New York Law Journal

NEW YORK, THURSDAY, JULY 13, 2000

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HMOs Face a Post-'Pegram' World

In a closely-watched case, *Pegram v. Herdrich*,[1] the U.S. Supreme Court unanimously handed HMOs a hard fought legal victory over the scope of federal court review under the Employee Retirement Income Security Act of 1974, as amended (ERISA).[2] In so doing, however, the Court opened up the door to sue HMOs for so-called "mixed eligibility" decisions in state court for medical malpractice. The Court also, possibly inadvertently, laid the foundation for attacking the arbitrary and capricious standard of judicial review when litigating most HMO disputes under ERISA.

Pegram began simply enough. Experiencing intense pain in her abdomen, Cynthia Herdrich went to her HMO's primary care physician, Dr. Lori Pegram. Upon examination, Dr. Pegram discovered a large inflamed mass. Instead of immediately sending Ms. Herdrich to a local hospital for an ultrasound, Dr. Pegram decided that Ms. Herdrich would have to wait eight more days for an ultrasound, to be performed at an HMO facility more than 50 miles away. During the eight-day period, Ms. Herdrich's appendix ruptured, causing peritonitis.

Ms. Herdrich sued Dr. Pegram and her HMO in the Illinois state courts alleging medical malpractice and common law fraud. Arguing that the case was subject to ERISA, defendants were successful in removing the case to federal court. Ms. Herdrich then added a claim for violation of ERISA's fiduciary duties. Ms. Herdrich alleged that the HMO's compensation arrangement financially rewarded doctors who limited the amount of medical care given to their patients. This created an inherent conflict of interest which violated the HMO's fiduciary duty to act solely in the interests of plan participants.

The state law malpractice claims were tried before a jury, resulting in a verdict of $35,000 in favor of Ms. Herdrich. The district court dismissed the ERISA claim for failure to state a cause of action. Ms. Herdrich appealed the

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ERISA claim to the U.S. Court of Appeals for the Seventh Circuit. In a two to one decision, the Seventh Circuit reversed the district court and remanded the case for trial.[3] Because of a split among the circuits, the Supreme Court granted certiorari.

In reversing the Seventh Circuit, the Supreme Court recognized that HMOs often wear two hats; one as a medical provider and one as an ERISA fiduciary. Only the decisions made in their role of an ERISA fiduciary are subject to the fiduciary duties of ERISA. In distinguishing between these roles, the Court identified three categories of HMO denials.

The first category are the so-called pure "eligibility" decisions. These decisions turn on the plan's coverage of a particular condition or medical procedure for its treatment. For instance, a plan may provide that appendicitis is not a covered condition or that acupuncture is not a covered procedure for pain relief. These "eligibility" decisions are subject to ERISA's fiduciary duties.

The second category are the so-called "treatment" decisions. These decisions are choices about how to go about diagnosing and treating a patient's condition. For instance, given a patient's symptoms, what is the appropriate medical response? These "treatment" decisions are not subject to ERISA fiduciary duties.

The third category are the so-called "mixed eligibility" decisions. They are a combination of "eligibility" and "treatment" decisions. These include: decisions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities outside the HMO; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition.

The Court believed that subjecting "mixed eligibility" decisions to ERISA's fiduciary duties would all but eliminate for-profit HMOs. Recognizing that Congress has promoted HMOs as an institution for many years, and that these decisions are very different from traditional common law fiduciary decisions, the Court held that mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA. The Court, therefore, dismissed Ms. Herdrich's ERISA claim, which would have subjected these decisions to ERISA's fiduciary standards.

Pegram establishes the existence of two distinct remedies against HMOs for mixed eligibility decisions. Take the scenario of an HMO deciding that a patient needs only 12 hours of nursing care a day instead of 24 hours. To the extent that the patient is injured by receiving only 12 hours of nursing care, and 12 hours of care is medically inappropriate, the plaintiff has a state court remedy for medical malpractice. To the extent that the patient wants to challenge the denial in order to receive 24 hours of care, the patient has a federal court remedy for past and future benefits under ERISA.[4]

In the past, HMOs have attempted to use ERISA as a shield against malpractice causes of action. HMOs would argue that ERISA is the exclusive remedy available to HMO participants and that state malpractice actions are preempted pursuant to the broad preemption provisions of Section 514 of ERISA.[5] Where successful, this left plaintiffs without a remedy because ERISA does not provide for malpractice-type relief.

