HMOs May Be Exposed to State Law Malpractice Actions for Mixed Treatment and Eligibility Decisions


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Overview

Inherent difficulties with prevailing case law regarding participants who have been injured as a result of negligent medical decisions made by health maintenance organizations foil attempts to obtain meaningful relief for the injured party. Out of frustration, some courts have engaged in creative rule-making that has led to questionable decisions. This article will discuss the Supreme Court's Pegram decision and, what, if any, impact it has had on established legal precedent in the area of health care litigation with respect to the issue of available remedies.

Introduction

For participants who have been injured as a result of negligent medical decisions made by a health maintenance organization (HMO), obtaining meaningful relief has often been frustrated by the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA). Especially, when the decision results in the death of the participant or a worsening of the participant's condition. Until relatively recently, the prevailing view in a lawsuit alleging state law claims, such as fraud, misrepresentation, or wrongful death, against an HMO was that the state law claims were preempted by ERISA. [See e.g., Kuhl v. Lincoln National Health Plan of Kansas City, Inc., 999 F2d 298 (8th Cir 1993) (HMO's utilization review governed by ERISA); Rodriguez v. Pacificare of Texas, Inc., 980 F2d 1014 (5th Cir 1993) (same); Corcoran v. United HealthCare Inc., 965 F2d 1321 (5th Cir 1992) (concluding HMO decision was plan administration and therefore ERISA preempted state law action)]

The rationale for applying ERISA preemption when an HMO performs utilization reviews (a review of a specific treatment by a person other than the treating physician) or engages in the precertification process (advance approval of treatment) has been that the HMO was acting in its fiduciary capacity as plan administrator. Accordingly, courts generally held that state law claims were completely preempted under ERISA's civil enforcement scheme, even when the HMO's decision impacted on the quality of care that a participant received.

A participant whose state law action was deemed preempted had two choices: drop the lawsuit or file a new action alleging an ERISA cause of action under Sections 502(a)(1)(B) and/or 502(a)(3). Neither provision, however, provides a meaningful remedy when the participant dies or his condition worsens as a result of the HMO's decision, because neither provision allows for money damages. Recovery under each provision is limited to equitable relief, which generally means that the participant is awarded the benefit under the plan.
ERISA Section 502(a)(1)(B), among other things, allows a participant to bring an action to recover benefits due to him under the plan. Under ERISA Section 502(a)(1)(B), if a court determines that a participant's benefit was wrongly withheld, the typical remedy is for the court to order the plan to give the participant the benefit. If the participant dies before a court issues its order, an order instructing the plan to provide the benefit, clearly provides no relief. If the participant's condition has worsened to the point that the benefit has lost its medical value, ERISA Section 502(a)(1)(B) again provides little relief. And, although the Supreme Court has decided that a participant can obtain individual relief under ERISA Section 502(a)(3) against a fiduciary for a breach of fiduciary duty, participants are nonetheless limited to equitable relief. [Varity Corp v. Howe, 516 US 489 (1996)] In this type of lawsuit, equitable relief typically means that the participant is awarded the benefit to which he or she is entitled under the plan.

As courts began to perceive more and more inequities in the managed care industry, some courts made inroads into the prevailing view that all utilization and precertification decisions were preempted by ERISA. [Bauman v. US Healthcare, Inc., 1 F Supp 2d 420 (D NJ 1998) (claim alleging that HMO adopted policies that caused physicians to provide inadequate care not preempted by ERISA); Dukes v. US Healthcare Inc., 57 F3d 350 (3d Cir 1995) (distinguishing between decisions that affect the quality of care versus quantity of care); Pappas v. Asbel, et al, 555 Pa 342, 724 A2d 889 (S Ct of Pa 1999) (holding mixed questions of eligibility and treatment not preempted)] But, other courts maintained that state court actions were preempted, irrespective of whether the decision affected the participant's medical treatment. [See, e.g., Person v. Physicians Health Plan, Inc., 20 F Supp 2d 918 (ED Va1998) (precertification decision completely preempted by ERISA)]

