a preemption intent must be "clearly manifest" before preemption will take place.\(^83\) Because the term "relate to" is so broad, the Court considers the intent and purpose of ERISA and the specific facts of the case to determine whether the state law under challenge not only relates to an ERISA plan in some way but also should be deemed preempted because of its impermissible interference with the scheme of the ERISA statute. A leading treatise summarized *Travelers* as follows:

Preemption was intended, the Court held, to affect state laws that operated directly on the structure of administration of ERISA plans, not laws that only indirectly raised the cost of various benefit options. The Court did recognize, however, that [the] possibility that state regulation of providers or insurers, downstream from ERISA plans, could be so severe as to determine in fact the choices of plan administrators, invoking preemption.\(^84\)

*Dillingham* continued this approach and found that state law regulating apprentice wages was not preempted by ERISA.\(^85\) *DeBuono* found that a New York tax on gross receipts for patient services that was imposed on certain health care providers was not preempted by ERISA\(^86\) and continued to use the *Travelers* approach of permitting state law to have an indirect impact on an ERISA plan (and to in fact "relate to" a plan in some way) and avoid section 514 ERISA preemption.\(^87\) As one commentator summarized:

The trilogy of Supreme Court cases, then, has established a more pragmatic or purposive approach to preemption, rather than an approach that simply views the language of § 514(a) as broadly preempting any state law with any "reference to or association with" ERISA plans . . . . The test is still whether

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\(^{83}\) See *Travelers*, 514 U.S. at 654. *Travelers* held that there was no ERISA preemption of a New York State statute that required hospitals to charge different rates to patients from different health plans, essentially based on whether the plan was conventional health insurance, an HMO, or employer self-insurance.

\(^{84}\) See *Furrow et al.*, supra note 32, at 427. Other scholars have adopted this assessment of *Travelers* and its progeny and the Court's "new" approach to ERISA preemption. See, e.g., Karen A. Jordan, *The Shifting Preemption Paradigm: Conceptual and Interpretive Issues*, 51 Vand. L. Rev. 1149 (1998); Fisk, supra note 14, at 102–03 (suggesting in immediate aftermath of *Travelers* that era of hypertextual "megapreemption" was over). But see David Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 So. Cal. L. Rev. 221, 230 (2000) ("though courts have grown more willing to allow some common law causes of action to proceed, ERISA's broad preemption provision means that many traditional common law causes of action are non-starters" despite *Travelers* and progeny).

\(^{85}\) See *Dillingham*, 519 U.S. at 330–34.

\(^{86}\) See *DeBuono*, 520 U.S. at 815–16.

\(^{87}\) "The [DeBuono] Court held that although New York's provider tax affected plans that own and operate medical centers more directly, the law nonetheless merely caused an increase in costs, which influences choices made by employers or plan administrators. Thus, whether direct or indirect, a mere economic effect on ERISA plans is insufficient to trigger preemption." See Jordan, supra note 24, at 439.
a state law has an impermissible connection with or reference to ERISA plans.
But the Court has provided two specific benchmarks for when a state law’s
effect on ERISA plans frustrates congressional purposes: (1) an economic effect
on ERISA plans, whether direct or indirect, is generally insufficient to trigger
preemption; and (2) the effect on ERISA plans of state laws regulating the
quality of health care is generally insufficient to trigger preemption. The result
therefore has been a narrowing of the range of state laws that should be found
to be within the scope of § 514(a).88

The courts continue to be divided, however, over the degree to which
ERISA preemption (primarily section 514 preemption but also section 502
preemption) may operate to bar state law-based claims against medical
providers. The majority of pre-

Pegram decisions appear to preempt claims
against health plan managers such as HMOs and some even preclude mal-

practice actions against physicians performing services for HMOs working
for an employee benefit plan.89 As discussed in the next section, the cases
barring such actions are generally in error in that they fail to appreciate
the change in ERISA preemption law effected by Travelers and its progeny,
a change in judicial approach reflected in Pegram’s analysis as well.

C. The Rise of HMOs, Consumer Backlash, and ERISA-Based Judicial
Resistance to Claims Against Medical Service Providers

Since the Second World War, most health care in the United States has
been dispensed under employer-provided group health plans, which are
favored because employers obtain tax benefits for most or all of the pre-
miums paid and because these fringe benefits are not taxed as income to
the employee.90 For group health plans, individual insurance coverage, and
the uninsured, there were substantial increases in the cost of medical care
during the 1960s.91 Some of the blame for cost escalation was laid at the
feet of (who else?) lawyers for bringing malpractice actions. A tight insurance
market led to the “malpractice crisis” of the 1970s, which fostered state-
or physician-supported insurance programs and tort reform such as
limiting malpractice damages, requiring alternative dispute resolution or
peer evaluation as a prerequisite to litigation.92

88. See Jordan, supra note 24, at 439–40.
89. See Furrow et al., supra note 32, § 8.5; Jordan, supra note 24, at 421–25.
90. See Furrow et al., supra note 32, § 9–1 at 462–64; Congressional Research Service,
Health Insurance and the Uninsured: Background Data and Analysis (1988); Robert
J. MED. 248 (1999).
91. See Furrow et al., supra note 32, §§ 9–1, 9–8.
92. See Furrow et al., § 6–20; Patricia M. Danzon, Medical Malpractice: Theory,
Evidence, and Public Policy (1985); Michael Saks, In Search of the “Lawsuit Crisis,” 14 L.
MED. & HEALTH CARE 77 (1986); W. John Thomas, The Medical Malpractice “Crisis”: A Critical
Examination of a Public Debate, 65 TEMPLE L. REV. 459 (1992). There was also a second medical
malpractice “crisis” in the 1980s that was part of a more generalized tight insurance market,
In the main, however, it was recognized that a significant portion of the cost increases arose from inefficiency in the delivery of medical care. Particularly blamed were duplication of facilities or programs, insufficient delegation to less-expensive personnel, and "defensive medicine," or the overtreatment of conditions either to minimize blame or pad billings. Although malpractice lawyers again became a bit of a scapegoat for defensive medicine, commentators also recognized that a good deal of overtreatment was due to the medical provider's profit motive in a fee-for-service-based health care system. Traditionally, a covered employee who became a patient went to the doctor and was treated, and the insurer received the bill. More treatment equaled more billings that equaled more profit for the medical provider.93

In response to this seeming spiral of cost increases, HMOs took hold and grew.94 HMOs sought to lower health care costs by managing the delivery of health care. Treatment was reviewed for appropriateness and physicians were discouraged from overtreatment. Certain treatment needed to be preapproved by the HMO, which could, at least in theory, rein in the doctor's incentive to order more tests and increase billings. In addition, HMOs tended to support more preventive care by agreeing to provide a regular checkup without additional fees as part of the basic coverage.95 HMOs caught on in the 1970s, sufficiently so that Congress encouraged their formation through legislation.96 HMOs continued to grow


93 See Furrow et al., supra note 32, § 9–8.
94 See id.
96 See Health Maintenance Organization Act of 1973, Pub. L. No. 93–222, codified at 42 U.S.C. §§ 280(c), 300(c). The purpose of the 1973 Act was to prevent state laws from impeding the development of HMOs. In particular, Congress was concerned that local physicians' political clout with state regulators would prevent HMOs from developing as a more efficient means of delivering quality health care. The legislative history of the 1973 Act contains numerous references to the perception that HMOs improve the quality of treatment because of their modernity and relatively little indication that Congress was enamored of HMOs because they rationed or limited health care. See S. Rep. No. 93–129, H. Rep. No. 93–451, 93rd Cong., 1st Sess. (1973). For example, the Senate Report found that there was "substantial evidence which establishes that HMO enrollees receive high quality care at lower costs—as much as one-fourth to one-third lower than traditional care in some parts of this country." S. Rep. No. 93–129, at 2; see also 42 U.S.C. § 300 (establishing minimum standards for federally qualified and hence, tax-advantaged HMOs, including twenty-four-hour availability and minimum physician participation); Bloche & Jacobson, supra note 19, at 2778 ("[T]he typical HMO in 1973 managed costs without shifting large financial risks to individual
in the 1990s and received at least an implicit political endorsement in the 1990s as well when President Clinton’s proposed health care plan gave a ringing endorsement to managed care. Several states enacted legislation endorsing HMOs or giving them favored legal status and also imposed regulatory requirements.\textsuperscript{97}

At the same time, however, a grassroots movement critical of HMOs was brewing. Increasingly, patients objected to having their doctor’s treatment decisions modified or overturned by managers (often nonphysicians) who were outside the doctor-patient relationship.\textsuperscript{98} In addition, some patients, of course, had adverse experiences and alleged malpractice by their treating physicians, an increasing number of whom were now working with or even directly for an HMO.\textsuperscript{99} The courts were presented with the issue of (1) whether ERISA barred state law malpractice claims against doctors delivering services pursuant to an ERISA plan, and (2) whether the ERISA plan itself could be sued under state law for policies or actions that contributed to deficient medical treatment.

