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AN HMO DOES NOT OWE AN ERISA FIDUCIARY DUTY TO ITS EMPLOYEE BENEFICIARIES: AFTER PEGRAM V. HERDRICH, WHO WILL SPEAK FOR THE WORKING CLASS?

L. DARNELL WEEDELEN

INTRODUCTION

In the past few decades an American health care system once defined by fee-for-service care has succumbed to domination by large, for-profit managed care organizations. The corollary of this national shift in health care has been a major transfer of financial and administrative power from doctors and hospitals to insurers and Health Management Organizations ("HMOs"). Critics of the current system believe this shift in power has given managed care

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1. David H. Johnson, ERISA Fiduciary Duty Claims and Managed Care Liability: Implications of Herdrich v. Pegram, 11 HEALTH L., May 1999, at 1, 1. "The current market power of managed care signals a major shift of both financial and administrative power away from physicians and hospitals to manage care organizations." Id. Johnson believes doctors still exercise considerable authority to control medical care, but that doctors' medical care authority is significantly compromised. Id. A key provision of managed care is the transfer of financial risk for the provision of medical services for an assigned group of patients to physicians, medical groups, and other provider organizations. Id. "This assumption of financial risk for patient care by [doctors] charged with responsibility for delivering that care is at the heart of the public debate around managed care." Id.


HMO's began requiring physician's [sic] to obtain approval for treatments prior to providing the care. This is called the prospective utilization review. The process normally requires treatment and hospitalization requests by physicians to be approved by an HMO review board prior to the patient receiving the treatment. HMO review boards then made recommendations as to what treatment the HMO would or would not reimburse. If the HMO chooses not to reimburse for treatment, the patient may still decide to proceed with the treatment. However, the patient would have to pay for the care. Utilizing the prospective utilization process, HMOs have been able to save billions of dollars in health care expenditures and have become very profitable.

Id. at 28.
organizations control over the direction and disposition of medical treatment because of their perceived undue influence on the pocketbooks of health care professionals. 3 Lawyers and policymakers on both sides of the managed care/health care debate are also sensitive to the growing resentment in the media and the public for the perceived substitution of economics for the Hippocratic Oath that once served as the cornerstone of medical care. 4 The debate reflects a popular fear that, under the managed care system, doctors may be forced to choose between enhancing patient welfare and enhancing their own financial wellbeing through economic incentives associated with reduced patient care. 5 This creates a significant problem of accountability from the public’s perspective. If doctors choose the latter option and patient care suffers as a result, what methods of redress are available?

Most Americans today participate in health care plans provided by their employers. For these individuals, there will be few, if any, avenues of relief for substandard treatment they may receive as a result of the current health care regime. This is because, as an employment-related benefit, their health plans are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). 6 ERISA is a statutory plan that regulates all “private employee benefits plans, including both pension plans and welfare plans.” 7 A “welfare plan” includes "any plan, fund, or program” maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries “through the purchase of insurance or otherwise.” 8 Because ERISA may preempt state law claims of medical malpractice, negligence, and other medical torts, individuals receiving health care coverage through their employers may be forced to resolve their health care grievances under the procedures set forth in the statute for a breach of fiduciary duty.


Managed health care has grown exponentially in recent years. The for-profit tempo of changes in the managed care field and the inter-relationship of organizations and professionals providing medical care services in and through organizations have an overriding or dominant rhythm that seems, like the rhythm of the business world, to permeate all decisions.

Id. at 357.

4. Id.

5. Johnson, supra note 1, at 1.


An employee may state a claim for breach of fiduciary duty under ERISA by alleging the following facts in the complaint: (1) that the defendants are plan fiduciaries; (2) that the defendants breached their fiduciary duties; and (3) that a cognizable loss resulted.9 In Pegram v. Herdrich, the Supreme Court recently expounded upon the requirements one must meet in order to prove that an HMO breached its fiduciary duty.10 The Supreme Court ruled that the initial inquiry in cases alleging such a breach is whether adverse, mixed eligibility, and treatment decisions11 made by an HMO’s physicians are fiduciary acts under ERISA.12 In cases alleging breach of an ERISA fiduciary duty, a closely related question is whether the decision-maker was under a fiduciary duty while forming an adverse decision.13

Whether an HMO is a fiduciary under ERISA when it acts through its physicians depends on some background of fact and law about HMOs and medical benefit plans.14 In the United States, physicians have traditionally provided care on a “fee-for-service” basis.15 A physician would charge a fee for a general exam or a medical procedure and then bill the patient for the services provided. If the patient had insurance, the doctor would submit the bill for the patient’s care directly to the insurer.16 Under such fee-for-service systems, as long as doctors continued to receive payments, a financial incentive existed for doctors to provide as much care as possible.17 The only check on this “more care incentive” was a physician’s duty to exercise reasonable medical skill and judgment in the patient’s interest.18

In the late 1960s, insurers and others developed the HMO as a new model for health care delivery.19

The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide speci-

11. See infra note 33 and accompanying text for a discussion of eligibility decisions.
13. Id. at 226.
14. Id. at 218.
15. Id.
16. Id. (citations omitted).
17. Id.
18. Id.
19. Id.
fied health care if needed. The HMO thus assumes the financial risk of providing the benefits promised: if a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes expensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant’s premiums.  

HMOs, unlike doctors in the fee-for-service system, take steps to control costs because they are not passed on to the patient. To this extent, HMOs make coverage determinations by scrutinizing requested services against the contractual provisions with the employer plan sponsor. This is to ensure “that a request for care falls within the scope of covered circumstances [e.g., pregnancy] or that a given treatment falls within the scope of the care promised [e.g., surgery].” HMOs also issue general guidelines informed by financial considerations to their physicians about appropriate levels of care. Unlike the fee-for-service system, a physician’s financial interest under an HMO plan “lies in providing less care, not more.”

The balancing mechanism against an HMO’s influence is the physician’s professional obligation to provide covered services with a reasonable degree of skill.

HMOs originally gained popularity as the perception grew that fee-for-service physicians were providing unnecessary or useless services at great expense. Now many doctors argue that HMOs often sacrifice the patient’s individual needs to improve the financial status of the HMO. One method commonly used by HMOs to reduce expenses is to provide “specific financial incentives” to doctors for reducing the use of health care treatment.

