Pegram v. Herdrich: The Supreme Court Passes the Buck on Managed Care

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As frustration has grown with arbitrary and often harmful restrictions on treatment imposed by managed care companies, physicians and patients have looked to the courts for remedies. However, existing law, on which judges must rely, offers few footholds for those seeking to challenge the practices of the managed care industry. This reality was demonstrated yet again in the decision of the U.S. Supreme Court in *Pegram v. Herdrich*, which dashed the hopes of many patient advocates that a statute that has been the industry's strongest shield could be turned against it in a dramatic way (1).

Cynthia Herdrich, the plaintiff in *Pegram*, is an Illinois woman whose husband's employer provided health insurance through a local health maintenance organization (HMO) that was owned by a physicians' group, the Carle Clinic. Herdrich went to her physician at the clinic, Dr. Lori Pegram, complaining of abdominal pain, and no further workup was done. Six days later, after the pain had worsened, she returned. At that point Dr. Pegram discovered a six by eight centimeter inflamed mass in her lower abdomen. Dr. Pegram decided that an ultrasound examination was indicated, but rather than ordering one immediately at the local hospital, she scheduled one for eight days later at a facility 50 miles away that was staffed by Carle Clinic doctors. Before the ultrasound could be performed, the mass—Herdrich's inflamed appendix—ruptured, resulting in peritonitis and a prolonged hospital stay.

Herdrich's anger over these events was compounded when she discovered that the physician-owners of her HMO—including Dr. Pegram—received a year-end distribution that was based on the money they saved from reducing expenditures on patient care. One means of saving money was to make referrals only to facilities operated by the Carle Clinic. Herdrich filed a lawsuit with several allegations, including malpractice on Pegram's part and a failure of the HMO and its physician-owners to fulfill their fiduciary duties.

The malpractice claim was litigated in Illinois state court, where Herdrich won an award of $35,000. But her other claim, which was at issue when the case reached the U.S. Supreme Court, ended up in the federal court system. To understand why, one needs to recall the influence over managed care liability issues of a much-discussed federal statute, the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA was adopted primarily to remedy problems with workers' pensions, but, as written, its reach extends to all nongovernmental employer-provided benefit plans, including health insurance. In establishing uniform standards and procedures across the country, ERISA preempted state law on many issues, including most questions of liability. Thus even in the event of negligence—for example, a refusal of an HMO to authorize medical care that is clearly necessary—administrators of ERISA plans can be sued only to recover benefits that were denied. Compensatory damages for harms that patients may have suffered and punitive damages are excluded. All claims that are preempted by ERISA must be litigated in federal court (2).

However, in addition to the protection that it provides, ERISA imposes certain obligations on persons who administer the plans, including the obligation to act as a fiduciary for the plan's beneficiaries. According to the statute, a "fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries" (3). This duty applies to any person "to the extent . . . he exercises any discretionary authority or discretionary control respecting management of such plan" (4). Herdrich alleged that the HMO and its owners violated this fiduciary obligation by creating a system in which the owner-physicians were given incentives to minimize the use of diagnostic tests, emergency consultations, and referrals to physicians and facilities outside Carle Clinic's system, to the detriment of the plan's beneficiaries, of whom she was one.

The federal district court dismissed Herdrich's claim on the grounds that she had failed to establish that a fiduciary duty had been breached. On appeal to the Seventh Circuit Court of Appeals, however, she found a more sympathetic venue. By a two-to-one vote, the judges of that court held that the HMO and its owners were fiduciaries of the employee health plan that covered Herdrich because they exercised "discretionary authority in deciding disputed claims" (5). In addition, since the physician-owners "simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals," the court concluded that Herdrich had met her burden of asserting that "the self-dealing physician-owners in this appeal were not acting 'solely in the interest of the participants' of the Plan." The Seventh Circuit, in an opinion larded with at-

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tacks on managed care from the popular press, ruled that the case could go to trial.

Before that could occur, though, the defendants appealed to the U.S. Supreme Court, which agreed to hear the case. They argued, among other things, that Herdrich's claim was in essence an attack on HMOs as part of the health care delivery system, since all HMOs have incentives to contain costs at the expense of patients' needs (6). Congress, they noted, had sought to encourage the growth of HMOs when it adopted the HMO Act of 1973, which recognized explicitly that risk-sharing mechanisms might be used to provide physicians and facilities incentives to minimize expensive treatment. Thus, the defendants contended, the courts were being used in an attempt to subvert the clear intent of Congress by threatening the existence of all HMOs.