Courts “have generally held that ERISA preempts claims based on plan strategies to discourage referrals to specialists.”\textsuperscript{100} These and other core functions of an HMO or other provider have been considered so central to administration of the ERISA plan as to be subject to both the “relate to” preemption of section 514 and the implied exclusive remedy preemption of section 502.\textsuperscript{101} In addition, in some cases ERISA was found to

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\textsuperscript{101} See Furrow et al., supra note 32, at 439 (“Claims that fall within the administrator’s core functions—determining eligibility for benefits, disbursing them to the participant, monitoring available funds and recordkeeping—are completely preempted.”); see also Bauman v. U.S. Healthcare, Inc., 193 F.3d 151, 161 (3d Cir. 1999) (HMO’s failure to provide in-home visits may not be subject of state law under-treatment claim due to ERISA preemption); Danca
preempt medical malpractice and related claims that are lodged against the HMO doctor (rather than the HMO entity itself). With even greater uniformity, courts have tended to prohibit state law-based claims for improper treatment that stem from a denial of coverage according to the doctor's medical judgment. For example, in one prominent case, Corcoran v. United Healthcare, Inc.,102 the Fifth Circuit held that ERISA preempted a wrongful death action claiming injury because of a denial of coverage based on a determination that treatment was not necessary.103 Corcoran has been described as a landmark decision that set the tone for other courts during the 1990s and established a majority rule of generalized HMO immunity from such claims.104

Corcoran and similar cases were based on the view that broad section 514 ERISA preemption was dictated not only by the "relate to" language of the statute but also by the need to prevent the "significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states."105 The concern was that the national uniformity sought by ERISA would be gutted by application of the tort law of the fifty states.

The wisdom and correctness of these decisions was always, of course, open to question. But under the extremely broad preemption analysis that dominated the U.S. Supreme Court prior to Travelers, the decisions were at least defensible and arguably correct. Post-Travelers preemption law, however, suggests that cases like Corcoran were wrongly decided. As discussed below, Pegram solidifies this view by drawing a distinction between medical treatment and eligibility decisions in an employee benefit health care plan.


103. Florence Corcoran was being treated for a high-risk pregnancy. Her obstetrician ordered hospitalization for her so that the health of the fetus could be closely monitored. The health plan (United Healthcare acting pursuant to Blue Cross & Blue Shield of Alabama, the employer-provided health plan) disputed the doctor's assessment and would pay only for ten hours of home care per day. While Ms. Corcoran was unattended, the fetus died, prompting the wrongful death action based on a theory of medical misjudgment.

104. See Jordan, supra note 24, at 421. See, e.g., Thompson v. Gencare Health Sys., Inc., 202 F.3d 1972 (8th Cir. 2000); Hull v. Fallon, 188 F.3d 939 (9th Cir. 1999) (ERISA preempts tort action for medical mistreatment where HMO overruled doctor's recommendation for thallium stress test and authorized only treadmill test); Parrino v. FHP, Inc., 146 F.3d 699, 704-05 (9th Cir. 1998) (ERISA preemption of state law-based challenge to HMO denial of coverage for proton beam therapy as experimental); Turner v. Fallon Community Health Plan, 127 F.3d 196, 200 (1st Cir. 1997) (preemption of claim challenging refusal to pay for bone marrow transplant and high-dose chemotherapy); Tolton, 48 F.3d 937 (preemption of claim of HMO misfeasance in refusing to authorize psychiatric care for patient who later committed suicide).

105. Corcoran, 965 F.2d at 1333. For a more detailed discussion of Corcoran and its progeny, see Jordan, supra note 24, at 425-32.
Because ERISA preempted some popular causes of action, plaintiffs began looking for alternatives, including arguing that ERISA itself created a right of action against doctors, HMOs, or insurers. One approach was to maintain a section 502 fiduciary action under ERISA for a medical provider's failure to make full disclosure to the patient or insured. In *Shea v. Esensten*, the widow of an HMO patient alleged gross malpractice caused by the doctor's impaired professional judgment. Shea's widow brought an ERISA claim for breach of fiduciary duty and a state law-based wrongful death action against the doctor and the HMO, contending that had Shea known of the doctor's conflict of interest, he would have sought a cardiologist at his own expense and received appropriate, life-saving treatment. Reversing the trial court, the Eighth Circuit rejected the HMO's ERISA-based defense that it need not disclose the financial interests compromising the doctor's judgment "because they are not 'material facts affecting a beneficiary's interest.'"

[W]e conclude Mr. Shea had the right to know Medica was offering financial incentives that could have colored his doctor's medical judgment about the urgency for a cardiac referral .... When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for

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107. The Court's recitation of the alleged facts of the case provides an almost paradigmatic illustration of consumer complaints about HMOs and managed care:

After being hospitalized for severe chest pains during an overseas business trip, Patrick Shea made several visits to his long-time family doctor. During these visits, Mr. Shea discussed his extensive family history of heart disease, and indicated he was suffering from chest pains, shortness of breath, muscle tingling, and dizziness. Despite all the warning signs, Mr. Shea's doctor said a referral to a cardiologist was unnecessary. When Mr. Shea's symptoms did not improve, he offered to pay for the cardiologist himself. At that point, Mr. Shea's doctor persuaded Mr. Shea, who was then forty years old, that he was too young and did not have enough symptoms to justify a visit to a cardiologist. A few months later, Mr. Shea died of heart failure.

Mr. Shea had been an employee of Seagate [which] provided health care benefits to its employees by contracting with [an HMO] known as Medica .... Unknown to Mr. Shea, Medica's contracts with its preferred doctors [including Shea's family doctor] created financial incentives that were designed to minimize referrals. Specifically, the primary care doctors were rewarded for not making covered referrals to specialists, and were docked a portion of their fees if they made too many. See *Shea*, 107 F.3d at 626-27.

108. See id. at 627. Under the procedures of the Medica HMO, Shea could only see a specialist and be covered under the HMO with a referral from the primary care physician. The court described the Medica arrangement as permitting the doctor to "earn a bonus for treating less." Id.

109. See id. The appellate court accepted the view that ERISA preempted the state law-based wrongful death action but found a claim for relief arising under section 502 of ERISA because of the HMO's failure to disclose its "referral-discouraging approach to health care." The duty was premised on a fiduciary's common law duties arising under the law of trusts to deal fairly and honestly with plan members. See id. at 628 (relying upon Varity Corp. v. Howe, 516 U.S. 489, 495-506 (1996)).
conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties.110

As noted above, complaints against HMOs alleging undertreatment for economic reasons are hardly rare. But cases like *Shea*, even if they survive *Pegram*,111 provide only limited protection to patients. Note that *Shea*, unlike the Seventh Circuit panel's decision in *Pegram*, did not forbid the HMO's use of incentives designed to keep sick people from specialists. The HMO in *Shea* was only liable for failure to disclose, not for the mere presence of financial incentives.112 Even after *Pegram*, which clearly found nothing wrong with the mere existence of such incentives, one would still, in light of *Shea*, expect boilerplate, fine-print form "disclosure" to patients or plan members through the summary plan description distributed to workers as part of group health insurance.113 If courts permit this sort of disclosure to insulate the HMO from legal liability, *Shea* may have little actual impact even if viewed as surviving *Pegram*. In addition, *Shea*'s manifesto for disclosure was not uniformly endorsed by other courts facing similar issues114 and may find less favor now that *Pegram* has found HMOs not to be ERISA fiduciaries.

110. See id. at 629.
111. Although *Shea*, like *Pegram*, was styled as a breach of fiduciary duty claim, failure to disclose actions probably survive *Pegram*'s holding that HMOs are not ERISA fiduciaries to plan member patients so long as the tort law theory is one that creates liability even where the HMO is not a fiduciary. Writing prior to *Pegram* in a second *Shea* opinion, the Eighth Circuit so held. See *Shea* v. Esensten, 208 F.3d 712, 715–17 (8th Cir. 2000). After the initial *Shea* opinion allowing the suit to proceed, trial resulted in a finding of no negligence by the physicians. Mrs. Shea, however, was allowed to continue to pursue her claim of negligent misrepresentation under Minnesota tort law. As discussed below, this type of patient cause of action does not appear to be barred by the *Pegram* holding. *But see* Peterson v. Connecticut Gen. Life Ins. Co., No. 00-CV-605, 2000 U.S. Dist. LEXIS 16522 (E.D. Pa. Nov. 14, 2000) (finding no cause of action against HMO for failing to disclose financial arrangements with physicians; *Shea* distinguished on basis that Mr. Shea made specific inquiry; *Pegram* was regarded as "not presented with the issue" raised in the instant case but was not read as foreclosing the failure to disclose claim). *See also* Neade v. Portes, 739 N.E.2d 496 (Ill. 2000) (finding no separate claim against physician for failure to disclose financial arrangements with HMO but regarding issue as subsumed in malpractice claim brought by aggrieved patient).
112. See *Shea*, 107 F.3d at 628–29.
113. Oddly, new regulations regarding the content of summary plan documents that have been promulgated by the Department of Labor (but not effective in some cases until late 2001) do not address this issue even though the thrust of the new regulations is generally pro-employee/insured. *See U.S. Dept of Labor, Pension and Welfare Benefits Administration, Amendments to Summary Plan Description Regulations 29 C.F.R. pt. 2520 (2000).*
Another tactic used by aggrieved HMO patients, the one at issue in *Pegram*, was to allege a breach of fiduciary duty against the HMO or the physicians because of the arguably conflicting loyalties generated by the HMO and its capitated payment scheme or other cost controls. The theory of these actions, such as the claim in *Pegram*, is that the HMO or other medical providers owe a high fiduciary standard of loyalty to the patient that is compromised by rules limiting treatment or providing greater profit for reduced treatment. Under this theory of liability, a physician who fails to disclose adverse financial incentives may be in greater trouble, but even a disclosure-providing doctor would arguably violate his or her fiduciary duty by putting personal economic interests ahead of adequate treatment of the patient.

Arguably, the “failure to disclose” and “breach of fiduciary duty” claims would never have sprung from the creative capacity of patients’ lawyers had patients been able to pursue the full panoply of state tort law remedies against HMOs and HMO caregivers. In a sense, cases like *Shea* and *Pegram* were born of the Court’s earlier, extremely broad, “relate to” preemption jurisprudence that has been repudiated since 1995 by the *Travelers* analysis and line of cases. But because many post-1995 lower court cases continued to act as though the sweeping rules of pre-*Travelers* preemption applied, many patients found state law claims foreclosed and turned to other ERISA-based theories of recovery, as occurred in *Pegram*.