In Pegram, the Supreme Court discussed the nature of pure

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20. Id. at 218-19.
21. Id. at 219.
24. Id.
25. Id. at 220.
26. Id. (citing Herdrich v. Pegram, 154 F.3d 362, 375-78 (7th Cir. 1998) for various criticisms of HMO practices); see also John P. Little, D.M.D., Note, Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health, 49 RUTGERS L. REV. 1397, 1399-1400 (1997) (arguing that, because of their overly broad concern with increasing their profit margins, HMOs are to blame for inadequate medical treatment and the erosion of the doctor-patient relationship).
27. Pegram, 530 U.S. at 219 (listing such incentives as rewarding physicians for using fewer HMO services and penalizing them for over-using treatments).
eligibility decisions, pure treatment decisions, and "mixed eligibility and treatment" decisions.28 Pure eligibility decisions are based on a plan's coverage of a specific medical procedure or treatment for a medical condition.29 By comparison, pure treatment decisions are choices about the diagnosis and substantive treatment of a patient's condition.30 Using the pure treatment decision, the physician evaluates a patient's symptoms and makes an educated guess about both the origin of the symptoms and the proper course of treatment.31 In practice, "eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment . . . ."32 When eligibility decisions are embroiled with treatment decisions, they are referred to as mixed eligibility and treatment decisions.33

The Pegram Court, recognizing that Congress imposed a flexible duty of loyalty on individuals administering ERISA plans, held that HMO owner-doctors34 do not act as fiduciaries when treating patients and making determinations about what types of injuries or illnesses are covered by their respective plans.35 The same fiduciary principles articulated in Pegram apply to all doctors working for HMOs, regardless of whether or not they own the HMO.36 As a result of Pegram, HMO owner-doctors can join other doctors who do not own HMOs in ignoring the single duty of loyalty to the beneficiary, which is imposed on a common law trustee.37 Because of a lack of the single-duty, fiduciary loyalty imposed on a common law trustee, a doctor's financial self-interests may influence his decision-

28. Id. at 228-29.
29. Id. at 228.
30. Id.
31. See id.
32. Id. at 229.
33. Id.

The kinds of decisions mentioned in Herdrich's ERISA count . . . are . . . mixed eligibility and treatment decisions: physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and [other] facilities; 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. Id. at 229-30.

34. See id. at 211. Owner-doctors are physicians who have formed their own HMOs. These HMOs "function as a health maintenance organization (HMO) organized for profit. Its owners are physicians providing prepaid medical services to participants whose employers contract with [it] to provide such coverage." Id. at 215.
35. Id. at 237.
36. Id. at 220-22.
37. Id. at 222 ("We think, then, that courts are not in a position to derive a sound legal principle to differentiate [a physician-owned] HMO . . . from other HMOs.").
making; HMOs are thus insulated from lawsuits at the expense of patients' rights.38

According to the Pegram Court, all HMOs are relieved of the ordinary duties owed by common law trustees because Congress never intended for an HMO to be characterized as a fiduciary to the extent that its physicians make mixed eligibility decisions.39 Congress did not consider a mixed eligibility decision-maker as a fiduciary, according to the Supreme Court.40 The common law trustee's primary concern has traditionally "been the payment of money in the interest of the beneficiary."41 The Supreme Court reasoned that because a doctor making a mixed eligibility treatment decision served a completely different role from that of the common law trustee those decisions are not fiduciary.42 Private trustees do not make treatment judgments of any kind, while physicians working for HMOs must make numerous mixed treatment judgments daily.43 The mixed treatment medical settings "bear no more resemblance to trust departments than a decision to operate [on a patient] turns on the factors controlling the amount of a quarterly income distribution."44 The Court rejected the application of the common law fiduciary relationship to an HMO physician's mixed eligibility and treatment decisions because such an application would have the unthinkable consequence of denying HMOs any profit for failing "to act solely in the interest of the patient without possibility of conflict."45

Because it is important that the public maintain confidence in the medical profession and the current health care system, it is not only proper but also necessary for Congress to amend ERISA to provide for patient relief. An amended ERISA should use traditional common law liability concepts of torts, contracts, and trusts to restore quality patient care consistent with the Hippocratic Oath serving as the bottom line.46

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38. Id. at 225 ("Under ERISA, however, a fiduciary may have financial interests adverse to beneficiaries.").
39. Id. at 231.
40. Id.
41. Id.
42. Id. at 231-32.
43. Id. at 232.
44. Id.
45. Id. at 233.
46. Robinson, supra note 3, at 357 (noting that the plaintiff bar has used expanded traditional liability concepts with limited success as an attack against managed care providers).
One commentator is concerned that an amended ERISA would impose increased liability on physicians and ultimately lead to higher medical costs for the consumer-patient, as well as increased malpractice costs for the managed care industry. Opponents of an amended ERISA also argue that any ERISA amendment that expands the potential medical liability of doctors and other managed care providers could lead to the collapse of a system already burdened with increased medical costs. However, any increased costs associated with amending ERISA are outweighed by authorizing plaintiffs to recover damages resulting from negligent medical treatment from managed care organizations and their employees. When plaintiffs are left without a remedy for their medical malpractice claims because of ERISA's preemption, it is simply viewed as an unfortunate consequence of preemption.

The purpose of this Article is to demonstrate that Congress should amend ERISA to allow plan beneficiaries/patients to assert medical malpractice claims and breaches of both fiduciary duty and contract against both doctors and HMOs in the managed care industry. Part I of this Article will begin by presenting the germane facts of Pegram. It will then analyze the Seventh Circuit's decision that ERISA does create a fiduciary duty for HMOs handling

48. Id. at 431 ("The American system of health care is at a crossroads. The system is on the verge of collapsing under the weight of increased spending which ... will dwarf the nation's defense budget and will comprise nearly 18% of the United States gross national product.") (citing Leonard A. Hagen, Physician Credentialing: Economic Criteria Compete with the Hippocratic Oath, 31 GONZ. L. REV. 427, 429 (1995-96)).
49. James P. Duffy, IV, HMO Doctors as ERISA Fiduciaries: A Bankruptcy Perspective, 8 AM. BANKR. INST. L. REV. 125, 149 (2000) ("The inability to collect personal damages is exacerbated by the fact that plaintiffs may not have a state law cause of action against HMO doctors who act negligently because of ERISA's broad preemptive powers.").
50. Id. at 150.
There is little doubt that present healthcare procedures give doctors incentives to act in a self-serving manner. It is also clear that these HMO practices often conflict with the statutory goals of ERISA. This suggests that Congress should revisit and revise ERISA to reflect current healthcare practices. Moreover, holding HMO doctors liable as ERISA fiduciaries creates the potential for damage awards which physicians could not bear. Many HMO doctors would be forced into bankruptcy by these awards. Many more physician partnerships could follow suit. There is no clear answer to this problem. Plaintiffs have legitimate concerns; however, physician bankruptcy may not be the best response. In the end, the question of whether HMO doctors may be ERISA fiduciaries is best left for Congress to decide.

mixed eligibility and treatment decisions. Part II of the Article will examine the Supreme Court’s rationale for reversing the Seventh Circuit in holding that the mixed decisions of HMO owner-doctors do not raise a fiduciary issue under ERISA. Part II will then discuss the impact of the Court’s decision and the method of analysis on managed care issues under ERISA. The Article will conclude, in Part III, with the Author’s recommendation that Congress amend ERISA to provide increased protection for plan beneficiaries asserting health care rights against HMOs.

