2001

Pegram's Regress: A Missed Chance for Sensible Judicial Review of Managed Care Decisions

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American Journal of Law & Medicine, 27 (2001): 421–438

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I. INTRODUCTION

Managed care was designed to bring stability and balance to healthcare delivery in the United States, but its experience in the legal system has involved only moderate stability and very little balance. There has been a trend toward broad deference to the industry, so that managed care organizations (MCOs) are largely immune from liability.[1] At the same time, some courts have suggested that the entire managed care model rests on sketchy legal ground.[2] Meanwhile, commentators have disagreed on such fundamental questions as whether legal disputes arising under managed care should be resolved according to contract law or tort law.[3] Moreover, the extent to which the Employee Retirement Income Security Act of 1974 (ERISA)[4] governs, or moots, patients' claims against MCOs has never been entirely clear—and

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1 *See, e.g.*, Mertens v. Hewitt Assocs., 508 U.S. 248, 260 (1993) (reading statutory provisions narrowly to allow only very limited remedies against MCOs); Reinert v. Giorgio Foods, Inc., 15 F. Supp. 2d 589, 595 (E.D. Pa. 1998) (employing very deferential review of a decision to deny benefits and an interpretation of plan terms); Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748 (S.D.N.Y. 1997). *See generally* Peter D. Jacobson & Scott D. Pomfret, *Establishing New Legal Doctrine in Managed Care: A Model of Judicial Response to Industrial Change*, 32 U. MICH. J.L. REFORM 813, 844-50 (1999) (describing courts' willingness to defer or grant immunity to MCOs in various contexts).

2 *See, e.g.*, Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 52-53 (D. Mass. 1997); Pomeroy v. Johns Hopkins Med. Servs., Inc., 868 F. Supp. 110, 116-17 (D. Md. 1994). The lower court in *Pegram* adopted such a view. *See* Herdrich v. Pegram, 154 F.3d 362, 375-78 (7th Cir. 1998), *rev'd*, 530 U.S. 211 (2000).

3 *See generally* RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (1997); CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995) (discussing the application of contract law); Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491 (1997); Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587 (1997); Peter D. Jacobson & Neena M. Patil, *Managed Care Litigation: Legal Doctrine at the Boundary of Tort and Contract*, 57 MED. CARE RES. & REV. 440 (2000) (discussing the tort-contract debate). For alternative views, see generally P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW & CONTEMP. PROBS. 287 (1986); Catherine G. McLaughlin & Paul B. Ginsburg, *Competition, Quality of Care, and the Role of the Consumer*, 76 MILBANK Q. 737 (1998).

4 29 U.S.C. §§ 1001-1461 (1994).

because ERISA controls a vast number of health insurance plans,[5] this legal issue is extremely significant.

Given this atmosphere of uncertainty and debate, many observers awaited anxiously—in every sense of that word—the Supreme Court's decision in *Pegram v. Herdrich*.[6] The plaintiff in that case, Cynthia Herdrich, had complained of abdominal pain to her physician, Lori Pegram, who practiced under Herdrich's managed care plan with Carle Clinic Association.[7] Pegram noticed a large inflammation, but instead of ordering an immediate ultrasound test at a local hospital, decided to arrange for the test to be performed eight days later at a more distant hospital overseen by Carle. In the interim, Herdrich's appendix ruptured, causing peritonitis.

Herdrich sued Carle and Pegram in state court for medical malpractice and fraud. After the defendants removed the case to federal court and successfully asserted that ERISA preempted Herdrich's fraud claims, Herdrich added a new claim *under* ERISA. She argued that she was not provided with an ultrasound diagnosis in a timely manner because the plan's financial incentives gave physicians a financial stake in limiting care, thus breaching the plan's and the physician's fiduciary duty to act in the patient's best interests. Herdrich won a jury award of $35,000 on her malpractice claims, but the district court dismissed her ERISA claim. She appealed, and the Seventh Circuit Court of Appeals reversed and remanded for trial, rejecting Carle's argument that allowing patients to challenge the use of financial incentives would destroy managed care.[8] Judge Flaum's vigorous, and rigorous, dissent[9]—and later, Judge Easterbrook's even more vehement dissent from denial of a rehearing *en banc*[10]—practically begged the Supreme Court to review and overturn the decision. The Court obliged, granting certiorari[11] and ultimately reversing the Court of Appeals.[12]

Justice Souter's opinion, written on behalf of a unanimous Court, offers preliminary discussions as to three categories of relevant background, and then analyzes the legal question before the Court. The first background discussion relates to the managed care industry. The opinion describes how managed care operates and outlines its rise as a common model for American healthcare delivery. The opinion

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5 Estimates differ as to the number of patients enrolled in MCOs governed by ERISA, but it is clear that the number is substantial. *See, e.g.*, Heather Hutchinson, *The Managed Care Plan Accountability Act*, 32 IND. L. REV. 1383, 1385 (1999) ("Today, over forty-five million Americans are enrolled in MCOs and ERISA governs the majority of those plans.") (citing Laura H. Harshbarger, Note, *ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy*, 47 SYRACUSE L. REV. 191, 192 (1996)); Joan H. Krause, *The Brief Life of the Gag Clause: Why Anti-Gag Clause Legislation Isn't Enough*, 67 TENN. L. REV. 1, 18 (1999) (referring to "the approximately fifty-one million Americans whose health plans are governed by ERISA"); John P. Little, Note, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1468 n.467 (1997) ("One hundred twenty million people are enrolled in MCOs that are covered by ERISA.") (citing Robert Pear, *H.M.O.s Using Federal Law to Deflect Malpractice Suits*, N.Y. TIMES, Nov. 17, 1996, at A24).

6 530 U.S. 211 (2000).

7 For discussion of the background facts provided in this paragraph and the following paragraph, see generally *Pegram*, 530 U.S. at 215-17 (providing a detailed description of the facts and the procedural history of the case); Herdrich v. Pegram, 154 F.3d 362, 365 n.1-367 (7th Cir. 1998) (describing the events that led Herdrich to file a suit alleging professional medical negligence).

8 *Pegram*, 154 F.3d at 380.

9 *See id.* (Flaum, J., dissenting).