III. THE *PEGRAM V. HERDRICH* LITIGATION

A. Underlying Claim in the Lower Courts

When Cynthia Herdrich experienced groin-area pain, she consulted Dr. Lori Pegram, a physician in Carle Health Insurance Management Company’s Carle Clinic. Palpation revealed a six- to seven-centimeter inflamed mass in Herdrich’s abdomen. According to the records:

Despite the noticeable inflammation, Dr. Pegram did not order an ultrasound diagnostic procedure at a local hospital, but decided that Herdrich would have to wait eight more days for an ultrasound, to be performed at a facility staffed by Carle more than 50 miles away. Before the eight days were over, Herdrich’s appendix ruptured, causing peritonitis.115

Herdrich then sued Pegram and Carle in Illinois state court, alleging medical malpractice and fraud. The defendants contended that ERISA preempted the fraud counts and removed to federal court, obtaining dismissal of one fraud count. The other fraud count survived in amended form as a

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115. See *Pegram v. Herdrich*, 120 S. Ct. 2143, 2147 (2000), citing to Seventh Circuit opinion reciting facts; see also *Herdrich*, 154 F.3d at 365 (providing additional discussion of facts).
claim that the Carle HMO was liable to Herdrich under ERISA for breaching its fiduciary duty to Herdrich. Herdrich argued that since the health benefits and contract with the Carle HMO were part of the State Farm employee benefit plan (Herdrich’s husband was a State Farm employee and she was a dependent covered under the plan), the HMO was a fiduciary under the plan, administering the health care benefits by making determinations of coverage eligibility and the type of treatment required.\textsuperscript{116}

According to Herdrich’s theory of the case, the HMO committed fiduciary breach and constructive fraud by having an arrangement that “rewarded its physician owners for limiting medical care” and that this “entailed an inherent or anticipatory breach of an ERISA fiduciary duty, since these terms created an incentive to make decisions in the physicians’ self-interest, rather than the exclusive interests of plan participants.”\textsuperscript{117}

Specifically, Herdrich sought relief under 29 U.S.C. § 1109(a), the part of ERISA that 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 . . . [and] subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary duty.\textsuperscript{118}

Herdrich argued that because the HMO worked for the employee benefit plan and its members by making eligibility and treatment determinations, the HMO was acting as a “fiduciary” under ERISA. Herdrich contended that the HMO breached its duties to the patient and plan member by creating financial incentives for Dr. Pegram and others to provide reduced treatment, inferior treatment, or disincentives to treatment—all so that the HMO could be more profitable.\textsuperscript{119}

The trial court initially rejected Herdrich’s ERISA-based claim, but a panel of the Seventh Circuit found the claim permissible. The three-judge panel reasoned that by controlling access to the valuable health care offered under the plan, the HMO was essentially acting as a plan administrator. Under ERISA, plan administrators are considered fiduciaries who owe the plan members the highest duty of care and must place the interests of the plan member ahead of their own interests. The claim against the HMO alleged that Carle was favoring its own profit interests ahead of the health interests of the plan members.\textsuperscript{120} In addition, the panel went into a rather detailed, even impassioned description of the economics of HMO medicine

\textsuperscript{116} See Pegram, 120 S. Ct. at 2147–48.
\textsuperscript{117} Id. at 2147.
\textsuperscript{118} See 29 U.S.C. § 1109(A).
\textsuperscript{119} See Pegram, 120 S. Ct. at 2147–48.
\textsuperscript{120} See Herdrich, 154 F.3d at 368–71.
and criticism of the potential for financial incentives undermining the judgment of the medical professional.121 The Herdrich panel observed that “doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients.”122 A dissent in the panel opinion argued that the doctor’s undisclosed financial interest alone did not constitute a breach of fiduciary duty.123

When the defendants petitioned for rehearing before the entire Seventh Circuit, the court was very divided but did not disturb the panel’s decision. Judge Frank Easterbrook wrote a substantial dissent from the denial of rehearing and was joined by Judge Joel Flaum (who had dissented from the panel opinion), then-Chief Judge Richard Posner, and Judge Diane Wood.124 Easterbrook’s dissent accused the panel of using “its view of good medical practice as the basis of a conclusion that the HMO structure

121. See Herdrich, 154 F.3d at 368–78 (7th Cir. 1998) (providing background information and powerful argument against HMO control over medical decision making). The Herdrich panel opinion quoted several articles in both the scholarly literature and the popular press criticizing the HMO structure and operation as unduly interfering in the doctor-patient relationship and resulting in inferior health care. See id. at 376 (“[M]any observers note that an increasing number of physicians are abandoning the profession because they are disenchanted with the notion of having ‘medically ignorant administrators’ dictate that they limit patient care so as to pad the pockets of the officers of insurance companies and HMO organizations. ‘More than money, this is what is driving these senior doctors crazy: some twenty-four-year-old HMO functionary who knows about as much about medicine as he does about cartography demanding to know why Mr. Jones, the diabetic in renal failure, has not been discharged from the hospital yet.’” (quoting Charles Krauthammer, Driving the Best Doctors Away: Physicians Are Getting Hammered by Managed Care Micromanagement and Malpractice Insurance Premiums, Wash. Post, Jan. 9, 1998, at A21.

122. See id. at 376.

123. See id. at 380 (Flaum, J., dissenting).

124. See Herdrich v. Pegram, 170 F.3d 683 (7th Cir. 1999) (Easterbrook, J., dissenting from denial of petition for rehearing en banc). The dissent began by summarizing the operation of HMOs and noting that the Herdrich panel had not even cited Anderson v. Humana, Inc., 24 F.3d 889 (7th Cir. 1994), an opinion in which the court had practically lionized HMO managed care. See Herdrich, 170 F.3d at 684, citing and quoting Anderson, 24 F.3d at 890 (“Each [economic] incentive encounters countervailing forces: patients, or insurers on their behalf, resist paying the bills for unnecessary services, and HMOs must afford adequate care if they are to attract patients. HMOs also have a reason to deliver excellent preventative medicine.”).

Viewed with some historical perspective, the arguably different descriptions of the managed care world found in Herdrich and Anderson can be seen as simply reflecting not only the different authors of the opinions but also the evolution of the views of policymakers and patients toward HMOs. During the early 1990s, there was almost a ridiculously sanguine view of HMOs as the light that would lead America out of health care darkness. By the late 1990s, this had been replaced with considerable concern that HMOs were frequently emphasizing cost control and profit at the expense of quality treatment. See, e.g., Michael Bradford, Report’s Release Angers Kaiser, Bus. Ins., Apr. 28, 1997, at 1 (noting Texas regulators’ findings of fault with HMO operations and $1 million fine); Lucette Lagnado, Old-Line Aetna Adopts Managed-Care Tactics and Stirs a Backlash: Some Doctors and Employers Recall as Insurer Copies Tough HMO It Acquired, Wall St. J., July 29, 1998, at A1 (noting adverse reaction to Aetna acquisition of US Healthcare).
violates ERISA"\textsuperscript{125} but focused the dissent on the distinctions between the provision of medical care and administration of the ERISA plan itself.

Carle [Herdrich's HMO] does not manage the State Farm plan or control its assets, so the panel emphasized [another portion of the statute] concluding that Carle has "discretionary authority or discretionary responsibility in the administration of such plan." Discretionary authority is obvious; but does Carle exercise discretion "in the administration of the plan," or only in the provision of medical services? This is a fundamental divide, for fiduciary status under ERISA is not an all-or-none affair. A person is a fiduciary only "to the extent that he does one of the listed things [in the statute]; many major exercises of discretion, such as selecting the plan's terms, are outside of ERISA's fiduciary duties, even though the same person is a fiduciary when implementing the plan.

... Unless the group exercises, not discretion in the abstract, but discretion "in the administration of the plan," it is not a fiduciary under ERISA. Lori Pegram, a physician employed by Carle, scheduled Herdrich for an ultrasound examination in Urbana on one day rather than in Bloomington on another; that does not sound like an exercise of discretion "in the administration of the plan." Similarly Carle's decision to establish one set of cost-saving incentives rather than another is not an exercise of discretion "in the administration of the plan"; it is an exercise of managerial discretion in the administration of Carle's business.\textsuperscript{126}

The Easterbrook dissent essentially argued that the HMO did not administer the employee benefit plan but was merely a vendor working for the plan and plan members concerning the health care component of the plan.\textsuperscript{127} Under this construction a vendor may be liable for negligent operation or fraud according to prevailing law but it is not a fiduciary for purposes of ERISA and thus logically not subject to a breach of fiduciary duty claim under ERISA.

\textsuperscript{125} See Herdrich, 170 F.3d at 684.
\textsuperscript{126} See id. at 685 (emphasis added).
\textsuperscript{127} See id. at 686:

If one conceived the CarleCare HMO system as the benefit promised by the ERISA plan, then Carle is not a "fiduciary." It is just the supplier of medical care ... Which characterization is best? Herdrich does not allege that State Farm hired Carle to administer a medical plan that offers defined medical procedures as benefits; she alleges, rather, that the benefit State Farm offered is the CarleCare HMO system. And, for reasons I have already discussed, to the extent there is uncertainty about the right way to characterize Carle's role, the court should prefer the characterization that preserves plan sponsors' (and participants') freedom of choice. This means treating the Carle HMO as the benefit, rather than treating Carle as the administrator of the ERISA plan. If the HMO system is the benefit, then Carle is not acting as a fiduciary.