I. SEVENTH CIRCUIT TANGLES WITH PEGRAM ISSUES: FINDING THE HMO’S DECISION WAS FIDUCIARY

A. Facts

Through her husband’s employer, Cynthia Herdrich (“Herdrich”) participated in a pre-paid health insurance plan (the “Plan”) operated by Carle Clinic Association, P.C. (“Carle”), Health Alliance Medical Plans, Inc. (“HAMP”), and Carle Health Insurance Management Company, Inc. On October 21, 1992, Herdrich filed a complaint in the Circuit Court of McLean County, Illinois, charging Carle and Lori Pegram, M.D. (“Dr. Pegram”) with medical negligence. Specifically, Herdrich alleged that she had suffered a ruptured appendix and contracted peritonitis due to the defendants’ “negligence in failing to provide her with timely and adequate medical care.” Herdrich amended her complaint on February 18, 1994, to add two counts (Counts III and IV) of state law fraud against Carle and HAMP. Count III alleged that Carle fail[ed] to disclose certain material facts regarding the ownership of HAMP, as well as fail[ed] to advise her that the compensation of plan physicians was increased to the extent that they did not order diagnostic tests, utilized facilities owned by those physicians, and did not make emergency or consultation referrals. Count IV alleged that HAMP breached its duty of good faith and
fair dealing by increasing its profits and the profits of its con-
tracted physicians through minimizing the use of diagnostic tests,
emergency consultation referrals, and facilities not owned by
such physicians, all to the detriment of plan beneficiaries. 56

Subsequent to the amendment, defendants removed the case
to federal court, asserting that the two new counts were preempted
by ERISA. 57 Defendants then filed a motion for summary judg-
ment as to Counts III and IV only. 58 The court granted the motion
with respect to Count IV, because Herdrich was seeking monetary
damages where ERISA authorized only equitable relief. 59 The trial
judge denied summary judgment on Count III, but concluded that
ERISA preempted the claim under Count III. 60 Accordingly, the
trial judge gave Herdrich leave to amend this count so as to more
fully state her basis for proceeding under ERISA. 61 Herdrich’s
amended Count III alleged that the “defendants breached their fi-
duciary duty to plan beneficiaries by depriving them of proper med-
cal care and retaining the savings resulting therefrom for
themselves.” 62 The defendants then moved to dismiss Herdrich’s
amended Count III for failure to state a claim upon which relief
could be granted. 63

“The case—including the defendants’ motion to dismiss—was
assigned to a magistrate judge, who recommended that the
amended count III be dismissed” because Herdrich failed to iden-
tify how any of the named defendants acted as a fiduciary to the
Plan. 64 Herdrich filed an objection to the magistrate’s recommend-
dation, which was denied by the district court on April 15, 1996. 65
Counts I and II were tried in early December 1996. 66 The jury re-
turned a verdict in Herdrich’s favor on both counts, awarding her
$35,000 in compensatory damages. 67

Herdrich appealed the district court’s dismissal of her amended

56. Id. at 366 n.2.
57. Id. at 366.
58. Id.
59. Id.
60. Id.
61. Id.
62. Id. at 366-67 & n.3.
63. Id. at 367. In recommending that the amended count be dismissed, the court
stated that Herdrich was not entitled to any relief under Count III because she failed
“to identify how any of the defendants is involved as a fiduciary to the plan.” Id.
64. Id.
65. Id.
66. Id.
67. Id.
Count III to the Seventh Circuit, contending that her complaint sufficiently stated "a claim for breach of fiduciary duty under ERISA."\(^{68}\) The defendants, in turn, argued that the Seventh Circuit lacked jurisdiction to hear the case because Herdrich did not "file a timely notice of appeal."\(^{69}\) Defendants also challenged Herdrich's damages request, arguing that beneficiaries of ERISA plans cannot recover "anything other than the benefits provided expressly in the plan."\(^{70}\) Though addressing each of defendants' arguments at length, the Seventh Circuit focused primarily on the issue raised by Herdrich: whether her pleadings sufficiently alleged that (1) the defendants were plan fiduciaries, (2) "the defendants breached their fiduciary duties," and (3) "a cognizable loss resulted."\(^{71}\) The remainder of Part I will explore the Seventh Circuit's analysis of these three elements, which are necessary to state a claim for breach of fiduciary duty under ERISA.\(^{72}\)

B. The Seventh Circuit's Decision

1. Defendants as Plan Fiduciaries

The Seventh Circuit rejected the magistrate's contention, adopted by the district court in its dismissal of Count III, that Herdrich failed to allege how the named defendants acted as fiduciaries to the Plan.\(^{73}\) In reaching this conclusion, the Seventh Circuit looked to both the plain language and legislative history of ERISA.\(^{74}\) The court focused specifically on 29 U.S.C. § 1002(21)(A):

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Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority of [sic] control respecting management or disposition of its assets ... or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.\(^{75}\)
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The court also noted that Congress, when enacting ERISA, in-

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68. Id.
69. Id.
70. Id.
71. Id. at 369-80.
73. Pegram, 154 F.3d at 369.
74. Id. at 369-70.
75. Id. at 369-70 (quoting 29 U.S.C. § 1002(21)(A) (1994)).
tended that the definition of "fiduciary" be broadly interpreted.76

Evaluating Herdrich's amended Count III in light of this statutory language and history, the court concluded that the amended complaint sufficiently identified defendants as plan fiduciaries.77 The court considered Herdrich's allegation that the "defendants have the exclusive right to decide all disputed and non-routine claims under the plan" as evidencing the "discretionary control and authority" required of a fiduciary under ERISA.78 The court also noted that the Plan's physicians comprised the entire board of directors, enabling them to control every aspect of the Plan's governance.79 On the basis of this infrastructure, the court found it reasonable to infer that Carle and HAMP were plan fiduciaries.80

2. Defendants' Breach of Fiduciary Duty

After determining that the defendants were in fact plan fiduciaries, the court went on to conclude that Herdrich's complaint sufficiently alleged a breach of the defendants' fiduciary duties.81 Again, the court reached this conclusion by reference to ERISA's statutory language.82 In accordance with 29 U.S.C. § 1104(a)(1), a plan fiduciary "shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries."83 Therefore, an ERISA fiduciary that acts in its own interests breaches its

76. Id. at 370. The Chairman of the House Committee on Education and Labor stated:

The Committee has adopted the view that the definition of fiduciary is of necessity broad . . . . A fiduciary need not be a person with direct access to the assets of the plan . . . . Conduct alone may in an appropriate circumstance impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary . . . .

120 CONG. REC. 3977, 3983 (Feb. 25, 1974) reprinted in 2 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 3293. The Seventh Circuit also noted that, in accordance with this expressed congressional intent, courts routinely construe "fiduciary" broadly under ERISA and emphasize "the importance of discretionary control and authority." Pegram, 154 F.3d at 370.