10 *See* Herdrich v. Pegram, 170 F.3d 683 (7th Cir. 1999) (Easterbrook, J., dissenting from denial of rehearing *en banc*).

11 Pegram v. Herdrich, 527 U.S. 1068 (1999).

12 Pegram v. Herdrich, 530 U.S. 211 (2000).

then notes the specific nature of the Carle HMO,[13] in which Herdrich was enrolled, but finds that it would be inappropriate to make a specific judgment "purporting to draw a line between good and bad HMOs,"[14] as "courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs."[15]

The second background discussion deals with the relevant law, ERISA, as elucidated by underlying trust-law principles and as interpreted by prior Court decisions. ERISA defines "fiduciary" to include someone who acts as an administrator for a plan;[16] ERISA fiduciaries are required to act "solely in the interest of the participants and beneficiaries" of the plan.[17] The Supreme Court previously had read this language to incorporate the duties imposed on fiduciaries under the common law of trusts.[18] The *Pegram* opinion points out, however, that "Beyond the threshold statement of responsibility . . . the analogy between ERISA fiduciary and common law trustee becomes problematic."[19] The ERISA fiduciary may have a more complex relationship with beneficiaries than would a traditional trustee; for example, the fiduciary may also be the beneficiaries' employer. Partly for this reason, ERISA's "fiduciary" label does not truly relate to persons so much as to *acts*. When and "to the extent"[20] that a person engages in specified acts, such as plan administration, ERISA's fiduciary duties will apply; in other situations, they will not.

The final background discussion focuses on the nature of Herdrich's claim, which the opinion describes as "difficult to understand."[21] Herdrich did not base her claim on any specific act or decision.[22] Rather, Herdrich asserted that Carle's general incentive scheme created an inherent conflict of interest that amounted to a breach of fiduciary duty.

All this left the Court, therefore, with two questions to answer: which specific acts was Herdrich alleging to be fiduciary acts under ERISA, and was that allegation accurate? The Court characterizes the decisions in question as "mixed" decisions, involving elements of both plan administration and patient care, and concludes that "Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians."[23] The Court concludes that Pegram's decision regarding Herdrich's care was not fiduciary and therefore did not fall within ERISA's ambit; accordingly, Herdrich's claim must be rejected.

We have argued elsewhere that, as a general matter, a legal regime rooted in the concept of fiduciary duties might provide a useful model for analyzing managed care disputes.[24] In doing so, we noted, but did not explore, the possibility of reading

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13 HMO stands for "health maintenance organization," a term that refers to a type of MCO, but is often used synonymously with the term "MCO."

14 *Pegram*, 530 U.S. at 221.

15 *Id.* at 222.

16 *See* 29 U.S.C. § 1002(21)(A)(iii) (1994).

17 29 U.S.C. § 1104(a)(1) (1994).

18 *See, e.g.*, Cent. States, S.E. & S.W. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 570 (1985) ("[R]ather than explicitly enumerating *all* of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility.").

19 *Pegram*, 530 U.S. at 225.

20 29 U.S.C. § 1002(21)(A).

21 *Pegram*, 530 U.S. at 226.

22 For this reason, as the opinion notes, Herdrich's claim "could have been brought, and would have been no different, if Herdrich had never had a sick day in her life." *Id.*

23 *Id.* at 231.

24 *See* Peter D. Jacobson & Michael T. Cahill, *Applying Fiduciary Duties in the Managed Care*

ERISA to employ such a model.[25] Part II of this essay argues that a proper interpretation of ERISA does place fiduciary duties at the heart of its framework for judicial review, and that *Pegram* was therefore wrongly decided. In doing so, Part II explains the practical and conceptual difficulties that may have led the *Pegram* Court to hold as it did.

Part III discusses the negative implications of *Pegram*. Essentially, the Supreme Court missed an opportunity to enable the use of ERISA to resolve managed care's serious allocative tradeoffs using a fiduciary-duty model of the kind we have proposed. Indeed, the decision effectively eliminates the possibility that federal courts can, or will, review MCOs' decisions about such tradeoffs at all, as *Pegram* found that such decisions do not fall within ERISA.

Part IV considers what, if anything, can be done after *Pegram* to maintain a balanced and significant role for the government, specifically the courts, in overseeing MCOs' decisions. Most obviously, because *Pegram* resolved only the federal ERISA question, there remains the possibility of using substantive state law—such as state common law regarding fiduciary duties—to develop a model for sound judicial review. In fact, because ERISA's remedies are extremely limited vis-à-vis the remedies that might be available under state law,[26] it may well be more desirable for such review to develop under state law—assuming, that is, that ERISA does not preempt states' potential to develop such models. Part IV also explores other methods that might enable development of a fiduciary-duty-based model such as we have proposed.

II. PITFALLS

It is hard to argue with *Pegram*'s direct judgment rejecting Herdrich's argument on appeal. Before the Supreme Court, Herdrich put forth a claim that challenged the entire HMO structure rather than any specific decision.[27] Such a generalized allegation clearly does not make out a legitimate claim. It might make sense to argue that a particular decision reflected unlawful disloyalty or lack of care, but Herdrich's claim would require a determination that *any* mixed decision under Carle's scheme was a breach of fiduciary duty *per se*. Under such a broad rule, any decision to deny, delay or limit care—even if completely medically justified—would potentially subject a physician or plan to liability.[28]

Although the *Pegram* Court quite possibly reached the right final disposition—a

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Context, 26 AM. J.L. & MED. 155 (2000).

25 *See id.* at 163 ("To date, courts have not defined the meaning of ERISA's fiduciary duty provision."); *id.* at 171 ("[The Jacobson & Cahill model] may usefully describe the proper implications of ERISA's undefined imposition of a fiduciary role on plan administrators.").

26 Recovery under ERISA is usually limited to restoring the dollar value of the benefits denied under the plan—say, the actual price of a procedure that a patient did not receive—whereas state-law tort damages may include awards for various costs and damages resulting from the patient's failure to obtain care in a timely fashion. *See, e.g.*, Arnold J. Rosoff, *Breach of Fiduciary Duty Lawsuits Against MCOs: What's Left After Pegram v. Herdrich?*, 22 J. LEGAL MED. 55, 61-62 (2001).