\textit{Id.} (Easterbrook, J., dissenting)
B. The U.S. Supreme Court Decision

The Court's unanimous opinion, written by Justice Souter, held that Carle and other HMOs are not fiduciaries under ERISA, at least not in the typical situation in which the HMO is merely a provider of services and does not administer the plan itself. Although an HMO may exercise discretion in treatment decisions and even in eligibility decisions (e.g., the HMO may find that a particular illness or procedure is not covered under the plan), this does not itself make the HMO a fiduciary. An ERISA fiduciary must be someone who acts as a "manager, administrator, or financial advisor" to an ERISA plan. Because the "HMO is not the ERISA plan," the general operation and decisions of an HMO are not the decisions of an ERISA fiduciary. An HMO can become an ERISA fiduciary only when it performs some administrative or managerial functions for the ERISA plan itself.

According to the Court, HMOs in theory can do two sorts of decision making. First, they may make "[w]hat we will call pure 'eligibility decisions'" that focus on "a plan's coverage of a particular condition or medical procedure" for treatment of the condition. Second, the HMO may make "treatment decisions" that are "choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?"

When the HMO makes a pure eligibility decision, the Court suggested that it may then be acting in the role of plan administrator subject to the fiduciary duty and liability sections of ERISA. When it makes a medical treatment decision, the HMO is clearly not a fiduciary and is neither subject to ERISA's fiduciary liability provisions nor shielded by ERISA preemption from state law claims. However, the Court found that a large portion of HMO decisions might be described as "mixed" in that they involve coverage under the contractual terms of the health plan but also determinations of medical treatment. The Court found the medical treatment component of such decisions to be interwoven with whatever determination of rights under the health plan might incidentally be determined. In these instances of mixed decision making, the "physician still must decide what to do in particular cases." Thus, "[i]n practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment."

129. See id.
130. See id. at 2152, 2153 n.7 ("The important point is that Herdrich is not suing the employer, State Farm, and her claim cannot be analyzed as if she were.").
131. See id.
132. See id. at 2154. Continued the Court:

[In the case before us, Dr. Pegram's decision was one of that sort. She decided (wrongly, as it turned out) that Herdrich's condition did not warrant immediate action; the conse-
Examining the *Herdrich v. Pegram* complaint and supporting papers with some detail, the Court determined that Herdrich was alleging medical mistreatment by the HMO because of adverse financial incentives rather than abuse of any fiduciary authority that the HMO might have as the delegated manager of the employer's health care plan subject to ERISA:

The kinds of decisions mentioned in Herdrich's ERISA count and claimed to be fiduciary in character are just such mixed eligibility and treatment decisions: physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than Carle's; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency and the emergency character of a medical condition.

We do not read the ERISA count, however, as alleging fiduciary breach with reference to a different variety of administrative decisions, those we have called pure eligibility decisions, such as whether a plan covered an undisputed case of appendicitis. Nor do we read it as claiming breach by reference to discrete administrative decisions separate from medical judgments; say, rejecting a claim for no other reason than the HMO's financial condition.133

The court brought legislative intent and statutory purpose into the analysis. "[W]e 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."134 In making this assessment, the Court expressed

doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature. At common law, fiduciary duties characteristically attach to decisions about managing assets and distributing property to beneficiaries . . . . [T]he common law trustee's most defining concern historically has been the payment of money in the interest of the beneficiary. Mixed eligibility determinations by an HMO acting through its physicians have, however, only a limited resemblance to the usual business of traditional trustees.135

According to the Court, congressional emphasis in drafting ERISA was on "fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the

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133. See id. at 2155.
134. See id. at 2143.
135. See id. at 2155. The Court thus rejected the view that an HMO might be analogized to a medical trust to create a situation sufficiently fiduciary to trigger this portion of ERISA. See id. at 2155–56.
financial mismanagement that had too often deprived employees of their benefits.\textsuperscript{136}

In light of its statutory analysis and characterization of the function of an HMO, the Court was convinced that HMOs were not ERISA fiduciaries, at least not when making mixed decisions of eligibility and treatment—and certainly not when making purely medical treatment decisions. Since this is the great bulk of HMO activity, the HMO was logically almost never a fiduciary under ERISA and was not subject to fiduciary liability under the statute. In short, the Court found ERISA inapplicable to the HMO itself in the instant matter, and probably in the course of most of the HMO's ordinary course of business. Although using a slightly different analysis than that of Judge Easterbrook's dissent from the Seventh Circuit's denial of rehearing, the Court in \textit{Pegram} reached essentially the following conclusion: an HMO is a business providing contract-based services for an employer that provides a health benefit plan; the HMO is not the plan itself and is not a fiduciary administrator of the plan.\textsuperscript{137}

The Court's analysis devoted significant time to reviewing the history and economics of managed care, noting that the very rationale of the HMO is a certain degree of health care rationing or limitation.\textsuperscript{138} Certain maladies or services are simply not covered or are subject to restrictions on treatment. The HMO attempts to obtain efficiencies for itself and the pool of patients as a whole even though this may result in less aggressive treatment for certain patients. As a result, the Court candidly acknowledged, HMOs as part of their ordinary course of business ration health care among the group of beneficiaries: "whatever the HMO, there must be rationing and inducement to ration."\textsuperscript{139}

Under this set of circumstances, the Court found that holding an HMO to a fiduciary standard of conduct would be irreconcilably inconsistent with the cost and service management and rationing functions of the HMO. If HMOs making "mixed" decisions (eligibility and treatment) were considered fiduciaries, the entire theory of HMOs would be undermined if the


\textsuperscript{137} See text and accompanying notes 124–27, \textit{supra} (discussing Easterbrook dissent).


physician were always required to treat aggressively to remove any doubt that it was placing the patient’s interest ahead of her own. In addition, the Court suggested that even “imposing a fiduciary obligation upon [the physician] would not lead to a simple default rule” of aggressive treatment because a physician’s best medical judgment, unhampered by economic incentive, may opt for less aggressive treatment.\textsuperscript{140}

The Court also stated that holding HMOs and HMO doctors out as fiduciaries would, as a practical matter, make it impossible for HMOs to function because every challenged treatment decision would potentially be the seed of a breach of fiduciary duty lawsuit. Pointedly, the Court rhetorically asked “what 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?”\textsuperscript{141}

IV. PEGRAM’S IMPACT: ERISA DOES NOT IMMUNIZE EITHER MEDICAL PROFESSIONALS OR HMOs FROM STATE LAW LIABILITY CONCERNING DELIVERY OF MEDICAL SERVICES UNDER THE AUSPICES OF AN EMPLOYER-PROVIDED HEALTH PLAN

\textit{Pegram} both gives and takes away from HMOs. On the one (obvious) hand, the decision is helpful to HMOs in that it relieves them of possible fiduciary obligation and liability under the ERISA statute that provides for penalties and counsel fees for prevailing plaintiffs.\textsuperscript{142} On the other (less obvious) hand, the decision suggests that HMOs should not be immune from otherwise valid state law claims against health care providers or physicians for negligence, misrepresentation, or fraud simply because the HMO is providing its services as a vendor under an ERISA plan.\textsuperscript{143}

The HMO making mixed or purely medical decisions is indistinguishable from the treating physician, at least as concerns ERISA. Also, we now conclusively know that the Court has no absolute objection to physician liability under these circumstances. The Court noted without disapproval that Herdrich’s original malpractice claim was tried to a jury and resulted in a $35,000 award.\textsuperscript{144} The Court also noted that states vary regarding whether to “allow malpractice actions against HMOs,” suggesting that there is no ERISA bar to such state law tort actions against HMOs.\textsuperscript{145}

\textsuperscript{140} \textit{Id.} at 2157.
\textsuperscript{141} \textit{Id.} at 2158.
\textsuperscript{142} \textit{See} Bloche & Jacobson, \textit{supra} note 19, at 2777 (“On its face, the Supreme Court’s decision in the case was a big win for managed care.”).
\textsuperscript{143} \textit{See Pegram}, 120 S. Ct. at 2177 (“managed care industry's victory could prove bittersweet”).
\textsuperscript{144} \textit{See id.} at 2148.
\textsuperscript{145} \textit{See id.} at 2158. The Court did not explain whether this was because such actions are
If an HMO is not a plan administrator or fiduciary to employees and is essentially a vendor providing supervised medical services, there is no compelling reason that ERISA should preempt claims against this medical vendor merely because this vendor attempts to manage its delivery of services under the contract so as to reduce its costs and increase its profits in connection with its contract with an ERISA plan. Thus, Pegram’s rationale supports the existence (and nonpreemption) of state law claims against a physician or against the HMO (including possible punitive damages awards against either entity) that delivers substandard care due to negligent operation. Pegram also indicates that a prospective plaintiff will not prevail merely because the HMO was practicing managed care. However, where the aggrieved patient can show that the HMO did something unreasonable that caused harm and violated a duty, recovery should be permitted. After Pegram and the Travelers line of more restrained preemption jurisprudence, the better view is that ERISA does not stand in the way.

The remaining HMO line of defense to such claims is to invoke the Court’s pre-Travelers line of cases according broad section 514 ERISA preemption through literalist construction of the “relate to” language or to argue that section 502 preemption is appropriate on the theory that state-based HMO liability is simply too fundamentally at odds with ERISA. Both types of preemption argument were implicitly rejected in Pegram and should fail in the future. The Court’s current, sounder approach to preemption will find no need to displace state law, particularly since almost all of an HMO’s activity (and even more of an HMO doctor’s activity) is not plan administration or other fiduciary activity under ERISA.146

Pegram not only suggests continued vitality for the restrained section 514 preemption analysis of Travelers but also effectively precludes an argument for section 502 preemption (on the ground that a claim under ERISA is the exclusive remedy for plaintiffs claiming medical mistreatment) because we now know that these entities are not fiduciaries subject to suit under ERISA. Hence, there is no remedy at all under ERISA for medical mistreatment unless HMOs working for ERISA plans are subject to the legal regime that governs all other medical providers, including the

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146. See text and accompanying notes 80–89, supra, describing Travelers approach to preemption; Jordan, supra note 24, at 421–25.
doctors utilized by the HMO, a result that borders on the absurd. Where HMOs are not fiduciaries, the deficient delivery of medical care should not be seen as a denial of benefits subject to suit for enforcement under section 502. *Pegram* implicitly found that medical treatment decisions are not plan eligibility decisions or denials of plan benefits by the plan provider. Thus, an ERISA-based claim for injunctive relief to provide benefits would not be inconsistent with state law-based claims against the treating physician or an HMO based on its medical care decisions.