77. Pegram, 154 F.3d at 370-71.
78. Id. at 370.
79. Id.
80. Id.
81. Id. at 371.
82. Id.
83. Id. The law also requires an ERISA fiduciary to discharge his duties "for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) with the care . . . . that a prudent man acting in a like capacity and familiar with such matters would use . . . ." 29 U.S.C. § 1104(a)(1) (1994).
duty of care. As noted by the Seventh Circuit, the ERISA fiduciary duty is aimed at managed care incentive schemes “tainted by a conflict of interest,” like the ones involved in Pegram and Shea v. Esensten. In Shea, the Eighth Circuit concluded that the defendants breached their fiduciary duty by failing to disclose to plan participants that they provided financial incentives to physicians who reduced the number of tests and referrals offered to patients. Following the lead of the Eighth Circuit, the Seventh Circuit in Pegram stated that the defendants’ infrastructure, which permitted the Plan’s physicians to also act as its administrators, at least facially violated its fiduciary duty. This dual role vested the doctor-owners with the authority to determine which claims would be paid, as well as the nature and duration of patients’ care—expenditures that would directly affect the physicians’ own year-end bonuses. The existence of a direct correlation between the amount of money spent on tests and treatment and the amount received by physicians in the form of bonuses led the court to infer that the defendants’ discharge of their fiduciary duties was colored by an incentive to minimize costs.

The Seventh Circuit, recognizing that a “fiduciary’s covert profiteering at the expense of insureds is inconsistent with its duties of acting ‘solely in the interest of the participants and beneficiaries,’” held that incentive schemes can, under certain circum-

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84. Pegram, 154 F.3d at 371 (citing James F. Jorden et al., Handbook on ERISA Litigation § 3.03[A], at 3-53 (1994)).
85. Id. (quoting Lowen v. Tower Asset Mgmt., Inc., 829 F.2d 1209, 1213 (2d Cir. 1987)).
86. 107 F.3d 625 (8th Cir. 1997).
87. Id. at 628-29.
88. 154 F.3d at 380.
89. Id. at 372.
90. Id. at 372-73.
91. Id. at 372 (citing Reis v. Humana Health Plan, Inc., 1995 WL 669583, at *7 (N.D. Ill. 1995)).

Drawing parallels to [Reis v. Humana Health Plan, Inc.], Herdrich sets forth, in the amended third count of her complaint, the intricacies of the defendants’ incentive structure. The Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators’ year-end bonuses were based on the difference between total plan costs (i.e., the costs of providing medical services) and revenues (i.e., payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. With a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the Plan were
stances, trigger a breach of the ERISA fiduciary duty. In so ruling, the court was careful not to contradict the well-established proposition that dual loyalties are tolerated under ERISA. Rather, the court simply recognized that tolerance of those dual loyalties does not extend to a fiduciary that jettisons its responsibility to the physical well-being of beneficiaries in favor of "loyalty" to its own financial interests. "Tolerance, in other words, has its limits."

In finding that Herdrich's amended Count III sufficiently alleged defendants' breach of their ERISA fiduciary duties, the majority gave no credence to the dissent's argument that only where there is a "breakdown in the market" will there exist a possible breach due to incentives. Unlike the majority, the dissent relied on market forces to protect against the potential negative effects of incentive schemes, reasoning that plan sponsors would withdraw their support if they perceived any resulting detriment to the Plan or its beneficiaries. The majority, however, sufficiently undercut the application of this market theory by reference to the facts in Pegram. Presumably due to the underlying incentive scheme, Herdrich was forced to wait more than a week to receive the appropriate diagnostic testing of the enlarged mass that Dr. Pegram discovered in her abdomen. As a result of this delay, her appendix ruptured and she suffered a life-threatening illness (peritonitis), which necessitated a longer hospital stay and more serious surgery at greater cost to both her and the Plan. If Cynthia Herdrich's experience is even remotely representative, it is reasonable to conclude that "market forces are insufficient to cure the deleterious...

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92. *Id.* at 373. The Seventh Circuit was very specific in stating that its decision does not imply that the existence of incentives automatically creates a breach of fiduciary duty. Rather, the court held that incentives may give rise to a breach when the complaint alleges, as in Pegram, that the fiduciary trust between plan participants and plan fiduciaries has been broken. *Id.*

93. *Id.* (citing Donovan v. Bierwirth, 538 F. Supp. 463, 468 (E.D.N.Y. 1981)).

94. *Id.*

95. *Id.*

96. *Id.* at 374.

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*
affects [sic] of managed care on the health care industry."\textsuperscript{101}

3. Depletion of the Plan's Assets Created a Cognizable Loss

Herdrich's allegations that the defendants' incentive system depleted plan resources for the benefit of the administering physicians, "possibly to the detriment of their patients," also survived a motion to dismiss by the defendants.\textsuperscript{102} The appeals court did not resolve this issue, instead remanding it for the trial court to decide whether the defendants breached their fiduciary duty to act only in the interest of plan participants and beneficiaries.\textsuperscript{103} The Seventh Circuit opined, however, that plan participants' interests were probably in conflict with the defendants' policy of depleting plan funds with year-end bonus payouts.\textsuperscript{104}

The Seventh Circuit believed that Herdrich's claim should not be dismissed because her allegations clearly stated that the Plan had suffered damages attributable to the defendants' breach of their fiduciary duty.\textsuperscript{105} Under ERISA, a plan beneficiary may sue a plan fiduciary for breach of duty.\textsuperscript{106} In such a suit, "plan beneficiaries have standing to bring an action on behalf of the plan itself to recoup monies expended in violation of ERISA, as the plaintiff [Herdrich] has done here."\textsuperscript{107} The ERISA fiduciary duty articulated in 29 U.S.C. § 1109(a) applies to the Plan, and not to any single person.\textsuperscript{108}

The Seventh Circuit correctly concluded that the defendants potentially breached their fiduciary duty to Herdrich.\textsuperscript{109} The court's rationale for stating that the plan's assets are subject to pos-

\textsuperscript{101} Id. at 374-75 (quoting various articles describing the mentality of doctors, nurses, and the public toward profit-based health care).

\textsuperscript{102} Id. at 380. The ultimate issue of whether the defendants violated their fiduciary obligations to act solely in the interest of the Plan participants and beneficiaries fell not within the jurisdiction of the Seventh Circuit, but instead within the jurisdiction of the trial court. \textit{Id.}

\textsuperscript{103} Id. at 380.

\textsuperscript{104} Id.

\textsuperscript{105} Id. "Herdrich alleges that as a result of the defendants' actions, the Plan was deprived of the supplemental medical expense payment amounts in controversy. We thus hold that she has alleged with sufficient clarity that the Plan suffered a loss as a result of the defendants' actions." \textit{Id.}

\textsuperscript{106} Id. (citing 29 U.S.C. § 1109(a) (1994)).

