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**Rationing Rationale: Supreme Court Declines to Outlaw Managed Care by ERISA Plans  
More than a third of all Americans receive their healthcare through employer-sponsored managed care plans; that is, through plans subject to ERISA.**

Pegram v. Herdrich, 120 S.Ct. 2143 (2000), was one of the most closely watched cases on the Supreme Court's docket last term because it had the potential to outlaw the use of managed care by ERISA plans. The proceedings in the Seventh Circuit before the case reached the Supreme Court caused many to view the case as a referendum on managed care. The Seventh Circuit's majority opinion was peppered with citations to articles critical of managed care, while the dissent argued that market forces would curb serious abuses.

The Supreme Court's decision was ultimately not the "blockbuster" that many hoped for, and others feared. The Supreme Court took pains to sidestep the managed care debate, acknowledging that while critics argue that managed care sacrifices patient care for cost savings, there are "contrary perspectives." The Court expressly declined to endorse either view. The Court held that HMOs do not violate ERISA by paying their employee physicians financial incentives to reduce the cost of patient care, and that no purpose would be served by allowing ERISA claimants to challenge treatment decisions made by plan physicians as a breach of fiduciary duty.

While Pegram may have been a narrower decision than many anticipated, it nevertheless is likely to have an important impact on healthcare litigation and regulation. To understand Pegram's affect on future cases, and on the continuing political debate over healthcare, it is necessary to understand what the Court actually decided in Pegram.

The plaintiff in Pegram was Cynthia Herdrich. She had obtained her health insurance coverage through her husband's employer, which in turn had purchased coverage from an HMO, called Carle. Like many HMOs, Carle paid its physician owners a year-end distribution based on cost savings achieved over the course of the year.

When Herdrich experienced abdominal pain she consulted a Carle physician, Dr. Pegram. Pegram discovered an inflamed mass in Herdrich's abdomen, but did not identify the problem as an emergency. She scheduled a diagnostic ultrasound for Herdrich at a Carle facility 50 miles away, which could not perform the procedure for eight days. Herdrich's appendix ruptured while she was waiting for the appointment, causing peritonitis.

Herdrich sued Carle and Pegram in state court, alleging medical malpractice and fraud. Carle and Pegram removed the case. Herdrich amended her complaint to add a claim under ERISA for breach of fiduciary duty, pointing to the Carle's practice of rewarding physicians for restricting patient care. The district court dismissed all but the malpractice claims, which went to trial. The jury found in favor of Herdrich. Herdrich then appealed the dismissal of the ERISA claim to the Seventh Circuit.

A divided panel of the 7th Circuit held that Herdrich had stated a claim for breach of fiduciary duty. The decision did not hold that all physician incentive mechanisms HMOs might use to hold down costs automatically constituted a breach of fiduciary duty under ERISA. Rather, the panel stressed that incentives could, in some cases, rise to the level of a breach, and that Herdrich's complaint was sufficient to state a claim under that theory.

The Supreme Court's opinion first examines the nature of managed care plans, and describes their operation in unusually blunt language. The Court concluded that all HMOs must limit their costs by "rationing care" and inducing their doctors to ration. Because, in its view, HMOs inherently ration care, the Court rejected the Seventh Circuit's attempt to draw lines between acceptable and unacceptable incentive schemes. It therefore tested Herdrich's claims for breach of fiduciary duty under ERISA as applicable to any HMO. In other words, if Herdrich's complaint stated a claim against Carle, it would state a claim against any HMO.

The Court next examined the allegations of Herdrich's complaint to identify the fiduciary acts underpinning the claim. The Court concluded that the claim was based on the plan's structure, not on any particular decision by the Carle or by Pegram. The Court noted that, during argument, Herdrich's counsel had conceded that Herdrich's claim for breach of fiduciary duty could have been brought against Carle, and would have been no different, even if Herdrich had never been sick.

The Court also divided the decisions that HMOs make into two categories -- "eligibility decisions" and "treatment decisions." Eligibility decisions turn on the plan's coverage for a particular condition or treatment; treatment decisions are choices about how to diagnose or treat a patient's condition. The Court observed that these two types of decisions are often intertwined and practically inextricable from one another.