Under the *Travelers* line of preemption cases, HMOs and HMO physicians are logically subject to state law claims unless the nature of the claim would interfere substantially with ERISA’s goal of federalizing pension benefit law applicable to the employer plan itself. The Fifth Circuit, in a case decided a week after *Pegram*, reached essentially this conclusion:

We faithfully followed the Supreme Court’s broad reading of “relate to” preemption under § 502(a) [and section 514] in its opinions decided during the first twenty years after ERISA’s enactment. Since then, in a trilogy of cases [*Travelers, Dillingham, and DeBuono*], the Court has confronted the reality that if “relate to” is taken to the furthest stretch of its indeterminacy, preemption will never run its course, for “really, universally, relations stop nowhere.” Justice Souter, speaking for a unanimous court in *Travelers*, acknowledged that “our prior attempt to construe the phrase ‘relate to’ does not give us much help drawing the line here.” Rather, the Court determined that it “must go beyond the unhelpful text . . . and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”

147. *See Corporate Health*, 215 F.3d at 532–33. The *Corporate Health* decision then discussed *Travelers, Dillingham*, and *DeBuono*. *See id.* at 533–34. The Fifth Circuit held that ERISA did not preempt Texas from adopting legislation or insurance department rules that “regulate the quality of health services when such efforts impose a duty of care upon service providers to ERISA plans.” *See id.* at 531.

*Corporate Health* did, however, reiterate the continuing ERISA preemption of state law claims impinging on eligibility determinations. *See id.* at 535–36, implicitly approving continued vitality of *Pilot Life* and also reaffirming the U.S. Supreme Court’s view that ERISA preempted state “any willing provider” laws. The Court has granted review of a case, *Egelhoff v. Egelhoff*, 989 P.2d 80 (Wash. 1999), *cert. granted*, 120 S. Ct. 2687 (2000) (argued Nov. 8, 2000), that involves an unsuccessful ERISA challenge to a state law regulating entitlement to life insurance benefits after the divorce of the decedent insured employee. The Court may use the case to further flesh out ERISA preemption issues, but past practice suggests that the Court will decide *Egelhoff* as narrowly as possible.

The Court may, however, more directly take on issues of state regulation of HMOs by reviewing *Corporate Health* and *Moran v. Rush-Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), which upheld an Illinois statute requiring independent review of claim denials similar to the portion of the Texas law struck down in *Corporate Health*. *See Robert Pear, Bush Set to Back State Laws to Extend H.M.O. Patients’ Rights*, N.Y. Times, Jan. 14, 2001, at A18; *Montemayor v. Corporate Health Insrs.*, 121 S. Ct. 733 (Jan. 8, 2001) (requesting solicitor general’s views on issue in light of pending petitions for certiorari).
Prior to *Pegram*, the leading treatise on health care law found that state
law claims against HMOs have survived the preemption defense and have
been permitted based on a number of theories or alleged deficiencies, in-
cluding:

a. breach of contract claims;
b. operational restrictions on subscriber choices;
c. managed care plan design and delivery of health care, including
   i. marketing representations,
   ii. recommendations about treatment,
   iii. policies that discourage doctors from offering required care, and
   iv. "substandard" design and administration of the managed care plan;
d. selection and retention of doctors; and

e. economic incentives to doctors.148

The primary test used in these cases is a division between an HMO's
coverage or eligibility decisions and its policies or decisions implicating
the quality of medical treatment. Even after *Travelers*, state claims challenging
coverage-eligibility determinations are often considered preempted149
while care-quality policies and determinations are not.150 Vicarious-liability
claims arising out of improper medical practice have generally been held
not to be preempted.151

Under even the "new" law of ERISA preemption, HMOs have con-
 tinued to enjoy substantial immunity where the challenge can be styled as one
objecting to the terms of the coverage provided to the benefit plan. Even
where the HMO's challenged action arguably involves the administration
of medical care, a significant number of late 1990s decisions continued to
find preemption. For example, post-*Travelers*:

courts have generally held that ERISA preempts claims based on plan strate-
gies to discourage referrals to specialists. Pre-certification and other forms of

859 F. Supp. 182 (E.D. Pa. 1994) (ERISA no bar to medical malpractice claims or claim of
active, direct negligence by HMO in providing medical service, but vicarious liability claim
against HMO prohibited); Elsesser v. Hospital of the Philadelphia College of Osteopathic
Medicine, 802 F. Supp. 1286 (E.D. Pa. 1992) (permitting malpractice action against physician
and also permitting claim against HMO for negligence in physician hiring and supervision);
preempt medical malpractice claims).

noncoverage of in-home visits is a benefit issue subject to section 502 implied preemption;
aggrieved patient may sue under ERISA to seek benefits but may not lodge state law tort
claim because in-home visits not covered); FURROW ET AL., supra note 32, § 8–5.

150. See, e.g., Crum v. Health Alliance-Midwest, Inc., 47 F. Supp. 2d 1013 (C.D. Ill. 1999);
due to inferior diagnosis and treatment not preempted); see also FURROW ET AL., supra note
32, § 8–5.

151. See, e.g., Herrara v. Lovelace Health Systems, Inc., 35 F. Supp. 2d 1327 (D.N.M.
utilization review are designed to filter out demands for “unnecessary” treatments. Such forms of review of physician medical decisions to determine their necessity and cost-effectiveness prior to treatment or hospitalization are either completely preempted under § 502(a)(1)(B) or subject to an ERISA preemption defense under § 514(a) ... Claims that fall within the administrator’s core functions—determining eligibility for benefits, disbursing them to the participant, monitoring available funds and recordkeeping—are completely preempted.152

Prior to Pegram, this treatise’s assessment was close to unassailable. After Pegram, it is still clear that a plan administrator’s core functions, such as shepherding and disbursing plan assets, are part of ERISA preemption and would be subject to claims for relief under ERISA’s right of action for either denial of benefits or breach of fiduciary duty. However, even prior to Pegram, it was questionable whether ERISA absolutely barred state law claims that attack an HMO’s decisions to impose precertification or utilization review that does not enforce the benefits contract so much as it adversely affects the quality of promised “necessary” medical care.

After Pegram, a claim for absolute ERISA preemption of state law claims attacking screening devices would seem to vary according to the facts of the case and the precise nature of the plaintiff’s theory of the case. If a post-Pegram plaintiff alleges that screening is used for enforcing the contours of coverage, ERISA immunity may hold (although in this case, the HMO may be a fiduciary under Pegram’s analysis and subject to suit under this provision of ERISA). If, instead, the post-Pegram plaintiff attacks an HMO screening device that errs in determining medical necessity or appropriate treatment, or unfairly distorts the doctor’s professional judgment, Pegram would appear to classify this type of claim as attacking an HMO’s mixed or medical treatment decisions, in which case ERISA fiduciary duty would not attach but neither would the HMO be shielded by ERISA preemption. In short, Pegram appears to have expanded HMO liability for aggressive means of discouraging or restraining treatment, even where these screening mechanisms are “coverage” decisions to some degree.

One thing is certain. After Pegram, the Corcoran line of cases granting nearly carte blanche ERISA preemption and immunity to HMOs can no longer be good law, regardless of the Fifth Circuit’s brave effort to maintain this with the metaphorical “straight face” when denying rehearing in Corporate Health Insurance, Inc. v. Texas Department of Insurance153 Pegram
states, in essence, that the bulk of an HMO's activity is the management of the delivery of medical services pursuant to a contract with an employer benefit plan. The HMO itself is not the plan and the HMO makes at most only a few "pure" decisions of eligibility under a benefit plan. Most decisions of the HMO are pure medical treatment decisions or are mixed decisions that turn largely on judgments about medical treatment. Hence, according to *Pegram*, HMOs are almost never fiduciaries under an ERISA plan and are almost never subject to fiduciary liability under ERISA. Logically, these same HMOs can almost never be pure plan administrators subject to ERISA preemption and immunity. Hence, actions against them will almost never affect the ERISA plan in a way that warrants preemption. Rather, state law claims against the HMO relate to the HMO and its performance.

As such, there can, after *Pegram*, be neither section 502 nor section 514 preemption of claims against the HMO unless the HMO in the instant case is acting as plan administrator in making a pure eligibility or coverage decision divorced of medical treatment implications. The typical action against an HMO alleges poor delivery of medical care and does not allege anything actionable under ERISA such as breach of administrative responsibility. In short, after *Pegram*, HMOs should generally be subject to suit on whatever terms would apply to any garden-variety provider of medical

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ever, we do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held otherwise.

In one of the footnotes to the quoted passage, the Fifth Circuit observed:

It may be that state causes of action persist only for actions based in some part on malpractice committed by treating physicians. If so, state causes of action against HMOs for the decisions of their utilization review agents would still be preempted, as *Corcoran* held. Because *Pegram* did not exhaustively discuss the specific kinds of state causes of action that it implied were not preempted, we make no additional inferences.

*Corporate Health*, 220 F.3d at 643, n.6.