\textsuperscript{107} Id. (citing 29 U.S.C. § 1132(a) (1994)).

\textsuperscript{108} Id. (citing Harsch v. Eisenberg, 956 F.2d 651, 657 (7th Cir. 1992)).

\textsuperscript{109} Pegram, 154 F.3d at 380 ("We conclude ... that the trial judge erred in dismissing the plaintiff's amended Count III against the defendants for breach of fiduciary duty under ERISA.").
sible misuse because they are annually depleted by the HMO owner-doctors is not clear, however, because the court fails to articulate that the depletion process is a "poor business decision" when inspired by substandard medical care.\textsuperscript{110} Implicit in the Seventh Circuit's rationale is the theory that a practice of providing questionable medical services in order to increase profits places the Plan assets at risk. This is because such practices are a reasonable, foreseeable, and proximate cause of the Plan not being particularly marketable to employers.\textsuperscript{111} The Herdrich complaint thus survived a motion to dismiss because the HMO's incentive scheme contextually created a reasonable "inference that market forces have failed . . . to protect the interests"\textsuperscript{112} of beneficiaries under the Plan to receive quality health care.

II. REVERSAL OF FORTUNE: THE SUPREME COURT DECISION AND ITS LEGACY

A. Impact of the Judiciary's Preemption Theory on Managed Care Issues under ERISA

Some commentators take the position that ERISA decisions concerning the role of managed care organizations "simply do not implicate the danger of judicial encroachment on legislative power."\textsuperscript{113} Congress intended for ERISA plan beneficiaries to be compensated when injured by an HMO's economic decision-making process.\textsuperscript{114}

\textsuperscript{110} Id. at 382 (Flaum, J., dissenting) ("In the long run, [denying valid claims] would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers. Thus, no conflict of interest exists because paying meritorious claims is in [the insurer's] best interest.") (citing Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020-21 (7th Cir. 1998)).

\textsuperscript{111} Id. at 383 (Flaum, J., dissenting) ("[C]ourts have a role in ensuring that incentives are implemented in accordance with the fiduciary duties imposed by ERISA . . . . [S]ponsors and beneficiaries need information about the financial incentives that are in place. Thus, . . . the failure to disclose financial incentives is a breach of fiduciary duty under ERISA."); see Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997).

\textsuperscript{112} Pegram, 154 F.3d at 382. "[T]here is no guarantee that a sponsor will be able to find satisfactory alternatives in the marketplace. The plaintiff's complaint, however, alleges only that an incentive to deny coverage exists, which [does not] support an inference that market forces have failed . . . to protect the interests of beneficiaries." Id.

\textsuperscript{113} Peter D. Jacobson & Scott D. Pomfret, Form Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence, 35 Hous. L. Rev. 985, 1038 (1998). The Jacobson article articulates a number of compelling reasons why courts should grant substantial justice to HMO beneficiaries by restricting ERISA pre-emption rationale. Id. at 1040-48.

\textsuperscript{114} Id. at 1039.
The Supreme Court in *Pegram* cited to the Jacobson and Pomfret article and tentatively adopted its suggestion that courts use a functional approach to hold managed care entities accountable for economic and medical decisions under ERISA. Approaching ERISA from a functional perspective allows one to view a court as a pragmatic and functioning entity. "[T]he judge steps into the legislator's shoes, exercising the same sort of practical intelligence that the legislator would have utilized had he or she foreseen the situation."  

The Supreme Court in *Pegram* held that ERISA preempts state law claims for substandard medical care, relying on ERISA's legislative history to support its conclusion that mixed eligibility and treatment decisions are not fiduciary decisions. Since ERISA dominates medical treatment issues in this nation, it is important that the preemption issue be addressed. Because of the lack of express congressional intent, the preemption issue presented under ERISA in the health care context is whether ERISA allows HMOs to escape liability for providing negligent medical treatment. Simply stated, did Congress, by implication, intend ERISA to allow HMOs to make eligibility and treatment decisions detrimental to patients because those decisions enhance the HMO's financial position? A court holding that ERISA preempts state law claims against substandard medical care provided by HMOs to covered employee plan beneficiaries would assign to Congress a mean-spirited intent "contrary to the law in all fifty states" which protects people against unreasonable medical treatment. A realistic judicial view of congressional intent toward HMOs supports the conclusion that Congress intended for an HMO to be liable to patient/plan beneficiaries when the HMO's economic interest is a substantial factor in its decision to provide beneficiaries with unreasonable medical services or no medical treatment at all.

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117. *Id.* at 995.
121. *Id.* at 988-89.
122. *Id.* at 995.
123. *Id.*
124. *Id.* ("As with any other business enterprise, MCOs [managed care organizations] make economic decisions. These decisions will occasionally impose costs on ER-
Jacobson and Pomfret make an insightful and convincing argument that the Supreme Court has committed significant error by "its misinterpretation of ERISA's legislative history"\textsuperscript{125} in its preemption theory.\textsuperscript{126} They argue that the Court's treatment of ERISA's preemptive legislative history is flawed for three reasons: (1) failure to consider ERISA's broad purposes, (2) failure to limit ERISA's preemption clause to ordinary field and conflict preemption, and (3) mischaracterization of ERISA as an "intricate, comprehensive statute."\textsuperscript{127}

The first reason cited by Jacobson and Pomfret deals with the Court's failure to follow the general rule of preemption analysis, which provides that courts should interpret a statute in light of its broader underlying policies.\textsuperscript{128} In this context, the Court failed to consider ERISA's policy of protecting the participants and beneficiaries of an employer sponsored health plan.\textsuperscript{129} The Jacobson and Pomfret article strongly disagreed with the view of commentators that the plan and the employer, rather than individuals receiving health care coverage, were the direct beneficiaries of the uniform administration of health plans created by the Court's preemption theory.\textsuperscript{130} Jacobson and Pomfret believe ERISA's legislative history as well as the provisions of the statute outlining its policies declare "unambiguously that the statute protects plan participants and beneficiaries."\textsuperscript{131} ERISA's legislative history appears to convincingly support those advocating that ERISA's uniformity goal "and the preemption that achieves it, prevents employers and plans from shifting higher administrative costs to employees and beneficiaries through reduced benefit levels."\textsuperscript{132}

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ISA plan participants. In addition, MCOs impose additional costs due to their negligence.\textsuperscript{133}
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\textsuperscript{125} Id. at 1008.
\textsuperscript{126} Id. at 1008-15.
\textsuperscript{127} Id.
\textsuperscript{128} Id. at 1010.
\textsuperscript{129} Id.
\textsuperscript{130} Id. at 1010-11.
\textsuperscript{131} Id. at 1011.
\textsuperscript{132} Id. (citing Seema R. Shah, Comment, Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burragge, 80 MINN. L. REV. 1545, 1573 (1996)).