Having framed Herdrich's claim broadly, the Court noted that since the claim was not directed to any particular decision that injured a patient, Herdrich could prevail simply upon showing that the profit incentive to ration care would generally affect mixed decisions. Hence, Herdrich's theory would eliminate all "for-profit" HMOs, and might eliminate all HMOs. The Court found nothing to indicate that Congress had this outcome in mind when it enacted ERISA.

The Court then determined that even the more limited case-by-case approach advocated by the Seventh Circuit would in every case be met with the defense that the physician acted for good medical reasons, not bad financial ones, and would therefore simply parallel a medical malpractice claim. The Court saw no advantage to opening the federal courts to this type of litigation.

At bottom, then, Pegram held that ERISA does not permit a claim for fiduciary duty based on the use of financial incentives to limit care were the claim is, in the Court's words, "untethered to claims of concrete harm." The Court expressly noted that it was not considering the viability of claims based on a particular harm-causing "eligibility decision." Nor was the Court considering a claim that an HMO had failed to disclose plan characteristics that affect the beneficiaries' material interests.

Although Pegram is not an ERISA preemption case, it plainly has ramifications for the scope of ERISA preemption, and hence for state regulation of managed care plans. The Supreme Court itself made this clear in *Pappas v. Asbel*, cert. granted sub nom, *United States Healthcare Systems of Pennsylvania, Inc. v. Pennsylvania Hospital Ins. Co.*, 120 S.Ct. 2686 (2000).

The question in *Pappas* was whether ERISA preempted claims against an HMO for negligently delaying a decision to authorize the emergency transfer of a patient from a community hospital to a better equipped teaching hospital. The patient claimed the hours-long delay resulted in quadriplegia. The Pennsylvania Supreme Court had held that the claim implicated the state's right to regulate the quality of healthcare, did not "relate to" an ERISA plan, and was therefore not preempted.

The HMO petitioned the Supreme Court to review the case, but the Court held the petition until six days after it filed its opinion in Pegram. It then disposed of the case by granting the HMO's petition for certiorari, vacating the Pennsylvania Supreme Court's decision, and remanding the case to that court "for further consideration in light of Pegram."

The Supreme Court's terse remand order offers few clues about how or why Pegram should change the state

court's analysis. Perhaps the answer lies in the discussion in *Pegram* explaining that the agreement between the HMO and the employer could be an ERISA plan, and that an HMO's administrative decisions could be fiduciary acts under ERISA. Or, perhaps the Supreme Court felt that the case presented a pure eligibility decision, which implicated issues of plan coverage -- not medical decisionmaking regulated by state law.

Another recent decision applying *Pegram* in the context of ERISA preemption is the Fifth Circuit's order on July 27, 2000, denying the petition for rehearing and rehearing en banc in *Corporate Health Ins. Inc. v. The Texas Dept. of Insurance*, \_\_\_ F.3d \_\_\_, WL 1035524 (5th Cir. 2000). Relying on *Pegram*, the State asked the panel to reconsider its decision that a Texas statute creating a system to independently review medical necessity decisions made by HMOs created an alternative mechanism to obtain ERISA benefits and was therefore preempted by ERISA. On rehearing, the State argued that *Pegram* showed that medical necessity decisions were mixed decisions governed by state law. The panel found that nothing in *Pegram* altered its earlier analysis.

*Pegram* has not yet been cited in any published decisions in California, but this is sure to change. Attorneys who represent plaintiffs who have been injured by their HMOs' failure to provide promised care can take heart in the *Pegram* Court's observation that, "HMOs, like traditional insurers, will in some fashion make coverage determinations, scrutinizing requested services against the contractual provisions to make sure that a request for care falls within the scope of covered circumstances." California law provides that when HMOs make these coverage determinations, they owe their members the same duty of good faith and fair dealing as traditional insurers. *Sarchett v. Blue Shield of California*, 43 Cal.3d 1 (1987).

Attorneys who defend HMOs and physicians will likely attempt to cast their clients' decisions as mixed eligibility and treatment decisions, arguing that these decisions are subject to review only under a malpractice standard. The Supreme Court's remand order in *Pappas*, however, suggests that it is possible to separate coverage decisions from treatment decisions. In cases where ERISA applies, this may result in ERISA preemption. But in cases not covered by ERISA it may result in the imposition of bad-faith liability on HMOs for their coverage decisions.

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