27 *See Pegram*, 530 U.S. at 232 ("First, we need to ask how this fiduciary standard would affect HMOs if it applied as Herdrich claims it should be applied, not directed against any particular mixed decision that injured a patient, but against HMOs that make mixed decisions in the course of providing medical care for profit.").

28 This is one of the central problems with the myriad class-action lawsuits now being filed against the managed care industry. Some of these suits, such as *Maio v. Aetna, Inc.*, 221 F.3d 472 (3d Cir. 2000), generally allege fraud in the operation of managed care without providing specific instances of how the fraud actually undermines healthcare delivery. Courts have not been amenable to allowing such unspecified challenges to proceed. *See id.* (affirming dismissal of complaint).

reversal of the Seventh Circuit's holding in Herdrich's favor—various aspects of its underlying reasoning are questionable. Section II.A contends that the Court failed to apply ERISA's own definition of what decisions are fiduciary in nature. Instead, the Court looked beyond ERISA to general trust-law principles, doing so in a way that contravened both ERISA and a previous Court decision. Section II.B argues that, although the facts may support the ultimate judgment in *Pegram*, the Court went further than was necessary to reach that result, thereby—perhaps inadvertently—addressing important but peripheral issues without exploring their implications fully.

A. WHAT ACTS ARE FIDUCIARY? NEGLECTING ERISA AND *VARITY*

Normally, the law imposes fiduciary duties on certain *actors* who stand in a particular relation to someone else. For example, agents have a fiduciary duty to their principals,[29] and lawyers have a fiduciary duty to their clients.[30] But as noted above, because ERISA plan administrators sometimes have complicated relationships with plan participants, some aspects of which do not entail fiduciary obligations, ERISA imposes fiduciary duties on the performance of certain enumerated *actions*. Specifically, ERISA says that acts are fiduciary when they involve exercise of "discretionary authority or discretionary responsibility in the administration of a plan."[31]

Accordingly, in *Pegram*, the Court correctly noted that the first step in addressing Herdrich's claim for breach of fiduciary duty was to decide whether the acts she challenged were subject to ERISA's fiduciary rules in the first place. In ascertaining which managed care decisions should be considered fiduciary for ERISA purposes, the Court first drew a distinction between two types of decisions that managed care entities must routinely make:

> What we will call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?[32]

The Court then noted, correctly, that "[t]hese decisions are often practically inextricable from one another,"[33] so nearly all actual decisions that MCOs make are "mixed decisions" implicating both the administrative and medical functions of the MCO.[34]

Pegram concludes that when an MCO or its agent makes a decision that involves both administration of the ERISA benefits plan and the proper course of medical treatment—a so-called "mixed decision"—that MCO or agent is not acting as a fiduciary. The *Pegram* opinion strongly suggests that only "pure eligibility determinations" can be challenged for fiduciary breach under ERISA.[35]

Under the ERISA definition quoted above, however, pure eligibility decisions often do *not* implicate a fiduciary duty, because they do not involve any genuine

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29 RESTATEMENT (THIRD) OF AGENCY § 1.01 (Tentative Draft No. 2, 2001).

30 RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 16 (1998).

31 29 U.S.C. § 1002(21)(A)(iii).

32 *Pegram*, 530 U.S. at 228.

33 *Id.* at 228.

34 *See id.* at 228-29.

35 *See id.* at 230-31.

discretion. Pure eligibility decisions, as defined by *Pegram*, involve examination of the terms of the contract itself, and an administrator has no "discretion" to interpret those terms when their meaning is plain,[36] even if the plan itself gives the fiduciary "discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[37] That is to say, the courts would not, and should not, treat an arguably "reasonable" decision that conflicted with the plan's plain terms as a "discretionary" matter entitled to deference upon review.[38]

In nearly every case involving a true exercise of discretion, a figure with authority is reacting to a particular situation and making a decision based on the circumstances. It is in such situations that the decision maker will be forced to apply and interpret those terms of the plan having an ambiguous or uncertain meaning. For example, many ERISA plans purport to cover all "medically necessary" care. This

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[36] Even under a deferential "arbitrary and capricious" standard of review, courts will not allow an administrator to violate a plan's plain terms. *See, e.g.*, Yochum v. Barnett Banks, Inc. Severance Pay Plan, 234 F.3d 541, 547 (11th Cir. 2000) ("The denial of Yochum's claim based on false and incomplete information was arbitrary and capricious, in that the plain language of the [p]lan and the [a]greement were violated."); Swaback v. Am. Info. Techs. Corp., 103 F.3d 535, 540 n.9 (7th Cir. 1996) ("We previously have concluded that, if fiduciaries or administrators of an ERISA plan controvert the plain meaning of a plan, their actions are arbitrary and capricious."). Accordingly, where the plan's plain language makes clear the proper decision, the standard of review becomes immaterial. *See* Davolt v. Executive Comm. of O'Reilly Auto., 206 F.3d 806, 809-10 (8th Cir. 2000) (holding that plan administrator properly denied coverage under plan's plain language regardless of whether decision was reviewed *de novo* or according to "sliding scale"); Dunnigan v. Metro. Life Ins. Co., 99 F. Supp. 2d 307, 316 (S.D.N.Y. 2000) ("In light of *Bruch*, it is likely that the deferential arbitrary and capricious standard of review is applicable here. However, I decline to reach this issue because under either standard—arbitrary and capricious or *de novo*—plaintiff is not entitled to interest on delayed benefits under the plain and unambiguous terms of the Plan."). *See also* Anderson v. Trumbull-Mahoning Med. Group, Inc., No. 99-3510, 2000 WL 331943, at *2 (6th Cir. Mar. 22, 2000).

> By now, the principle is well-established that "a denial of benefits challenged under [ERISA] is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority. . . ." In this case, however, we, like the district court, find it immaterial whether we examine the plan's benefit determination under the *de novo* or under the arbitrary and capricious standard because we are convinced that the plain, unambiguous language of the policy supports the conclusion reached by [the insurer].

Id. (internal citations omitted).