Contrary to the view taken by some, ERISA's goal of uniformity was not designed to protect employers, employee benefit plans, or plan fiduciaries. In fact, ERISA bestowed the advantages of federal uniformity to ensure that employers and employee benefit plans would not offset their administrative costs onto vulnerable employee beneficiaries and their dependents. Regulatory uniformity was the means to achieve the desired end of protecting employees.
The second error in the Supreme Court's interpretation of ERISA's preemption legislative history is the mistaken conclusion that ERISA preempts state laws regulating employer sponsored health benefit plans even in the absence of a conflict because Congress has not expressly or implicitly occupied the field. As a general rule, when Congress exercises its enumerated power to create federal legislation, the federal law usurps any parallel state law. When there is conflict between the federal and state legislation, the Supremacy Clause dictates that state law is inferior and must give way to the superior federal law. In creating a law, Congress may expressly decide to "occupy the field," thus disallowing corresponding state laws. Preemption issues are rarely presented in an unambiguous environment because Congress does not always clearly articulate its purpose. Sometimes it may be merely implied that Congress has occupied the field.

The Court's preemption rationale for HMOs should be consistent with requiring HMOs to act in a way that protects the interest of plan beneficiaries. The Court could hold that since Congress has not expressly or implicitly preempted state laws allowing for traditional negligence actions against employer sponsored health plans, traditional negligence remedies still exist. In the absence of convincing evidence demonstrating a Congressional intent to override traditional negligence remedies because of conflict, or a congressional desire to occupy the field in the managed care industry, the Supreme Court should not presume that state negligence laws do not apply to defendant HMOs. A healthy respect for the principles of federalism makes it necessary for courts to construe

Given ERISA's purpose, HMOs should not receive ERISA's solicitude; any special benefits arising from ERISA's regulatory control should be conferred to the employee-participants of health care plans, not the ERISA-regulated HMO plan. Preemption of malpractice claims would give HMOs a protective benefit that disrupts ERISA's intended balanced protection.

Shah, supra, at 1573 (citations omitted).

135. -Id. (citing U.S. Const. art. VI, cl. 2).
136. -Id.
137. -Id.
138. -Id.
139. Jacobson & Pomfret, supra note 113, at 1011 (declaring that the overriding purpose of ERISA is to protect plan employee beneficiaries).
140. See Nowak & Rotunda, supra note 134, at 351 (citing Malone v. White Motors Corp., 444 U.S. 911 (1979) and stating that the state statute relating to pensions was not preempted by older federal law even though a new federal statute expressly
ERISA against traditional state regulatory policies.\textsuperscript{141} Congress, in its ambiguous ERISA preemptive debate, did not intend to undermine federalism, according to Jacobson and Pomfret.\textsuperscript{142} It would threaten the spirit and rationale of \textit{Palsgraf v. Long Island R.R. Co.}\textsuperscript{143} to hold that HMOs do not have a duty to use reasonable care toward plan beneficiaries because they were unforeseeable victims of substandard medical treatment.\textsuperscript{144} Justice Cardozo said in \textit{Palsgraf} that "the risk reasonably to be perceived defines the duty to be obeyed."\textsuperscript{145} There is little doubt that an HMO can foresee that, by communicating an excessive emphasis on profits to its doctors, it creates an increased risk of doctors providing plan beneficiaries, as a class, with substandard services. If managed care organizations do not owe a standard of due care to plan beneficiaries, to whom is this duty owed?

As Justice Andrews said in his dissenting opinion in \textit{Palsgraf}, "Due care is a duty imposed on each one of us to protect society from unnecessary danger, not to protect A, B, or C alone."\textsuperscript{146} Not even in an election year would Congress be so irrational as to relieve HMOs of any legal liability for negligent conduct that is a substantial factor in harming plan beneficiaries. "The proposition is this: Every one owes to the world at large the duty of refraining from those acts that may unreasonably threaten the safety of others."\textsuperscript{147} When the unreasonable conduct of an HMO is a substantial factor in creating a greater risk of harm to a plan beneficiary, the managed care entity should be liable under the same tort theories applicable to others that act unreasonably.\textsuperscript{148} If an HMO's standard business practice places greater emphasis on saving money

\begin{footnotes}
\item[141] Jacobson \& Pomfret, \textit{supra} note 113, at 992.
\item[142] \textit{Id.} at 992-93 (explaining that "courts have viewed state law as the relevant backgrounds against which Congress legislated, an assumption that tends to limit the scope of preemption and thereby respects federalism") (footnotes omitted).
\item[143] 162 N.E. 99 (N.Y. 1928).
\item[144] \textit{Id.} at 99 (describing how the the defendant railway's guard pushed a boarding passenger and the passenger's package covered by a newspaper fell on the rails and exploded, the shock of which threw down scales at the other end of the platform that injured the plaintiff).
\item[145] \textit{Id.} at 100.
\item[146] \textit{Id.} at 102 (Andrews, J., dissenting).
\item[147] \textit{Id.} at 103 (Andrews, J., dissenting).
\item[148] \textit{Cf.} Hairston v. Alexander Tank \& Equip. Co., 311 S.E.2d 559 (N.C. 1984) (involving wrongful death action brought by deceased motorist's wife against an automobile dealer and the driver of a flatbed truck, after truck struck and propelled a van into the motorist's disabled vehicle and crushed the motorist to death).
\end{footnotes}
than on protecting and saving lives, the resulting harm to the beneficary is not "so highly improbable and extraordinary an occurrence" as to bear no reasonable connection to the HMO's original negligence in advocating substandard medical treatment. 149

Even the court's mistaken conclusion that the legislative history allows for a more expansive preemption than field and conflict preemption 150 does not support relieving an HMO of liability unless the connection between the HMO's negligence and the treating doctor appears unnatural. 151

If the connection between negligence and the injury appears unnatural, unreasonable and improbable in the light of common experience, the negligence, if deemed a cause of the injury at all, is to be considered a remote rather than a proximate cause. It imposes too heavy a responsibility for negligence to hold the tortfeasor responsible for what is unusual and unlikely to happen or for what was only remotely and slightly probable. 152

A flawed expansive ERISA preemption theory which extends beyond field and conflict preemption should not deny that states have an important interest in holding managed care organizations liable for negligent conduct. HMOs must be held responsible for negligent conduct that is the natural, reasonable, and probable result of a policy that places greater emphasis on profits than on the quality of health care.

Jacobson and Pomfret state that ERISA's third legislative history problem relates to the Court's false characterization of ERISA as an "intricate comprehensive statute addressing employee health plans and the preemption provision." 153 When the Court characterizes ERISA legislation as intricate and comprehensive, it decides that the "scheme warrants a cautious approach to inferring remedies not expressly authorized by the text." 154 Any claim that ERISA is comprehensive with respect to employee health plans

mischaracterizes the statute. In legislative debates, Congress engaged in limited discussion about employee health plans, in comparison to its exhausting and far-reaching debate concerning employee pension plans. This legislative history clearly suggests that ERISA is not a comprehensive health plan statute but rather a comprehensive pension statute.