Some courts have developed theories of vicarious liability to allow suits against HMOs. [See, e.g., Dukes, 57 F3d 350; Independence HMO, Inc. v. Smith, 733 F Supp 983, 987-89 (ED Pa 1990) (medical malpractice claim brought against HMO under theory of vicarious liability not preempted); Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine, 802 F Supp 1286 (ED Pa 1992) (same)] Other courts rejected these theories. [See Ricci v. Gooberman, 840 F Supp 316 (D NJ 1993) (rejecting vicarious liability claim against HMO); Butler v. Wu, 853 F Supp. 125 (D NJ 1994); Nealy v. US Healthcare HMO, 844 F Supp 966 (SD NY); Altieri v. Cignna Dental Health, Inc., 753 F Supp 61 (D Conn 1990)] Vicarious liability theories, however, only work where the treating doctor committed malpractice and the doctor was an employee of the HMO. This is not always the case. Sometimes, the doctor recommends the right treatment, but the managed care gatekeeper disagrees with the doctor. In these instances, it's not always clear that medical malpractice has been committed.

Cases involving HMO decision-making (arguably absent doctor malpractice) have been the most troublesome for the courts, because the participants were often left without a meaningful remedy. These were the cases that caused some members of Congress to push for the Patients Bill of Rights. But, to date the bill has not been enacted. Out of frustration, some courts began engaging in creative rule-making that led to absurd decisions. One such decision was the Seventh Circuit's ruling in
Herdrich v. Pegram, [154 F3d 362 (7th Cir 1998)] In Herdrich, the Seventh Circuit ruled that a doctor who practiced medicine with a doctor-owned HMO breached her fiduciary duties within the meaning of ERISA when she misdiagnosed the severity of her patient's appendicitis. Herdrich was appealed to the Supreme Court where it was reversed. [Pegram v. Herdrich, 120 S Ct 2143 (2000)]

This article will discuss the Supreme Court's Pegram decision and, what, if any, impact it has had on established legal precedent in the area of health care litigation with respect to the issue of available remedies.

**The Facts In Pegram**

In *Pegram*, Cynthia Herdrich was covered by Carle Health Insurance Management Co., Inc. (Carle), a doctor-owned HMO. The fee arrangement between the HMO and its doctor-owners included financial rewards for those doctors that kept health care expenses down by recommending less aggressive or expensive treatment options. Herdrich was examined by Dr. Pegram, who discovered a six-by-eight centimeter inflamed mass in Herdrich's abdomen. Instead of sending Herdrich to a local hospital for an ultrasound diagnostic procedure, Dr. Pegram decided that Herdrich could wait eight days and drive 50 miles to a Carle-staffed hospital. Before the eight days passed, Herdrich's appendix ruptured, causing additional complications.

Herdrich sued the HMO and Dr. Pegram for malpractice and for breach of fiduciary duty under ERISA. The district court dismissed the breach of fiduciary allegation, and the malpractice action proceeded. Herdrich prevailed on her malpractice claim and was awarded $35,000. Herdrich then appealed the district court's dismissal of the fiduciary breach allegation. The Seventh Circuit reversed the district court and held that Carle was a fiduciary when its doctors made medical treatment decisions that allegedly presented the doctors with a conflict of interest because of the fee incentive arrangement.

Carle appealed the decision to the Supreme Court. Carle asked the Court to decide "whether treatment decisions made by a health maintenance organization, acting through its doctor employees, are fiduciary acts within the meaning of [ERISA]." The Court said no. It also rejected Herdrich's argument that a distinction should be drawn between doctor-owned HMOs and other HMOs. Herdrich had argued that, because the possibility for a conflict of interest in doctor-owned HMOs was inherent in the fee incentive arrangement, these types of HMOs should be subject to ERISA.