[37] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). Without such explicit authorization, the fiduciary would have *no* "discretion" to interpret the plan's terms, as a reviewing court would examine the interpretive question *de novo*:

> Firestone argues that as a matter of trust law the interpretation of the terms of a plan is an inherently discretionary function. But other settled principles of trust law, which point to *de novo* review of benefit eligibility determinations based on plan interpretations, belie this contention. As they do with contractual provisions, courts construe terms in trust agreements without deferring to either party's interpretation.

Id. at 112.

[38] *See, e.g.*, Jenkins v. Montgomery Indus., Inc., 77 F.3d 740, 743 (4th Cir. 1996) ("Federal courts interpret ERISA regulated benefit plans without deferring to either party's interpretation, by 'using ordinary principles of contract law and enforcing the plan's plain language in its ordinary sense.'") (internal citations omitted) (quoting Bailey v. Blue Cross & Blue Shield of Va., 67 F.3d 53, 57 (4th Cir. 1995)); Kiefer v. Ceridian Corp., 976 F. Supp. 829, 848 (D. Minn. 1997) ("Because the administrator acted contrary to the plain meaning of the unambiguous language of the Plan, this Court will not defer to the administrator's interpretation."); Sigmund Cohn Corp. v. Dist. No. 15 Machinists Pension Fund, 804 F. Supp. 490, 494 (E.D.N.Y. 1992) ("Although a fund's interpretation of its own pension agreement deserves some deference, such construction must abide by the plain meaning of the plan's terms. An application of the plan's provisions that conflicts with its unambiguous meaning must be considered unreasonable and not entitled to any deference.") (citation omitted); *cf.* Sim v. N.Y. Mailers' Union No. 6, 166 F.3d 465, 470 (2d Cir. 1999) (noting that great deference ordinarily is given to unions' interpretations of their own constitutions, but pointing out that "courts will ignore interpretations made by union officials which run adverse to the plain meaning of contract language").

phrase certainly is ambiguous, but administrators are forced to resolve the ambiguity only when confronted with a *specific* case, so that their reading of the phrase will necessarily implicate a particular patient's course of treatment and will therefore be a "mixed" decision. Plan physicians do not sit around asking themselves whether, in the abstract, it is "medically necessary" to perform appendectomies within twenty-four hours of identifying an inflamed appendix. Rather, they confront questions such as, "Given what I know about Cynthia Herdrich and her condition, is it acceptable to wait eight days before operating?" To say that only the former question leads to a fiduciary decision reduces the reach of ERISA's fiduciary obligations to the point of trivialization.

Thus, in the managed care context, legitimately discretionary decisions will always, or very nearly always, resolve "mixed" questions, and therefore will *not* be fiduciary decisions under the *Pegram* analysis. Under the clear language of ERISA, then, the Court's analysis of "mixed" versus "pure" questions as they implicate fiduciary duties is questionable, because it defines many non-discretionary decisions as fiduciary, and many discretionary decisions as non-fiduciary.

The Court's position in response to this argument would appear to be that ERISA duties apply only to discretion exercised in "the administration of a plan," and that mixed decisions do not involve administration. But that argument begs the question. The entire issue here is which decisions involve "discretion in the administration of a plan" and which do not. We maintain that mixed decisions involve both "discretion" and "the administration of a plan"—by definition, the decisions "mix" treatment and administration—and therefore fit squarely within ERISA's definition of fiduciary acts.

The Court sidestepped that question of statutory analysis, however. The decision quoted the ERISA definition,[39] but then failed to apply it. Instead, the *Pegram* Court looked to general principles of trust law to define what acts are fiduciary.[40] This would appear to make sense because, as previous Supreme Court ERISA cases have pointed out, ERISA relies on the backdrop of preexisting trust law to explain the meaning of the otherwise undefined term "fiduciary."[41] But those previous decisions—with one notable exception—used trust law to define the nature of the *duties* that attach to fiduciary acts, not to define those acts themselves.[42]

The exception was *Varity Corp. v. Howe*,[43] and the differences between the Court's approach in that case and in *Pegram* are striking.[44] *Varity*'s analysis turns

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39 *Pegram*, 530 U.S. at 222-23.

40 *Id.* at 224-25.

41 *See, e.g., id.* at 224 (citing Cent. States, S.E. & S.W. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 570 (1985)); Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110-11 (1989).

42 *See Cent. States*, 472 U.S. at 570 ("[R]ather than explicitly enumerating *all* of the *powers and duties* of trustees and other fiduciaries, Congress invoked the common law of trusts to define *the general scope of their authority and responsibility*.") (second and third set of emphases added).

43 516 U.S. 489 (1996).

44 Arguably, even *Varity*'s reading of what acts are fiduciary under ERISA was overly narrow because like *Pegram*, *Varity* treated the terms "fiduciary" and "trustee" as coextensive for ERISA purposes. *See id.* It is true that all trustees are fiduciaries. *See* RESTATEMENT (THIRD) OF TRUSTS § 2 (Tentative Draft No. 1, 1996) (defining "trust" as a fiduciary relationship). For this reason, the Court's earlier cases were correct in finding it useful to look to trust law for descriptions of the duties to which a trustee is subject. However, not all fiduciaries are trustees; the law defines various relationships as "fiduciary" in nature. *See* Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1046 (1991) ("Familiar forms of fiduciary relationships include trustee-beneficiary, agent-principal, corporate director/officer-corporation, and partner-partnership, although courts have emphasized that these categories are not exclusive."). For example, attorneys have fiduciary duties to their clients, and agents have fiduciary

first to the "statutory definition of 'fiduciary' acts,"[45] and then employs trust law to explicate the meaning of the specific term "administration." *Varity* does not catalogue specific trustee acts that constitute "administration," but defines the term generally and broadly to include the exercise of "such powers as are necessary or appropriate for the carrying out of the purposes" of a trust or plan:[46]

> There is more to plan (or trust) administration than simply complying with the specific duties imposed by the plan documents or statutory regime; it also includes the activities that are "ordinary and natural means" of achieving the "objective" of the plan. . . . Indeed, the primary function of the fiduciary duty is to constrain the exercise of *discretionary* powers which are controlled by no other specific duty imposed by the trust instrument or the legal regime. If the fiduciary duty applied to nothing more than activities already controlled by other specific legal duties, it would serve no purpose.[47]

However one defines the "objective" of an ERISA healthcare plan—providing quality care, controlling costs or even merely ensuring that the plan's terms are implemented effectively and fairly—mixed eligibility-treatment decisions have a profound effect on whether that objective is achieved. *Varity*, then, seems to suggest that mixed decisions involve "administration" of a plan and are therefore fiduciary acts under ERISA.