Jacobson and Pomfret correctly postulate that "[t]he Court seems to use its conclusion that ERISA is comprehensive with respect to health plans to legitimize its deregulation of health care via preemption." If the Court had recognized that ERISA was not comprehensive with respect to health plans, but was essentially a pension statute, it might have been more hesitant to preempt so much state health care regulation. It is clear that the Supreme Court is hard pressed to justify a position that ERISA's comprehensive approach to pensions allows HMOs to be unregulated by states for substandard medical care proximately caused by their negligent health care policies toward plan beneficiaries.

B. Reasoning Behind ERISA's Preemption Rationale Rule Threatens Traditional State Regulation of Health Care

Supreme Court decisions concerning which state laws are appropriately preempted under ERISA have been regarded as a failure by both legal commentators and Justice Scalia. The Court's generous use of the preemption rationale in analyzing ERISA jeopardizes the states' ability to regulate health care, an area of traditional state concern. When the Court interprets ERISA so as to deny a state the ability to regulate its own health care laws without express preemption from Congress, it calls into question the Supreme Court's basic commitment to federalist principles. The

156. Id.
157. Id. ("ERISA only regulates three aspects of health plans and leaves the remainder unregulated. Such minimal regulation is simply not comprehensive by any stretch of the imagination.") (footnote omitted).
158. Id. (footnote omitted).
159. Id.
160. Id. at 1009 (stating that "a court begins its preemption analysis with a determination of whether Congress intended a particular area to go unregulated by the states") (footnote omitted).
162. See id. at 1004.
163. Cf. United States v. Morrison, 529 U.S. 598, 615-16 (2000) (holding a section of the Violence Against Women Act unconstitutional by reasoning, in part, that Con-
The Court’s ERISA preemption theory is flawed because it precludes states from providing established tort, contract, and fiduciary remedies for plan beneficiaries suffering from inadequate health care at the hands of the managed care industry.\(^\text{164}\) It is at least debatable whether Congress can expressly preempt state regulation of traditional health care remedies.\(^\text{165}\)

The Supreme Court’s federalism theory in *Pegram* is flawed because the Court states that the federal courthouse doors could not be opened to plan beneficiaries seeking a fiduciary malpractice claim against an HMO without unequivocally opening state courthouse doors to those asserting lack of reasonable care malpractice claims.\(^\text{166}\) The Court in *Pegram* should have simply declared that because mixed eligibility and treatment decisions made by HMO doctors are not fiduciary decisions under ERISA, the plaintiff Herdrich does not have a fiduciary claim. The *Pegram* Court should have concluded that a plaintiff’s right to establish a negligence malpractice claim against an HMO and its physicians for mixed eligibility and treatment decisions must be resolved in state court because health care is “a subject of traditional state regulation”\(^\text{167}\) which has not been preempted.

C. The Court Discusses ERISA’s Fiduciary Standards for HMOs Making Mixed Eligibility and Treatment Decisions

In *Pegram*, the Court held that mixed eligibility and treatment decisions made by HMO doctors are not fiduciary acts under ERISA because Congress did not intend for the common law trustee fiduciary standard to apply to such decisions.\(^\text{168}\) The Court finds any extensive analogy between an ERISA fiduciary and a common law trustee to be troublesome.\(^\text{169}\) Whereas the trustee at common law characteristically wears only one fiduciary hat when he takes action to affect a beneficiary, an ERISA trustee may wear different hats such as being employer to the beneficiaries.\(^\text{170}\) ERISA, how-

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164. Cf. *United States v. Lopez*, 514 U.S. 549, 567-68 (holding that gun-free school zones law was unconstitutional because it prohibited the state from exercising judgment in an area traditionally regulated by the states).
165. See id.
167. Id. at 237.
168. Id.
169. Id. at 225.
170. Id.
ever, requires its fiduciary to wear only one hat at a time, and to “wear the fiduciary hat when making fiduciary decisions.”

ERISA allows an employer serving as a plan fiduciary to make a decision adverse to an employee beneficiary, such as firing the employee, only when the decision is not related to the ERISA plan. Under ERISA an employer sponsoring a plan may modify the terms of the plan by providing employees with fewer benefits without breaching its ERISA fiduciary duties. Thus, while superficially distinguishable, the fiduciary responsibilities owed under both the common law and ERISA are substantively similar because, in each case, the fiduciary is prohibited from acting in a manner that harms the beneficiary’s interest.

The Court also found that Congress never intended for any HMO to be treated as a fiduciary in making mixed eligibility and treatment decisions. Exposing HMOs to financial liability for their physicians’ mixed eligibility and treatment decisions on a fiduciary duty theory would have an adverse impact on those HMOs providing medical care for profit. Herdrich proposed as a remedy the return to the plan of profits gained by the HMO’s owners as a result of such mixed decisions. To grant Herdrich this remedy, in the Court’s opinion, “would be nothing less than elimination of the for-profit HMO” and “could portend the end of nonprofit HMOs as well.”

The Court also noted that a refusal to dismiss Herdrich’s complaint could destroy HMOs altogether and undermine Congress’ goal of allowing HMOs to make profits by assuming financial risks.

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172. Id.
173. Id.
174. Id.
175. Id. at 227-28.
176. Id. at 233.
177. Id. (citing 29 U.S.C. § 1109(a) (1994) (“[R]eturn of all profits is an appropriate ERISA remedy.”)).
178. Id.
179. Id. at 233 n.11.
for the provision of health care.\footnote{180} The Court's opinion established that it is not consistent with congressional intent “to translate fiduciary duty into a standard that would allow recovery from an HMO whenever a mixed decision [is] influenced by the HMO's financial incentive [and results] in a bad outcome for the patient.”\footnote{181} The Supreme Court recognized that a “mixed decision made solely to benefit the HMO or its physician would violate an ERISA fiduciary duty.”\footnote{182} The Court noted, however, that the fiduciary standard articulated by Herdrich is far more restrictive by requiring “an eye single” toward participants' interests.\footnote{183} Thus, the Court rejected Herdrich's standard,\footnote{184} concluding that under her single-eye fiduciary requirement “every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.”\footnote{185} The fact that the HMO's defense would be that its physician acted for good medical reasons led the Court to characterize the single-eye fiduciary standard as nothing but a pretext to federalize the traditional medical malpractice standard.\footnote{186} The only value to plan participants of such ERISA fiduciary litigation would be eligibility for attorney's fees if their claims were successful.\footnote{187} A doctor could also “be subject to suit in federal court applying an ERISA standard of reasonable medical skill.”\footnote{188} Allowing doctors to be sued under that circumstance would appear to preempt a state malpractice claim, even though ERISA does not preempt such claims absent a clear manifestation of congressional intent.\footnote{189}

\footnote{180} Id. at 233 (“[F]or over 27 years Congress has promoted the formation of HMO practices. The Health Maintenance Organization Act of 1973 allowed the formation of HMOs that assume financial risks for the provision of health care services, and Congress has amended the Act several times, most recently in 1996.”) (citations omitted).