Before reaching its conclusions, the Court analyzed the structure and purpose of HMOs and distinguished between pure eligibility decisions, which are covered by ERISA, and pure medical treatment decisions and mixed eligibility and treatment decisions, which the Court held were not subject to ERISA.
The Court Refused To Distinguish Between Doctor-Owned HMOs And Other HMOs

To determine whether a doctor-owned HMO should be distinguished from other HMOs, the Supreme Court examined the history and purpose of HMOs. It noted that HMOs had come into existence in the late 1960s as a new model of health care delivery that was defined by receipt of "a fixed fee" for each enrolled patient that was kept by the HMO, whether or not the participant used the medical benefits available under the plan. [Pegram, 120 S Ct 2143, 2149] The Supreme Court noted that a primary goal of HMOs was to hold down the cost of health care by imposing some form of cost controls and that fee incentive arrangements were one method of keeping costs down. Another method was the use of utilization and precertification reviews prior to allowing the treatment.

The Court stated that unlike a fee-for-service system, which rewards doctors if they provide more care, not less care, HMOs reward doctors if they provide less care, not more. In both settings, however, the check on doctors is their ethical duty to deliver medical services with a reasonable degree of skill and judgment in the patient's interest. [Id.] The Court stated that [s]ince inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others (ruptured appendices are more likely; necessary appendectomies are less so), any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risks. [Id., at 2150]

The Court therefore refused to distinguish between doctor-owned HMOs and others, stating that to do so would require courts to amass data to which they do not have ready access--for example, data sufficient to correlate malpractice rates with different types of HMOs and the same type of information for fee-for-service models.

The Court rejected Herdrich's argument and proceeded to resolve the case under the theory that all HMOs should be treated alike for the purpose of determining when an HMO functions in a fiduciary capacity and when it does not.

The Court Decides that Mixed Questions of Eligibility and Treatment are not Subject to ERISA

The Court stated that to determine when doctor-owners act in a fiduciary capacity and when they do not, the "pleadings must be parsed very carefully." [Id., at 2153] Pure eligibility decisions, the Court said, "turn on the plan's coverage of a particular condition or medical procedure for its treatment." [Id., at 2154] Simply put, these are traditional plan administration decisions, such as, interpreting a plan provision, determining whether a plan covers treatment for a particular condition, and whether a person is eligible for coverage under the plan. Pure eligibility decisions are governed by ERISA Section 502(a)(1)(B), because the HMO is acting in its fiduciary capacity as the plan administrator. Accordingly, state law claims brought against an HMO for eligibility disputes will continue to be preempted by ERISA.
"Treatment decisions," the Court said, are decisions "about how to go about diagnosing and treating a [patient's] condition." [Id.] Claims against a doctor for making a negligent treatment decision are brought under state malpractice law, and such actions historically have not been preempted by ERISA.

The Court noted that eligibility and treatment decisions "are often practically inextricable from one another." [Id., at 2154] The Court concluded that Congress did not intend for a HMO to be treated as a fiduciary when it made mixed eligibility and treatment decisions, because such decisions are far removed from traditional fiduciary responsibilities. It noted that fiduciaries, under the common law, were most concerned with "managing assets and distributing property to beneficiaries." [Id., at 2155] The Court stated that [t]raditional trustees administer a medical trust by paying out money to buy medical care, whereas doctors making mixed eligibility decisions consume the money as well. Private trustees do not make treatment judgments, whereas treatment judgments are what doctors reaching mixed decisions do make, by definition. Indeed, the doctors through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day, in every possible setting. [Id., at 2156]

The Court concluded that applying fiduciary standards to mixed eligibility and treatment decisions would federalize medical malpractice actions. The Court explained that in a case alleging that the doctor violated his or her duty of loyalty under ERISA because the fee incentive arrangement created a conflict of interest, the HMO would defend the action by claiming that the doctor did not act out of financial interest but for good medical reasons, the plausibility of which would require reference to standards of reasonable and customary medical practice in like circumstances. That, of course, is the traditional standard of the common law. [Id., at 2157]

The Court found no value in federalizing medical malpractice actions against HMOs or their doctors. [Id., at 2158] It decided mixed eligibility and treatment decisions were not subject to ERISA and that state malpractice law should govern these actions.