Perhaps. But for the reasons set forth in this article, *Corcoran* is quite clearly inconsistent with *Pegram* and actions against HMO utilization review themselves appear not to be preempted by either the language of ERISA, the *Travelers* line of preemption cases, or logic. An HMO's review of medical necessity in an individual case will, in even a situation involving expensive medicine, have at most a negligible effect on the finances of the ERISA plan. The HMO, like any insurer, owes at least minimal duties to its group members. Errors of medical judgment in the administration of medical services should subject the HMO to liability in a manner consistent with the liability regime governing physicians.

services under the applicable state law. This includes the HMO’s gatekeeping mechanisms unless these screening devices can be successfully characterized by the HMO solely as benefit and eligibility determination devices.

In order to fully appreciate the scope and impact of *Pegram*, a review of its predecessors may be illustrative. The early case law of claims against HMOs favored defendants except in cases alleging negligence by the treating physician. The broad “relate to,” pre-*Travelers* preemption analysis of cases like *Pilot Life* was invoked by HMOs successfully, arguing that states’ law-based liability of an HMO working for an ERISA plan related to the plan and would unduly interfere with its operation and the uniformity sought by ERISA. 154 *Corcoran v. Aetna United Healthcare, Inc.* above, 155 is a classic illustration and found wrongful death claims against an HMO preempted on the theory that the claim related to an ERISA plan (that used the HMO to deliver health care coverage). The plaintiff had been denied hospitalization and round-the-clock monitoring of a distressed fetus, which ultimately was lost during the at-home care that the HMO was willing to approve. As one commentator has observed, *Corcoran* was decided “at a time when the Supreme Court precedent suggested an expansive and practically unlimited view of ERISA preemption.” 156 However, after *Travelers*, the dike of ERISA preemption in such cases began springing more than a few leaks as cases rejecting preemption accumulated. 157

*Corporate Health Insurance, Inc. v. Texas Department of Insurance* 158 underscores these developments and the impact of *Travelers* and *Pegram*. *Corporate Health*, in addition to summarizing the evolution of ERISA law, comes close to overruling in part the Fifth Circuit’s own infamous *Corcoran*

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155. See text and accompanying notes 102–05, *supra*, describing *Corcoran*.

156. See Jordan, *supra* note 24, at 421.


For example, in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), the court rejected a defense of implicit section 502 preemption in the face of a claim of HMO negligence. The court found that the ERISA-based cause of action did not encompass quality of care decisions. Consequently, there was no ERISA bar to litigating quality of care issues under state law. See Furrow et al., *supra* note 32, at 437–38 (discussing *Dukes*).

158. 215 F.3d 526 (5th Cir. 2000).
case but then flinches. At issue in *Corporate Health* was Texas legislation that (1) "created a statutory cause of action against managed care entities that fail to meet an ordinary care standard for health care treatment decisions," (2) "established procedures for the independent review of health care determinations to decide whether they were appropriate and medically necessary," and (3) "protected physicians from HMO-imposed indemnity clauses and from retaliation by HMOs for advocating medically necessary care for their patients." The court found no ERISA preemption of the statute that established HMO liability for substandard medical care. However, the portion of the Texas law providing for independent review of HMO treatment decisions was held preempted by ERISA and was severed from the statute, which was upheld. The court also found that "the anti-indemnity and anti-retaliation provisions are not preempted: they too address traditional state concerns regarding the quality of health care." The Fifth Circuit reaffirmed this view in response to the state's motion for rehearing.

State legislation requiring independent or improved review of claims may be sustained in states outside the Fifth Circuit. For example, *Moran v. Rush Prudential HMO, Inc.*, sustained a state law requiring independent review of HMO decisions as to the level of care to which the insured was entitled.

Even in the absence of such litigation, under *Pegram* an aggrieved patient would appear entitled to argue that denial of coverage based on the HMO's determination that treatment was unnecessary or excessive (rather than simply excluded outright from the terms of coverage) is a "mixed" decision...

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159. See text and accompanying notes 147, 153, *supra*, discussing *Corporate Health*, 220 F.3d 641 (opinion on rehearing motion).

160. See *Corporate Health*, 215 F.3d at 531.

161. The court did not find total ERISA preemption of the statute in this regard. The use of independent review "as a prerequisite to filing suit" rather than as a means of overturning an HMO's decision was found "preempted neither under ERISA or FEHBA [the Federal Employees Health Benefit Act, 5 U.S.C. § 8901] because they allow suit for health services actually delivered, not for coverage disputes." See id. at 532.

162. See id. at 536–37.

163. Id. at 540.

164. See *Corporate Health*, 220 F.3d at 643.

165. 230 F.3d 959 (7th Cir. 2000).

166. The Illinois HMO Act "requires HMOs to submit to an independent physician review when..."
for which the HMO is neither a fiduciary nor exempted from applicable state law. Under *Pegram*, cases like *Corcoran* should come out the other way if decided today. Oddly, however, in a second opinion denying the rehearing petition filed by Texas, the *Corporate Health* court expressly stated that *Corcoran* was still good law.\(^{167}\)

V. A BETTER CRITERION FOR ASSESSING ERISA PREEMPTION AND HMO LIABILITY UNDER STATE LAW: DISTINGUISH BETWEEN THE PLAN AND CORE PLAN FUNCTIONS AND OTHER ACTIVITY DONE ON BEHALF OF THE PLAN

*Pegram* certainly is correct in its narrow sense of finding that the HMOs are not fiduciaries. HMOs are in essence simply vendors for ERISA plans. When measured against the traditional criteria of the fiduciary relationship of great trust and reliance coupled with need for absolute loyalty and confidentiality, HMOs begin to look more like plumbers, electricians, and purveyors of retail goods. This, of course, is because there is a big difference between the ERISA plan itself and those contracting with an ERISA plan. The plan itself owes a high duty to employees. They depend on the plan to be there upon retirement or in the event of illness, disability, or death. The failure of pre-ERISA plans to fulfill this duty led to ERISA’s enactment.

By contrast, those who do business with an HMO generally are not in the same position of trust, reliance, need for stable loyalty, or control of vast amounts of the plan’s assets. Only when a nonplan entity has this close relationship to the core of the plan (such as an investment advisor or a bank trustee) does it make sense to consider a nonplan entity to be an ERISA fiduciary, or to be outside the reach of the otherwise applicable state law. Service providers such as HMOs are not doing the type of plan

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\(^{167}\) See notes 147 and 153, *supra*. Professor Jordan, writing prior to the *Pegram* decision, essentially makes this analysis as well. She criticizes *Corcoran*, advocates an approach similar to that actually adopted by the U.S. Supreme Court in *Pegram*, and notes with favor and optimism the trial court decision in *Corporate Health*, which was affirmed in almost all respects by the Fifth Circuit. See Jordan, *supra* note 24, at 425-30.

Unfortunately, many courts have elected to follow *Corcoran* without independent analysis of the continued soundness of the reasoning used by the *Corcoran* court. One exception is the decision in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, in which a federal district court held that ERISA does not preempt a Texas legislative provision that authorizes civil suits against managed care entities. The managed care entities’ strongest argument supporting preemption was the fact that the civil action authorized by the statute constitutes a state common law suit akin to the suit in *Corcoran*, thereby warranting preemption. The [trial] court in *Corporate Health* expressly opined that, if decided today, *Corcoran* would "perhaps be decided differently." Nonetheless, the court felt compelled to remain consistent with *Corcoran* and thus construed the Texas provision as authorizing a suit distinguishable from that at issue in *Corcoran*. *Id.* at 430 (footnotes omitted).
administration that Congress sought to place outside the reach of state regulation that might prove inconsistent with the federal scheme.

This common sense logic based on statutory purpose suggests that the ERISA world can properly be divided with a rather bright line between the plan itself and its core activities (collecting, managing, and investing pension funds; designating the plan; amending as necessary; and holding plan assets) and the activities of those nonfiduciaries with which the plan is doing business. Pegram recognizes a good deal of this dichotomy in its division between pure eligibility decisions and mixed or pure medical treatment decisions. Only when purely determining eligibility are HMOs closest to the plan to be considered fiduciaries. Under Pegram, the fiduciary status of an HMO and its exposure to state law claims will turn on whether the challenged behavior is a pure eligibility determination, a medical treatment decision, or a mixed decision. Pegram seems to say that only the pure eligibility decision acquires fiduciary status, which both subjects the HMO to potential fiduciary breach liability and is subject to preemption (both section 514 and section 502) and therefore outside the reach of state laws. Mixed decisions and medical treatment decisions do not expose the HMO to fiduciary claims. But the logical that price the HMO pays for this insulation from strict fiduciary liability is exposure to state law tort and statutory claims and limited state regulation.

The net effect of this approach seems sound enough, at least as measured against the backdrop of past ERISA precedent, but will require the courts to engage in some, perhaps a significant degree of, fact adjudication to

168. At one point, the U.S. Supreme Court appeared poised to make finer distinctions between the core ERISA plan itself and things done by an ERISA plan or entity connected to an ERISA plan. See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 7–8 (1987) (concept of “plan” under ERISA separate from concept of “benefit”; preemption requires challenged law to impact administration of plan itself) (finding that Maine law requiring one-time severance pay benefit for employees terminated because of plant closing not preempted by ERISA).

Fort Halifax was a polarized five-four decision, with Justice White in dissent (joined by Chief Justice Rehnquist, Justice Scalia, and Justice O’Connor), arguing that the majority had created a “loophole” in ERISA’s preemption provision that “will undermine Congress’s decision to make employee-benefit plans a matter of exclusive federal regulation.” See 482 U.S. at 23. In the subsequent ten years, Justice White’s view came to dominate the Court on ERISA preemption, with Justice O’Connor writing broad preemption decisions such as Pilot Life. With the 1995 Travelers shift to more traditional, less textual preemption analysis, further distinction between the plan and its service provision takes on additional attractiveness.