Pegram, however, does not take the view suggested by *Varity*. In fact, its discussion of whether mixed decisions are fiduciary under ERISA does not even cite *Varity*. Instead, *Pegram* considers the fiduciary-act issue by asking what trustees generally do in the course of their "usual business"—a seemingly broad and inclusive inquiry, except that the *Pegram* opinion's analysis proceeds by listing particular things that trustees do, and contrasting those things with MCO physicians' mixed decisions.[48] *Pegram* concludes that mixed decisions have "only a limited resemblance to the business of traditional trustees," and thus are not fiduciary under ERISA.[49] The Court points out two specific differences between trustees and physicians making mixed decisions.

First, "[t]raditional trustees administer a medical trust by paying out money to buy medical care, whereas physicians making mixed eligibility decisions consume the money as well."[50] This analysis, though, focuses only on the treatment aspect of the decision, under which the physician receives the plans' funds, and wholly ignores

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duties to their principals. *See* RESTATEMENT (THIRD) OF AGENCY § 1.01 (Tentative Draft No. 2, 2000) (defining agency as a fiduciary relationship); RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 16 cmt. b (1998) (describing lawyer as a fiduciary and specifying duties of a lawyer to a client); RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 49 (1998) (discussing client's cause of action against lawyer for breach of fiduciary duty). The conduct of such other fiduciaries in the fulfillment of their duties may vary greatly from the acts trustees perform on behalf of their beneficiaries. For this reason, it is incorrect to define the universe of fiduciary acts by looking only to things a trustee does or may do, while ignoring the fiduciary activities of, say, lawyers or agents—or doctors.

45 *Varity*, 516 U.S. at 502.

46 *Id.* (quoting 3 AUSTIN W. SCOTT & WILLIAM F. FRATCHER, THE LAW OF TRUSTS § 186, at 6 (4th ed. 1988)).

47 *Id.* at 504 (quoting GEORGE G. BOGERT & GEORGE T. BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 551 at 41-52 (rev. 2d ed. 1992)).

48 *Pegram*, 530 U.S. at 231-32.

49 *Id.* at 231.

50 *Id.* at 231-32.

the administrative aspect of the decision, under which the physician—or, quite possibly, a separate MCO administrator—is deciding whether and how to spend the plan's funds, perhaps with an eye toward her own stake in any unused funds. It also reflects a potentially mistaken equation of "fiduciaries" and "trustees."[51] Other, non-trustee fiduciaries, such as corporate officers and directors, or attorneys pursuing litigation on a contingency basis, commonly have a significant stake in the assets they oversee.

The second difference is that "[p]rivate trustees do not make treatment judgments, whereas treatment judgments are what physicians reaching mixed decisions do make, by definition."[52] Actually, mixed decisions are only "treatment judgments" by *half* of the definition. The other half of the definition holds that administrative judgments are involved as well; that, after all, is why the decisions are mixed. As with the first example, the distinction recognized here only holds true if one devotes attention purely to the medical aspects of the decision and neglects the administrative aspects, which are the very aspects that potentially bring the decision within the purview of ERISA.

B. A BLINKERED VIEW OF THE POSSIBILITIES

As presented to the Supreme Court, *Pegram* was an easy case;[53] and sure enough, the Court ultimately issued a unanimous decision with no separate opinions. Unfortunately, the *Pegram* opinion did not limit its holding or reasoning to the case at hand, but went further than was necessary or desirable. The opinion's central argument in rejecting Herdrich's claim is that allowing such a claim would amount to a *de facto* declaration that the entire managed care system is legally suspect.[54] But the opinion also moves beyond this basic point to address the possibility of using fiduciary duties for review of specific acts, and in addressing that possibility, it goes awry.

The opinion reflects an overly simplistic view of the possible forms of review that a court might use to assess a fiduciary's decisions. The opinion uncritically repeats the notion that review of mixed decisions would require a *per se* rule that any "mixed decision"—any decision implicating both patients' medical needs and the plan's financial administration—constitutes a violation of fiduciary duty.[55] The only other recognized possibility is that review of fiduciary decisions would simply devolve into the usual tort-law standard of care.[56] But, as we have contended elsewhere,[57] other superior methods for review of managed care decisions for breach of fiduciary duty are available.

In our view, an effective system of oversight would have two features. First, it would involve a review of the procedures and history underlying the decision, as opposed to its objective substantive merit. Second, it would engage in a substantive

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51 *See* sources cited *supra* note 44.

52 *See Pegram*, 530 U.S. at 232.

53 *See supra* text accompanying notes 27-28.

54 *See Pegram*, 530 U.S. at 233 ("[Herdrich's] remedy in effect would be nothing less than elimination of the for-profit HMO.").

55 *See id.* at 234 ("Nor would it be possible to translate fiduciary duty into a standard that would allow recovery from an HMO whenever a mixed decision influenced by the HMO's financial incentive resulted in a bad outcome for the patient.").

56 *See id.* at 235 ("Thus, for all practical purposes, 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.").

57 *See generally* Jacobson & Cahill, *supra* note 24.

review of the medical basis for the decision. This review, however, would differ from the standard tort-law inquiry in two ways: it would seek a "medical basis" that considers the decision's consequences for the overall *population*, not just the individual *patient*; and, so long as the decision making process survived the procedural scrutiny of the first layer of review, it would employ a deferential standard of review.

Such a system represents a logical and practical middle-ground position between the *Pegram* rule—*per se* rejection of all mixed-question claims—and the strawman alternative the Court identified—*per se* victory for plaintiff on all mixed-decision claims. At the same time, this method of review would not amount to a mere replication of state law with no real meaning other than conferring federal-question jurisdiction to tort plaintiffs.[58] Properly understood, fiduciary-duty analysis poses questions (e.g., Was the decision making process fair and reasonable? Did the fiduciary legitimately balance the individual against the population, instead of sacrificing care in the name of cost reduction?) that differ significantly from tort law's substantive, objective question about the quality of care (i.e., Was this care reasonable, or not?).[59] Unlike the abdication of judicial authority reflected in *Pegram*, the model we propose maintains a distinct role for the courts in overseeing the complex legal judgments and ethical tradeoffs involved in allocating medical treatment to a general population, as opposed to determining the course of treatment for a single patient.