**Discussion**

The holding in *Pegram* is arguably quite narrow: a doctor that treats a patient negligently should be sued for malpractice and not under ERISA for a breach of fiduciary duty. The problem is that the Supreme Court does not stop with this point.

In *Pegram*, the Court said that mixed eligibility and treatment decisions involve "how and when" to provide medical treatment. [Id., at 2154] In its opinion, the Court defined eligibility decisions as ones involving questions of plan coverage of a particular condition or medical procedure. Despite the Supreme Court's ruling that "how and when" decisions are mixed decisions, decisions involving "how and when" to provide medical treatment sound more like pure medical decisions than decisions involving mixed questions of treatment and eligibility. Such decisions do not necessarily involve coverage disputes.
In spite of the Supreme Court's determination that Dr. Pegram's decision involved a mixed question, arguably, Dr. Pegram's treatment choice did not involve a coverage dispute. The plan apparently covered treatment at a hospital that was not staffed by Carle employed doctors, if the treating doctor determined exigent circumstances justified the use of a non-Carle owned facility. Therefore, the issue in *Pegram* does not appear to raise a coverage question that necessitates the conclusion that Dr. Pegram's decision involved a mixed treatment and eligibility question. The issue in *Pegram* was that Dr. Pegram decided that Peggy Herdrich could wait eight days and drive 50 miles for an ultrasound at the Carle-owned facility because her condition was not sufficiently critical to warrant sending her to the more expensive hospital that was closer to her home. Her decision could have been characterized strictly as one involving a treatment question. The Court, however, characterized Dr. Pegram's decision as a mixed eligibility and treatment decision and broadly stated that such decisions are governed by state law.

The Court expressly disavowed any distinction between a doctor-owned HMO and an HMO that is not doctor-owned. Accordingly, whether ERISA governs a decision made by an HMO turns on the nature of the decision and not the structure of the HMO. In other words, a pure coverage question will be governed by ERISA. A pure treatment or mixed eligibility and treatment decision will be governed by state law. Which law applies, however, will ultimately turn on how the lower courts interpret what type of decision was made. The Supreme Court's ruling in Pegram will likely lead to inconsistent results, despite the Court's effort to carefully craft definitions for each of the three types of decisions. *Pegram* will likely lead to more consistent lower court rulings when the decision-maker is a doctor, irrespective of who owns the HMO. If the HMO gatekeepers are not doctors, however, will *Pegram* apply to a mixed eligibility and treatment decision? Will a participant's remedy, after *Pegram*, depend on who makes the decision and not just on the nature or structure of the HMO? Lower courts will likely struggle with these questions, because, if read broadly, *Pegram* appears to invite a challenge to *Corcoran v. United Healthcare, Inc.* [965 F2d 1321 (5th Cir), cert. denied, 113 S Ct 812 (1992)] and those cases following *Corcoran*, where the courts have held that malpractice claims against third-party administrators that run a plan's precertification review program are preempted. It seems more likely than not that courts will decide that state law claims will govern mixed eligibility and treatment decisions irrespective of who makes the decision, especially in those instances where ERISA provides no meaningful remedy.

The Department of Labor (DOL) will also influence the direction that courts will take. In the first post-*Pegram* case where the DOL filed an amicus curia brief interpreting *Pegram*, the DOL states that HMOs can be sued under state law for mixed eligibility and treatment decisions. The DOL's brief in *Pappas v. Asbel* [555 Pa 342, 724 A2d 889 (1998)] recognizes that its position is a reversal from its pre-*Pegram* position. Historically, the DOL has taken the position that mixed eligibility and treatment decisions were preempted by ERISA.
Conclusion

The breadth of the *Pegram* decision will have to await the outcome of more lower-court decisions. What is clear without question is that *Pegram* will subject HMOs to more litigation in cases involving mixed eligibility and treatment decisions and that courts are likely to rule inconsistently, depending on how they interpret the definition of mixed eligibility and treatment decisions and whether they limit *Pegram* to medical malpractice cases or apply the *Pegram* holding to other professional service providers.

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