Fort Halifax may be incorrectly decided because what one pays employees upon termination seems rather closely connected to the employer’s pension benefit system that was the focal point of ERISA. Furthermore, the Maine law arguably dictated the content of employer benefits to employees, which seems inconsistent with ERISA. In addition, requiring severance benefits upon plant closings could conceivably have a dramatic financial impact upon the employers’ overall provision of benefits. Nonetheless, the Fort Halifax majority was probably on to something when it attempted to distinguish more cleanly between core ERISA plan administration and matters ancillary to the ERISA plan.
determine the nature of the HMO behavior under challenge in the litigation. Rather than open the door to this investment of disputing resources, the Pegram Court might better have simply stopped when it noted that an HMO is not an ERISA plan and then held that the HMO’s management decisions are not ERISA plan administration.\textsuperscript{169} This is in essence the position taken in the Easterbrook dissent in the Seventh Circuit’s denial of rehearing en banc.\textsuperscript{170} It would have the advantage of providing a brighter line for determining the nature of HMO liability and reducing disputing costs. In addition, it would be more consistent with the post-Travelers view of ERISA preemption.

Under this proposed modification of the Pegram analysis, courts would use a test that determines whether a litigation defendant is an ERISA plan, engaged in core plan functions such as managing assets, or is simply an entity doing work on behalf of an ERISA plan. In effect, HMOs, insurers, or others providing benefits in return for compensation by an ERISA plan would be viewed as vendors rather than plan administrators or sometime fiduciaries. As vendors, the HMOs are not held to the standard of a fiduciary any more than a plumber or electrician is a fiduciary. But neither is the HMO immune from the consequences of its negligence in design or delivery, the tendency of its rules to bring inferior care, or for any misrepresentations made by the HMO.

As a vendor, the HMO is logically liable when its policies or practices bring harm to an employee or dependent to whom a duty is owed. Claims against an HMO or other entity arranging for the provision of health care could always be assessed under the state’s applicable tort law and other laws. HMOs would then clearly be subject to claims for medical malpractice (where the HMO is vicariously liable under state law or has engaged in conduct that in significant part caused the malpractice; HMOs would presumably not be responsible for the isolated errors of physicians that could not have been prevented by the HMO except to the extent that the doctors in a staff model HMO are “employees” to which respondeat superior applies). HMOs would also be subject to suit for breach of contract through erroneous denials of treatment. Similarly, these vendors would face liability if they tortiously interfere with the doctor-patient relationship (although mere use of financial incentives and health care rationing would not suffice to prove a tortious interference claim). The applicability of state law to the HMO would be clear without any need to engage in Pegram’s “eligibility or treatment” analysis.

\textsuperscript{170} See text and accompanying notes 124–27, supra (reviewing Easterbrook dissent). However, Judge Easterbrook’s joinder in Judge Posner’s dissent from the denial of rehearing in Moran, 230 F.3d 959, 973, may indicate that he does not currently hold what I regard as the clear implications of the views expressed in his Pegram dissent.
Such an approach would be much truer to the original purpose of ERISA in that it would preserve as much state law as possible without interfering in any way with the national uniformity sought regarding the regulation of the core activity of employee benefit plans, most particularly pension plans.\footnote{See text and accompanying notes 33–99, supra, discussing the legislative history and congressional intent of ERISA.} The HMO, even when making eligibility or coverage decisions, should not be considered the plan administrator. Rather, the HMO is a service provider. The employer is the true plan administrator. Although the employer may retain others to assist in plan administration, the HMO is not really retained for that purpose. The HMO is retained to provide health care services pursuant to the contract.

A nonhealth care analogy is instructive. An ERISA plan might provide for an employee fitness center and contract with an outside company to run the facility. If a security guard denies entrance to a plan employee because the employee forgot his or her membership card, the security guard could be characterized under current ERISA law as having just made an “eligibility” or “coverage” determination. But this seems an almost ludicrously broad view of what constitutes plan administration. If the employee denied access becomes agitated or the security guard is officious and short-tempered (imagine Bobby Knight in a second career), fisticuffs may ensue. If the employee is injured and sues the guard and the manager of the fitness club, does ERISA preempt this state law tort claim on the ground that the scuffle arose from and is related to plan administration? What if the security guard has a pattern of denying access to racial minorities but not white employees? Under a coverage-versus-quality analysis, ERISA preemption could arguably apply to the security guard working for the fitness company that has a contract with the employer’s ERISA plan.

This seems ridiculous but the same shaky reasoning applies to current law considering a vendor’s eligibility or health care coverage determinations. These are not really the types of ERISA plan administration decisions that Congress had in mind when enacting ERISA. Rather, the security guard is just a more pronounced version of the HMO that administers the ERISA plan only in that it is under a contract to provide plan benefits under certain terms and conditions. One could apply Pegram’s test to this hypothetical—a court could consider whether the guard was making a pure eligibility decision (“without an ID card, you can’t get in”), a pure fitness treatment decision (“don’t use the Stairmaster that way or I’ll have to ask you to get off”), a pure security decision (“if you keep abusing the equipment, I’ll have to eject you”), or a mixed decision (“under the terms of the contract, retirees are not allowed to use the sauna because
of heart attack and stroke concerns"). But why bother with the Pegram test when we know that the entity whose conduct is at issue simply is not the ERISA plan and is not administering the "plan" but only managing the delivery of services promised the plan? Similarly, questions regarding the quality of delivery of medical care and failure to deliver contractually promised care were not what Congress intended to reach with the ERISA preemption clause.

Under the proposed modification of Pegram, a court would limit both preemption and fiduciary status to claims that directly attack an ERISA plan, trustee, or other fiduciary as a defendant or that otherwise are logically preempted by the statute. For example, ERISA provides for a claim against "interested persons" that do business with fiduciaries. A state law claim against such interested parties would appear to be precluded if it seeks the same recovery as provided for under ERISA, interferes with the ERISA enforcement scheme, or is presented after adjudication of the ERISA claim on grounds of claim preclusion merger and splitting the cause of action. Absent a showing of state law interference with the federal legislative scheme in ERISA, the traditional presumption against preemption reinvigorated in the Travelers line of cases would hold. Claims against entities working for an ERISA plan should thus ordinarily not be considered claims sufficiently related to the plan to warrant preemption.

To the extent that a plan or plan administrator or fiduciary violates ERISA, a cause of action exists under the statute. Remedies are limited to conferral of benefits and perhaps attorneys' fees without extracontractual damages. Nonetheless, relief would be available consistent with the congressional will to encourage fiscally sound pension plans and other employee benefits subject to minimum standards and minimum protections for employees. State law would apply to all matters concerning the nonfiduciary outside entities that contract with the ERISA plan to provide services under the plan. In essence, this modification of Pegram would create a bright line between the core ERISA plan and the entities that retain to carry out the plan. ERISA plan beneficiaries would enjoy the full extent of state law rights available to others who receive medical care.\textsuperscript{174}

\textsuperscript{172} One could, I suppose, attempt to apply this characterization to investment advising by arguing that the advisor is only carrying out contractual duties to the plan, but this argument would fail because the nature of managing assets of the plan is qualitatively different from determining whether an employee is allowed to use a plan benefit. An investment advisor or trustee can lose millions of dollars in plan assets with the click of a mouse. An HMO administrator, even one with excessive generosity toward claimants, does not imperil plan assets in the same way. Further, the language and legislative history of ERISA clearly show that core plan administration, including asset management, was subject to ERISA's fiduciary requirements and was intended to be under a strictly federal legal regime. See text and notes 33-99, supra.


\textsuperscript{174} The proposed modification of Pegram would arguably be inconsistent with Pilot Life
Preemption would exist only where the state law in question was so invasive to the vendor as to undermine ERISA's statutory scheme. Although HMOs and others might argue that tort regimes, particularly the availability of punitive damages, create such interference, this is unlikely to be a successful argument. Already, courts have rejected a similar argument that tort liability, including punitive damages, for doctors creates such interference. Applied to areas of current controversy, the proposed "plan/nonplan" test would suggest that state "any willing provider" laws are probably preempted as unduly interfering with the configuration of the ERISA plan because they effectively preclude the employer from engaging in contracts that restrict the pool of participating physicians. However, state laws requiring independent or improved review of delivery of medical services would not be barred by ERISA, under either our analysis or the Pegram coverage-mixed-medical split.

In practice, the Pegram approach may not be difficult to apply because, as Pegram itself noted, HMOs are usually making medical decisions and not plan administration decisions. But modifying Pegram to make fiduciary status and ERISA preemption turn on whether the defendant entity is really operating the ERISA plan would make for clearer, more predictable jurisprudence. In addition, it would reduce the degree to which fiduciary duty might unfairly be imposed or to which an HMO might unfairly escape state law liability merely because it is "dabbling" in the business of ERISA plan administration.

VI. THE POSSIBILITY OF LEGISLATION

In response to complaints about HMOs, Congress has considered and occasionally taken action. Hearing complaints about the postdelivery short-stay hospitalization authorized by many HMOs, Congress acted to prohibit "drive-thru deliveries." 175 Various states have enacted "any willing provider" laws attempting to limit HMOs from excluding medical providers

_Ins. Co. v. Dedeaux_, 481 U.S. 41 (1987). The proposed modified Pegram approach could be distinguished from _Pilot Life_ in that the HMO, even when determining eligibility, is not making the same sort of coverage qua coverage decisions that are made by an insurer, which is in the business of making coverage decisions as the bulk of its work. This distinction is strained, however, since HMOs often function as both insurers and health care providers because they shift and distribute risk where they enroll plans and beneficiaries for set premiums. Modifying Pegram in the direction proposed may require overruling or modifying _Pilot Life_.

from their networks, although most such laws will be preempted by ERISA unless determined to be part of the state’s overall insurance regulation.