Our model, therefore, would not amount to a mere replication of existing tort remedies. Instead, it would apply in different circumstances, sometimes denying recovery where malpractice law would grant it, other times, the reverse.[60] In addition, and perhaps more importantly, the model's focus on implementing a sound process for decision making at the MCO level might obviate the need for litigation in many cases.

III. PROBLEMS

Pegram's influence will likely be far-reaching. ERISA governs an enormous number of persons enrolled in MCOs and thus, an enormous number of potential patient claims against those MCOs.[61] Therefore, *Pegram* is sure to have an immense impact on healthcare litigation. In this Part, we discuss what that impact will be, why it is problematic from a practical standpoint, and why an alternative approach would have been better. Section III.A elaborates *Pegram*'s likely consequences and their potential harms. We contend that *Pegram* abrogates an important sphere of judicial

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58 *See Pegram*, 530 U.S. at 235 ("[T]he formulaic addition of an allegation of financial incentive would do nothing but bring the same [state-law malpractice] claim into a federal court under federal-question jurisdiction.").

59 *See also infra* note 72 and accompanying text (noting distinction between reach of causes of action for malpractice and breach of fiduciary duty).

60 Nor would our model supplant existing remedies; rather, it would complement them so that a plaintiff might pursue both a malpractice claim and a claim for breach of fiduciary duty under certain circumstances. Further, our reading of ERISA to allow a claim for breach of fiduciary duty would not automatically entail the conclusion that ERISA preempts similar state-law claims. Plaintiffs might be able, under our view, to bring such claims under both ERISA and state law. *Cf.* Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 833 (1988) (noting that both ERISA claims and state-law claims may be brought against ERISA plans); LeBlanc v. Cahill, 153 F.3d 134, 147 (4th Cir. 1998) (allowing plaintiff to bring ERISA claim and holding that state-law fraud claim based on same alleged misconduct is not preempted).

61 *See supra* note 5 (demonstrating the breadth of ERISA's coverage).

authority and will force courts, to the extent they retain authority to hear these cases, to resolve them using the blunt instruments of state tort law and existing ERISA law. Section III.B discusses the benefits of the position *Pegram* could have taken, but did not.

A. LIKELY EFFECTS AND THEIR DIFFICULTIES

The *Pegram* Court was right, we believe, to conclude that MCOs' decisions should be entitled to judicial deference.[62] As with initial agency decisions in the administrative law context,[63] deference devolves responsibility for difficult, fact-intensive decisions to those who have the expertise to make such decisions. This does not mean, though, that judicial review of MCO fiduciaries' mixed decisions should be eliminated altogether. Retention of a limited oversight role for the courts will ensure neutral review of major legal issues and, perhaps as important, will give the initial decision makers an incentive to generate a thorough record to justify their decisions, thus ensuring that they will be upheld on review.

As is often the case in determining the proper role for the courts in overseeing complex commercial activity, a balance must be struck. The *Pegram* Court, however, effectively eviscerated the possibility of serious judicial review of MCOs' decisions. The Court disavowed any judicial role in making assessments about inequalities in the distribution or quality of healthcare, on the grounds that such issues require expertise the courts lack and that they are properly addressed by Congress:

> [A]ny legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk. A valid conclusion of this sort would, however, necessarily turn on facts to which courts would probably not have ready access. . . . But such complicated factfinding and such a debatable social judgment are not wisely required of courts unless for some reason resort cannot be had to the legislative process, with its preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health care expenditure. . . . The very difficulty of these policy considerations, and Congress' superior institutional competence to pursue this debate, suggest that legislative not judicial solutions are preferable.[64]

The Court's strong deference to Congress sends an unmistakable signal that it does not view its mandate as alleviating market deficiencies or inequalities.

One of the most troubling aspects of *Pegram* is that the Court went further than necessary to resolve the case. The Court easily could—and should—have retained an institutional oversight role to ensure that incentives operate fairly. Because *Pegram* instead found institutional justifications to avoid such a role, it will henceforth be difficult, if not impossible, to convince the judiciary that its excessive reliance on institutional reasons to ignore policy issues leaves patients vulnerable and inequalities festering.

A second problem relates to an underlying tension that may generate difficulties

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62 *See supra* note 15 and accompanying text (noting the Supreme Court's recognition that the judiciary is not institutionally competent to evaluate the quality of HMOs).

63 *See generally* AM. JUR. 2D *Administrative Law* § 85 (1994) (stating that deference should generally be accorded to administrative agency interpretation).

64 *Pegram*, 530 U.S. at 221-22 (internal quotations and citations omitted).

for all healthcare recipients. In effectively granting blanket immunity, at least under ERISA, to physicians' mixed decisions, *Pegram* skirts profound questions about physicians' divided loyalties in the era of managed care. By treating physicians' incentives to contain costs as problematic only insofar as they have an undesirable impact on overall levels of care, the Court failed to address the additional quality-of-care costs imposed by the conflicts of interest[65] and loyalty[66] such incentives create. Even setting aside any potential concerns about a physician's direct financial stake in treatment decisions, managed care inevitably demands allocative tradeoffs between caring for an individual patient and preserving resources for other patients that poorly comport with the medical norm of undivided concern for each patient's regard. A given patient's recognition of these pressures may lead her to believe that her doctor's decision to limit or withhold care stems from a subjugation of her best interests in favor of others, undermining the trust a healthy doctor-patient relationship requires.[67]

Apparently, the Court wanted to escape the complicated task of drawing lines between acceptable and unacceptable incentive schemes. But at the very least, courts can and do regularly draw clear lines to prohibit conduct that is obviously beyond the pale, even if they wish to avoid more sophisticated and fact-intensive analysis of closer cases. It is part of a court's traditional function to correct for market imperfections by defining fiduciary duties to curb betrayals of trust.[68] Despite physicians' own best efforts, pressures to curb costs may lead to erosion of their professional norm of loyalty to individual patients, making it possible that doctors' undivided loyalty will become a commodity only the wealthy can afford.[69]

B. THE COURT'S MISSED OPPORTUNITY

We consider it unfortunate that the Supreme Court did not take a more nuanced approach in *Pegram*. The Court should have made fiduciary duties the hallmark of judicial scrutiny under ERISA, and thus, effectively, of any federal judicial scrutiny of managed care decisions. A fiduciary-duty model of reviewing managed care decisions would have several desirable features.[70]

First, the concept of fiduciary duty is not a novel means of making legal

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65 *See* Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604, 605 (1995) (stating that under managed care, physicians have an incentive to reduce services even when it is in the patient's best interest to receive them and the physicians' responsibility as fiduciaries to provide them).