Of all the complex issues considered by the court, it was the justices' concern that they were being asked to overturn an existing policy choice already made by Congress that dominated the exchange during oral arguments in the case (7) and appeared to have the greatest impact on the court's decision. Writing for a unanimous court—a rare event given the widely different political orientations of the current group of justices—Justice David Souter began his analysis by asserting that "no HMO organization could survive without some incentive connecting physician reward with treatment rationing" (1). Because he could identify no legal principle that could distinguish the end-of-year distribution of profits to the physician-owners of the Carle plan from any other incentive structure, to open the door to such claims would spell the end of HMOs. If this was the direction in which health policy were to move, Souter concluded, it should be Congress and not the courts that made this decision.

Having announced the policy considerations that would keep the court from endorsing Herdrich's claim, Souter then moved—in a somewhat unusual sequence—to lay out the court's views of the major legal issue: whether the defendants were operating as ERISA fiduciaries. The decisions made by Pegram and the other Carle physicians were inextricably tied to choices about the nature of the treatment patients should receive, the court held. These "mixed eligibility decisions" were not the kind of administrative choices that Congress had in mind when it described the extent of fiduciary duties under ERISA. Thus Herdrich's claim must fail. In addition, the court expressed its concern that to adopt the requested rule would transform every claim of malpractice by an HMO physician into a federal claim that could be litigated under ERISA—also not Congress' intent.

Cynthia Herdrich's attempt to hold her HMO—not just her treating physician—liable for the negligent care that she received fell short of success under the burden of the statutory framework within which she had to operate. With Congress having endorsed HMOs as cost-saving systems of care, and with ERISA's definition of a fiduciary duty not clearly applying to the behavior in question, the Supreme Court was reluctant to take a step that seemed to be "portending wholesale attacks on existing HMOs." Herdrich's inability to devise an approach that would limit the impact of the relief she requested, such as by identifying a set of incentive practices that could still be retained as consistent with fiduciary duties, further doomed her case.

Advocates for patients' rights had mixed feelings about Herdrich's argument in the first place. If claims regarding harms that occurred because of an HMO's incentive structure were subject to review under ERISA's fiduciary standard, they would all be removed to federal court and litigated under ERISA's rules. No compensatory damages would be allowed, and any payment of funds judged to have been misused for incentives rather than patient care would revert to the employee health plan rather than to the plaintiff. Thus there would be little motivation for injured patients like Cynthia Herdrich to bring cases in the first place.

On the other hand, if the Supreme Court held that the design and implementation of incentive structures was not subject to ERISA—as it did—then presumably states could choose to create their own rules about permissible approaches. Indeed, a number of states have already legislated in this area—for example, banning incentive schemes that seem too likely to distort physicians' judgment (8). The court's decision would appear to suggest that such state regulation is permissible, and even that states could enable patients who have been harmed to bring suit against HMOs by alleging that their injuries were due to an illegitimate incentive scheme.

Should we take this optimistic view of the failure of Herdrich's claim against her HMO? Two words of caution are in order. First, the court's reference to the HMO Act of 1973 as indicating a congressional desire to promote HMOs may lend credence to the argument that this law, rather than ERISA, preempts any state action that might severely affect HMOs. Indeed, as the defendants in *Pegram* pointed out to the court, the HMO Act itself preempts "state laws which impair the formation or operation of health maintenance organizations . . ." (6,9). Second, unlike the Seventh Circuit, the Supreme Court was not at all critical of HMOs in its opinion. In fact, Justice Souter's portrait of the upheavals to come if HMO incentive schemes were limited and "rationing" of health care were impaired may well discourage legislatures—already subject to heavy lobbying from insurers and large employers—to stay away from this area.

Pegram's ultimate lesson is one that has been taught before in countless courtrooms where the ill effects of managed care have been litigated. Current statutory structures, particularly ERISA, make it extremely difficult for injured parties to recover against managed care entities. Resort to the courts may be helpful in certain cases, but legislative action by Congress is the most direct route to reining in the egregious excesses of managed care. This is where the efforts of those who are concerned about the damage being wrought by managed care should be focused. ♦

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Continues on page 1238

Continued from page 1226

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