Central among these controversies and potential legislative responses has been activity for and against a federally mandated patient’s bill of rights. The Clinton administration proposed a patient’s bill of rights that has substantial congressional support precisely because of the ravages of such perverse incentives.176 Several versions of such legislation have circulated in Congress.177 The most prominent bill favored by congressional liberals seeking greater patient rights from HMOs has been the Norwood-Dingell bill.178 The legislation was passed by the House in 1999 but floundered in the Senate.

Norwood-Dingell included “provisions that would exempt from ERISA preemption state law claims against managed care plans by patients injured by denials of or delays in medical care.”179 Norwood-Dingell would permit claims against HMOs or insurers for coverage denials, essentially overruling Pilot Life and that portion of Pegram that continued to accord ERISA preemption to that portion of an HMO’s activity that constitutes a pure coverage or eligibility determination or act of plan administration. Although state claims would be allowed, Norwood-Dingell provided for restrictions on punitive damages by providing a safe harbor of sorts for utilization review decisions.180

The other legislation introduced on the issue would have restricted HMO liability quite substantially by barring certain claims, limiting damages, and creating additional defenses for HMOs181 and thus could be seen as considerably less “pro-patient” than Norwood-Dingell. For example,


178. See H.R. 2723, 106th Cong. (1999) (Norwood-Dingell bill). See Jordan, supra note 24, at 432 n.112. The bill is titled the Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723 § 1(a). After passage of the Norwood-Dingell bill, the House passed a Republican package of tax breaks and insurance reforms designed to increase access to health care coverage. Following that vote, the Norwood-Dingell bill was merged with the access bill. The combined bill kept the bill number of the access measure. For convenience, this article will continue to refer to the legislation that passed the House in 1999 as the Norwood-Dingell bill.

179. See Jordan, supra note 24, at 432.

180. Under Norwood-Dingell, a managed care entity would not be liable for punitive damages if the claim relates to an “externally appealable decision,” the external appeal was initiated in a timely manner and completed, and the plan complied with the determination resulting from the external appeal. Jordan, supra note 24, at 434, citing H.R. 2723, § 302(a) (amending section 514 of ERISA by adding § 514(c)(1)(B)(ii)-(iv)).

181. See Jordan, supra note 24, at 432.
one bill would ban punitive damages altogether if a denial of medical services is upheld after external review.\textsuperscript{182} Another would cap punitive damages at $250,000 or twice the patient’s economic damage, whichever is greater.\textsuperscript{183} Norwood-Dingell itself does not permit recovery for emotional distress alone but only for some form of tangible harm.\textsuperscript{184} Norwood-Dingell also limits the defendants to its “new” (maybe not so new after \textit{Pegram}) cause of action. The employer or plan sponsor may not be sued and only the person making the “sole final decision” adverse to the plaintiff is a proper defendant.\textsuperscript{185}

Norwood-Dingell expands beneficiary rights in that it overrules \textit{Pilot Life} in part and allows claims challenging coverage decisions. In return, however, the legislation may provide less relief for the victim of bad doctoring and HMO medical or mixed wrongdoing that exists in the wake of \textit{Pegram}.

Under this set of circumstances, consumer advocates can make a strong case that the best course of action is for Congress to do nothing, particularly if the states are permitted significant latitude in regulating HMO health care conduct. Case law during the 1990s has steadily evolved away from the overbroad ERISA preemption that dominated the 1980–1995 period. Under cases like \textit{Travelers, Pegram, Corporate Health}, and \textit{Dukes v. U.S. Healthcare, Inc.},\textsuperscript{186} the negligence or malfeasance of treating medical professionals is clearly actionable under state law and damages are limited only insofar as provided under state law. In many states, the HMO or other managed care entities may be held vicariously liable for the doctor’s misdeeds and may be liable to the fullest extent of state law for their active negligence or other wrongdoing on medical matters or mixed questions of medicine and eligibility for treatment. Only where the HMO makes a pure coverage or plan administration decision does ERISA immunity attach through preemption of the state claims, and then the HMO is arguably a fiduciary liable for breach of its fiduciary responsibilities.

Of course, there can be considerable debate about what further the interests of patients. Insurers and HMOs have long argued that without protection from or limitation of state law claims, health benefits will be

\textsuperscript{182} See \textit{id.}
\textsuperscript{183} See \textit{id.}
\textsuperscript{184} See H.R. 2723, § 302(a) (amending section 514 of ERISA by adding § 514(e)(1)(A); Jordan, \textit{supra} note 24, at 469.
\textsuperscript{185} See Jordan, \textit{supra} note 24, at 468–69.
\textsuperscript{186} 57 F.3d 350 (3d Cir. 1995). \textit{Dukes} is regarded as a key case that tended to break the logjam of excessive ERISA preemption and immunity in claims involving medical treatment. See \textit{Furrow et al.}, \textit{supra} note 32, at 437 (\textit{Dukes} a “watershed decision, opening up a substantial crack in preemption doctrine”). \textit{Accord}, Jordan, \textit{supra} note 24, at 452–53. See also \textit{Bauman v. U.S. Healthcare}, 193 F.3d 151 (3d Cir. 1999); \textit{Rice v. Panchal}, 65 F.3d 637 (7th Cir. 1995); Moscovitch v. Danbury Hosp., 25 F. Supp. 2d 74, 80–83 (D. Conn. 1998) (cases following \textit{Dukes} approach and permitting suit against HMO for medical matters).
come more costly, perhaps even prohibitively expensive, forcing more employers to discontinue medical coverage as a fringe benefit. But like many such arguments by commercial entities resisting regulation or legal liability, there has been little empirical evidence to substantiate the claim. Insurers and medical providers have continued to sell products and services to those outside ERISA’s preemptive shield. If ERISA immunity were necessary, one would expect to see medical coverage only for ERISA beneficiaries, which is not the case. Without a doubt, many factors contribute to rising health care costs. But tort liability is almost certainly not the primary reason and should not be the scapegoat for this social problem. Even under a regime of considerable ERISA immunity, costs rise and employers on occasion discontinue or reduce coverage. To be sure, a relaxation of ERISA immunity could bring some increase in costs that must be borne by employers or employees. But this tradeoff may be well worth making if it protects patients from bad medicine.

Ironically, of course, the ridiculously broad ERISA preemption that dominated the 1980s and early 1990s was almost certainly not what Congress intended. Thus, the preemption morass of the past quarter-century is largely the judiciary’s own doing (with some help from crude drafting by the legislature). Fortunately, the common law may retain some genius after all: ERISA preemption analysis has improved considerably with Travelers and its progeny. Pegram continues a sound approach to these issues, but arguably does not fully rectify the lingering problems wrought by the Court’s textual ERISA jurisprudence of the 1980s. Carrying Pegram one step farther would mean consistently making HMOs that work for ERISA plans accountable for their actions on the same basis as are other health care providers and insurers. Patients may benefit more by Pegram or by

187. See Furrow et al., supra note 32, § 8-5; Jordan, supra note 24, at 468–70 (discussing costs and benefits of expanded HMO and insurer liability).

188. See Allison Bell, Some HMOs Return to Fee for Service Model, Nat’l Underwriter, Dec. 18–25, 2000, at 14 (Prop. & Cas. ed.) (attributing move to both “cost increases” and “turmoil” surrounding criticism of capitated plan model HMO); Lucette Lagnado, In a Poor Baby’s Fight to Survive, a Parable of a Medicaid HMO, Wall St. J., Dec. 27, 2000, at A1 (describing efforts to save premature baby estimated to cost $4,000 per day):

[T]his HMO system is fraught with life-and-death tensions far beyond the common middle-class complaints that have made managed care so contentious. For a wider, more ambitious issue confronting Medicaid managed care has been to try to make a dent in the distressingly high infant-mortality rates among African-Americans, particularly the poor urban blacks who make up a large part of [the inner-city hospital] clientele. This has sent a flood of desperately sick children into [the hospital]—many of them high-dollar, emotionally draining preemies like [the baby discussed in the article]. While they get state-of-the-art care, their parents and doctors also come under the kinds of pressures that the middle-class clients of HMOs have long bridled against—pressures to move patients into cheaper care, or to discharge them as soon as they are deemed fit.

Id.
the modified *Pegram* that we propose than they would under any proposed legislation likely to be enacted.

VIII. CONCLUSION

In *Pegram*, the U.S. Supreme Court showed an appreciation for the real world of managed care, patients' rights, and ERISA in operation but was too credulous of industry claims that HMO survival depends upon severe bright-line rules of rationing.189 Under *Pegram*, HMOs will not be liable merely because they ration care or establish a system of cost controls and incentives. But where an aggrieved patient can demonstrate that HMO operations adversely affected his or her medical care, the Court's apparent embrace of rationing will not insulate the HMO from liability. Properly interpreted, *Pegram* is as much a victory for consumers as for HMOs. Unfortunately, courts may listen more to *Pegram*'s rhetoric of rationing rather than assessing *Pegram*'s analysis under the current regime of limited pre-emption by ERISA.190

Moreover, *Pegram* retains some undesirable uncertainty because its analysis turns on the activity of the HMO rather than on the status of the HMO as distinguished from the ERISA plan itself. *Pegram* also creates an inconsistency between the status of medical providers and insurers, as well as between the medical treatment activity of the HMO and its insurer activity. Although potentially promising, legislation may no longer be the preferred solution to the problems of ERISA immunity. Fine-tuning *Pegram* to provide a bright-line division between ERISA plan administration and delivery of benefits pursuant to an ERISA plan would better serve patients, the public interest, and the courts themselves.

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189. See Bloche, *supra* note 15, at 226 (noting that Aetna U.S. Healthcare has agreed to limits on such financial incentives for participating physicians, something it would not do if such limits really caused a pronounced adverse impact on its business).

190. See note 148, *supra* (describing judicial reluctance to overturn precedents rendered infirm by *Pegram*).