Pegram makes it clear that to the extent that state malpractice actions do not assert claims challenging "eligibility" for benefits, they are not preempted. Indeed, one of the principal rationales behind the Court's holding was to avoid opening the federal courthouse to a mere replication of state malpractice actions.

In many ways, HMO participants are better off with a malpractice claim than a breach of fiduciary duty claim under ERISA. In a malpractice action, plaintiffs could obtain consequential damages including pain and suffering. Under ERISA, relief is limited to contractual benefits.[6] In a malpractice action, plaintiffs are entitled to a jury trial. Under ERISA, a jury trial is not permitted.[7]

The only advantage of an ERISA action would be a possible award of attorney fees. But the potential of receiving a lodestar-based attorney fee award at the end of a case is often not attractive enough to convince a plaintiff's attorney to handle the case on a contingency basis. Many of these cases must either be litigated pro se or abandoned.

The Pegram decision may have a profound effect on the litigation of HMO claims under ERISA. Possibly inadvertently, the Court laid the foundation for attacking the arbitrary and capricious standard of review — which in many cases is an outcome determinative factor.

In *Firestone Tire & Rubber Co. v. Bruch*, the Supreme Court established the standard of review for ERISA benefit claims. The standard is de novo unless the plan document gives the plan administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan.[8] When such authority is granted, the Court will accord the administrator's decision deference and review it under the arbitrary and capricious standard of judicial review. As expected, to the extent that ERISA plans did not already so provide, most such plans were quickly amended to include discretionary authority.

Under the arbitrary and capricious standard of review, the Court will not reverse a fiduciary's decision unless it is "without reason, unsupported by substantial evidence or erroneous as a matter of law."[9] This is a very difficult standard to overcome. In practice, most plaintiffs cannot survive a defendant's motion for summary judgment.

In the HMO arena, the arbitrary and capricious standard has all but insulated "mixed eligibility" decisions from court scrutiny. All close calls are routinely ruled in favor of the HMO. Differences in opinion between the HMO medical director and the patient's treating physician are also likely be ruled in favor of the HMO. Plaintiffs can only prevail when the decision is clearly erroneous.

With *Pegram*, that may change. The arbitrary and capricious standard is applicable only to fiduciaries and their fiduciary decisions. It has its basis in trust law.[10] *Pegram* has now made it clear that when an HMO's physicians issue a mixed-eligibility decision they are wearing their hat as a medical provider rather than as an ERISA fiduciary. Because mixed eligibility decisions are not fiduciary decisions, they should not be entitled to deference under the arbitrary and capricious standard of review.

This is likely to affect most HMO disputes because the vast majority of litigated disputes involve "mixed eligibility" decisions. "Eligibility" decisions, which will continue to be subject to the arbitrary and capricious standard, are usually clear cut and do not result in litigation.

Pegram is good news and bad news for both HMO patients and HMOs. One thing is certain — the lower courts will be sorting out *Pegram* for years to come. In practice, differentiating between "eligibility" decisions subject to ERISA and "mixed eligibility" decisions not subject to ERISA will be very difficult and case specific.

It will also lead to an ironic reversal of positions. In the past, plaintiffs have argued that HMOs were fiduciaries in order to invoke ERISA's fiduciary standards. Now, it will be HMOs arguing that they were acting as fiduciaries in order to invoke the arbitrary and capricious standard of review.

(1) Slip Op., dated June 12, 2000.
(2) 29 U.S.C. §1001, et. seq.
(3) *Hedrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), reh'g en banc denied, 170 F.3d 683 (7th Cir. 1999).
(4) Section 502(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B).
(5) 29 U.S.C. §1144.
(6) *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 148, 105 S.Ct. 3085 (1985).
(7) *Sullivan v. LTV Aerospace and Defense Company*, 82 F.2d 1251, 1257-1258 (2d. Cir. 1996).
(8) 489 U.S. 101, 115, 109 S.Ct. 948 (1989).
(9) *Miller v. United Welfare Fund*, 72 F.2d 1066, 1070 (2d. Cir. 1995); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442 (2d. Cir. 1995).
(10) *Firestone*, 489 U.S. at 110-112.