\footnote{181} Id. at 234.

\footnote{182} Id. at 235.

\footnote{183} Id. (citing Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir. 1982)).

\footnote{184} Id.

\footnote{185} Id.

\footnote{186} Id. at 235-36 (“[I]n States that do not allow malpractice actions against HMOs the fiduciary claim [offers] a further defendant to be sued for direct liability, and ... the HMO might have a deeper pocket than the physician. But ... ERISA was not enacted out of concern that physicians were too poor to be sued ... ”).

\footnote{187} Id. at 236.

\footnote{188} Id.

\footnote{189} Id. (citing N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654-55 (1995)).
III. Conclusion: Congress Should Amend ERISA To Put Patients Before Pocketbooks

Those who believe that the marketplace will operate to maintain an appropriate balance of power between patients' needs and the corporate bottom line should remember this word of caution from the Seventh Circuit's majority opinion in Pegram. Doctors, and not insurance executives, are the experts in determining what is best for their patients. Accordingly, only trained doctors, after consultation with their patients, should be allowed to make decisions related to medical care. Unfortunately, however, modern doctors are constrained by the bureaucracy, administration, and financial incentives associated with HMOs, which "overturn doctors' decisions, deny treatment and then claim in court that they don't practice medicine, only provide coverage, so that HMOs cannot be sued for medical malpractice."

The legislative history of ERISA simply does not clearly manifest intent to absolve HMOs and their physicians of negligent conduct, which is a substantial factor in a beneficiary receiving unreasonable medical care. In Corporate Health Insurance v. Texas Department of Insurance, the Fifth Circuit held that ERISA does not preempt Texas law by allowing people to sue their managed care health plans for malpractice for negligent treatment decisions. An HMO sued in federal district court to challenge a Texas statute on ERISA preemption grounds. The statute gives potential plaintiffs a cause of action against HMOs that do not exercise ordinary care in making their health care treatment decisions. Judge Higginbotham said the Texas law does not encompass claims based on an HMO's "denial of coverage for a medical service recommended by the treating physician: that dispute is one over coverage ...." The provision in the Texas law, however, permits "suit for claims that a treating physician was neg-

190. Herdrich v. Pegram, 154 F.3d 362, 377 (7th Cir. 1998).
191. Id. ("Medical care should not be subject to the whim of the new layer of insurance bureaucracy now dictating the most basic, as well as the important, medical policies and procedures from the boardroom.").
192. Id. at 378 (quoting Jamie Court, In Critical Condition: Holding HMOs Accountable for their Egregious Conduct, Chi. Trib., June 22, 1998, at 13).
194. 215 F.3d 526 (5th Cir. 2000).
195. Id. at 534.
196. Id. at 531.
197. Id. at 534.
198. Id.
ligent in delivering medical services, and it imposes vicarious liability on managed care entities for that negligence."\textsuperscript{199} The provision was determined to be valid and not preempted by ERISA.\textsuperscript{200} The \textit{Corporate Health Insurance} opinion conceded that a state law that regulates an HMO in its administrative capacity is preempted under ERISA.\textsuperscript{201} However, when HMOs are wearing their health care providers' hats, they are subject to traditional state regulation of the health care industry.\textsuperscript{202} The Fifth Circuit takes the position that ERISA preemption applies when a doctor is making a coverage decision under the plan.\textsuperscript{203} According to the court, however, the ERISA preemption rationale cannot insulate doctors from malpractice claims and "accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions."\textsuperscript{204} The Fifth Circuit properly concluded that Congress did not intend "for ERISA to supplant ... [a] state[’s] regulation of the quality of medical practice."\textsuperscript{205} States are only using their traditional police power in regulating the quality of health care treatment decisions.\textsuperscript{206} "A suit for medical malpractice against a doctor is not preempted by ERISA simply because those services were arranged by an HMO and paid for by an ERISA plan."\textsuperscript{207}

Congressional failure to make it completely clear that ERISA

\textsuperscript{199.} Id.

\textsuperscript{200.} Id. at 535.

\textsuperscript{201.} Id. at 534.

\textsuperscript{202.} Id.

\textsuperscript{203.} Id.

\textsuperscript{204.} Id. at 534-35.

\textsuperscript{205.} Id. at 535.

\textsuperscript{206.} \textit{Corporate Health Ins.}, 215 F.3d at 535.

\textsuperscript{207.} Id. ("Likewise, the vicarious liability of the entities for whom the doctor acted as an agent is rooted in general principles of state agency law. Seen in this light, the Act simply codifies Texas's already-existing standards regarding medical care.").
does not preempt traditional state health law claims against HMOs leaves many, including doctors, to seek a judicial solution through creative litigation. In March 2001, three state medical associations representing doctors filed a lawsuit accusing HMOs of engaging in a pattern of racketeering activity to deny necessary medical care.\footnote{See Milt Freudenheim, Doctors Insist HMOs Pay Up: Suits Cite Conspiracy to Cut Costs, Hous. Chron., Mar. 27, 2001, at A1, available at 2001 WL 3008836 (discussing the lawsuit filed by the Texas Medical Association and similar groups against eight health insurers alleging that the insurers intentionally delayed or denied payments to doctors in violation of civil racketeering and other laws).}

A representative of one of these state medical associations said "[w]e felt we had to go to the courthouse to force the companies to respect the patient-doctor relationship."\footnote{Id.}

When an HMO's conduct is a substantial factor in beneficiaries receiving substandard medical treatment, basic principles of federalism require Congress to protect the states from federal judicial encroachment created by Congress' own ambiguity with regard to ERISA's preemption intent. Either Congress or the Supreme Court should clarify that Congress did not intend for ERISA to allow HMOs to escape liability for negligent health care treatment decisions that proximately cause a plaintiff's injury. The Supreme Court should hold that HMOs might be held liable for any conduct that unreasonably interferes with the provision of medical services to an ERISA beneficiary because Congress did not intend to deny state law tort remedies to employees needing medical services. Only the Court's failure to properly understand ERISA's legislative history precludes it from finding that HMOs may be defendants for unreasonably interfering with the delivery of health care to covered employees. This congressional ambiguity demonstrates a lack of political will and is itself political negligence. Patients and doctors continue to suffer because of HMOs' preoccupation with profits. Congress must end this suffering by enacting legislation that will clearly allow states to hold HMOs accountable for substandard care under state tort law. Congress should not continue to ignore pleas from patients and doctors alike to recognize that an HMO owes a duty of reasonable care to covered beneficiaries—a duty to ensure they receive services doctors believe are medically necessary without regard to financial profit.