66 *See* M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268, 269 (1999) (noting that physicians owe their patients a duty of loyalty and advocacy when insurers try to avoid paying for care that physicians deem necessary).

67 As one of the present authors has written:

> To the extent that patient trust and professional trustworthiness matter—because they encourage patients to reveal diagnostically useful information, cooperate with recommended treatment, and take comfort from clinical explanations and personal engagement with caretakers—conflicts of interest and loyalty undermine the efficacy and humanity of medicine. At best, patients forewarned about their doctors' double agendas will be more wary about intimate disclosure, following advice, and taking comfort. At worst, patients who put faith in their physicians' undivided loyalty risk intimate betrayal.

M. Gregg Bloche & Peter D. Jacobson, *The Supreme Court and Bedside Rationing*, 284 JAMA 2776, 2778 (2000).

68 *See* Cooter & Freedman, *supra* note 44, at 1046 (noting that "courts have emphasized that [the standard fiduciary] categories are not exclusive").

69 *See* Bloche & Jacobson, *supra* note 67, at 2779.

70 For a more thorough discussion of the benefits of this approach, see Jacobson & Cahill, *supra* note 24, at 170-72.

determinations, but an existing concept with a substantial history. The courts can implement this concept easily and, in doing so, will be rooted in a traditional understanding of the courts' role in monitoring commercial relations. This historical pedigree, which the Supreme Court traditionally has recognized in using common-law trust principles to read ERISA, would ensure some stability in the courts' decisions from the start and facilitate the development of stable doctrines over time. Even so, developing rules through case law would also enable more flexibility in responding to changing circumstances than might exist under a more rigid and precisely defined statutory scheme. In short, such a model preserves an appropriate oversight role for the courts.

At the same time, our model vests initial decision making authority, and especially the power to create and evaluate a factual record, in a party with expertise in the area. In addition, disputes among the parties could be resolved in the first instance within the managed care system itself. This would reduce litigation and create the potential to re-establish relationships of trust between all the parties, and focus on the ethical foundations of physicians' and institutions' fiduciary duties to individual patients.[71] A remedy based on fiduciary duty recognizes the fact that traditional malpractice principles fit uneasily with the managed care regime, in which decisions affecting the course of treatment are frequently made by someone other than the bedside physician.[72] The concept of fiduciary duty, though also rooted in longstanding tradition, applies more readily to the current realities of healthcare delivery.

The dissent in the recent New York case of *Batas v. Prudential Insurance Co.*[73] recognized the inadequacy of existing state-law remedies. The plaintiffs sought their insurers' approval for extended hospitalization beyond the automatic coverage period under their respective plans: for Musette Batas, so that the severe intestinal swelling caused by her chronic condition could be monitored; for Nancy Vogel, so that she could be observed following a difficult abdominal hysterectomy to remove two large tumors. Both were denied coverage on the ground that further hospitalization was not "medically necessary." Later, Batas was rushed to the emergency room, at which time her doctor requested "pre-authorization" for exploratory surgery. The insurer "pre-authorized" the surgery five days later—two days after Batas' intestine had burst, necessitating surgery to remove part of her colon. Following the surgery, Batas was again discharged, despite her physician's protests, on the ground that further hospitalization was not "medically necessary."

Batas and Vogel sued their health plans, alleging, among other things, that their MCOs' failure to disclose the standards by which they made determinations of medical necessity was a breach of fiduciary duty.[74] In a 3-2 decision, the Appellate Division affirmed the trial court's dismissal of the fiduciary duty claim. The court held that the plaintiffs failed to state a cause of action on this ground.[75]

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71 *See* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL., POL'Y & L. 661 (1998); Bloche, *supra* note 66, at 272 (discussing mediation principles that focus on patient trust).

72 *See* Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After* Pegram v. Herdrich*: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 40-44 (2001) (discussing significant treatment decisions made by MCO medical directors and the difficulty of contesting such decisions via traditional malpractice theories).

73 724 N.Y.S.2d 3 (App. Div. 2001).

74 *See id.* at 14 (Saxe, J., dissenting in part) (stating that plaintiffs' claims arise from a failure to disclose "important characteristics of the plan").

75 *See id.* at 5.

The dissent, however, argued in favor of recognizing a state-law action for breach of fiduciary duty. Judge Saxe, joined by Judge Wallach, noted that other states allow similar tort claims by insureds against insurers, usually framing the tort as "bad faith" or "breach of the implied covenant of good faith and fair dealing."[76] The dissenters recognized that New York's similar tort claim was narrowly defined, but noted their frustration with this fact:

> What is needed is a cause of action permitting an appropriate remedy when an insurer acts in bad faith in denying its own insured benefits provided for by the policy. This deficiency could be rectified by adopting the approach of numerous other States, under which a health insurer's obligations to provide promised benefits constitute a tort duty, which would allow for a corresponding tort remedy.[77]

The dissent argued that such a tort duty could be framed as a fiduciary duty, pointing out that the insurance relationship is often described as fiduciary or quasi-fiduciary in character,[78] and noting that even *Pegram* admitted the possibility of a breach-of-fiduciary-duty suit for failure to disclose characteristics of a plan.[79] The dissent concluded that "[w]hen we consider the nature of the health insurance industry, it becomes apparent that medical insurers, even more than most, should be held to a special standard of conduct toward their policyholders, beyond that required of parties to an ordinary, commercial contract."[80]

We argue that such a "standard of conduct"—whether formally styled as a "duty of good faith and fair dealing" or as a fiduciary duty—should exist, and its contours should be defined by reference to the model we have elaborated. *Pegram* was a missed opportunity to impose such a model using ERISA's statutory scheme and its fiduciary duties. Other opportunities, however, still remain.

IV. PROSPECTS

Pegram is a major decision, but it need not be the last word. We believe there are three possible avenues of attack by which a sound means of judicial review, focusing on the concept of fiduciary duty, might develop in the wake of *Pegram*: through the courts, through legislative action or through private arrangement.

A. JUDICIAL ALTERNATIVES

The first possibility is that subsequent court decisions—prompted, perhaps, by effective advocacy on the part of plaintiffs' lawyers—may read *Pegram* narrowly, thereby limiting its scope. We think there is one obvious, and possibly viable, argument that litigating plaintiffs could make to "get around" *Pegram* and pursue an action under ERISA.[81] The Court's opinion sometimes suggests that it is to apply

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76 *Id.* at 11-12 (Saxe, J., dissenting in part) (citing statutes and cases from California, Rhode Island, Wisconsin, Arkansas, Oklahoma, Florida and Pennsylvania).

77 *Id.* at 12-13 (Saxe, J., dissenting in part).

78 *See id.* at 13 (Saxe, J., dissenting in part) (citing, *inter alia*, LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE 3D § 198:7, at 198–14 (1997), and 7C JOHN A. APPLEMAN, INSURANCE LAW AND PRACTICE § 4711 at 378, § 4712 at 448 (Walter F. Berdal rev. ed. 1979)).

79 *See id.* at 14 (Saxe, J., dissenting in part) (quoting *Pegram*, 530 U.S. at 227 n.8).

80 *Id.* at 15 (Saxe, J., dissenting in part).

81 Also possible, but less viable, is the argument that *Pegram* should be limited to its facts, as a case involving only a blanket challenge to an alleged "inherent" breach of fiduciary duty, rather than a

only to mixed decisions by physicians themselves. This leaves open the position that the mixed decisions of non-physician plan administrators fall outside *Pegram* and may be subject to a viable ERISA claim for breach of fiduciary duty.

Another judicial avenue of attack is the pursuit of breach-of-fiduciary-duty suits under *state* law. This seems a more likely alternative and, as noted above, would remain a desirable and important development even if *Pegram* had recognized an ERISA claim, because state law is considerably more generous with its remedies. As an example of the possibility of such an approach, we note the dissent in the *Batas* case, which mapped out one version of a viable tort claim for fiduciary breach.[82] We maintain that state courts can, and should, review MCOs' decisions using the concept of fiduciary duty, and that such an approach should proceed according to the model we have outlined.

One complication, however, is that both federal and state courts have been divided as to whether *Pegram* affects the availability of state-law remedies in addition to denying a remedy under ERISA. The question is whether ERISA not only denies plaintiffs a federal claim for breach of fiduciary duty, but also preempts any similar potential state-law claim. The Pennsylvania Supreme Court, in a case remanded by the U.S. Supreme Court for reconsideration in light of *Pegram*,[83] has concluded that *Pegram*, in denying authority under ERISA to challenge "mixed" decisions, also dictates—at least tacitly, in combination with prior Supreme Court cases—that ERISA does not preempt any such challenges under state law.[84] Some commentators agree.[85] The Court of Appeals for the Fifth Circuit, however, has refused to "read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment."[86] No court or commentator has yet expressed the view that, under *Pegram*, state law claims challenging mixed decisions *are* categorically preempted by ERISA.[87] The issue remains unresolved and requires, and surely shall receive, further examination

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challenge to specific treatment decisions. This argument is, to say the least, a stretch, as it seems clear that the Court's opinion aims to deal comprehensively with the treatment of mixed decisions by physicians (and possibly others) under ERISA.

82 *See Batas*, 724 N.Y.S.2d at 8-16 (Saxe, J., dissenting in part).

83 *See* Pappas v. Asbel, 724 A.2d 889 (Pa. 1998), *vacated by* United States Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co., 530 U.S. 1241, 1241 (2000), *remanded sub nom.* Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001) (reconsidering case in light of *Pegram*).

84 *See* Pappas v. Asbel, 768 A.2d 1089, 1095 (Pa. 2001) ("*Pegram* instructs that an HMO's mixed . . . decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. Thus, if [a third party claim arises] out of a mixed decision, it is, according to *Pegram*, subject to state medical malpractice law. . . . Moreover . . . it is not preempted by ERISA.").

85 *See, e.g.*, McLean & Richards, *supra* note 72, at 4 ("It is the premise of this Article that in its holding, the *Pegram* Court also removed the preemption bar to state law claims for medical malpractice and breach of state fiduciary law. Paradoxically then, although the defendant HMO in *Pegram* won, the managed care industry lost.").

86 *See* Corp. Health Ins., Inc. v. Tex. Dept. of Ins., 220 F.3d 641, 643 (5th Cir. 2000); *see also* Schusteric v. United Healthcare Ins. Co. of Ill., No. 00-C-4156, 2000 WL 1263581, at *2 (N.D. Ill. Sept. 5, 2000) ("*Pegram*'s discussion of whether the plaintiff could state a claim for breach of fiduciary duty under ERISA § 1109 says nothing about whether a negligence claim of the type alleged in this case is completely preempted by § 502(a) [of ERISA, 29 U.S.C. § 1132(a)]."); *cf. Pappas*, 768 A.2d at 1097 (Saylor, J., dissenting) ("I agree with the majority that nothing in *Pegram II* requires a full reversal of its prior disposition [allowing a state-law claim to go forward].").

87 *But cf. Corporate Health Ins.*, 220 F.3d at 643 n.6 ("It may be that state causes of action persist [after *Pegram*] only for actions based in some part on malpractice committed by treating physicians. If so, state causes of actions against HMOs for the decisions of their utilization review agents would still be preempted . . ."); *Pappas*, 768 A.2d at 1096 n.7 (characterizing dissent of Saylor, J., as arguing that "ERISA invariably preempts a state law claim for medical malpractice arising out of an HMO's mixed eligibility and treatment decision").

in the courts.

B. LEGISLATIVE ALTERNATIVES

A second possibility is for legislative action to trump the effect of *Pegram*.[88] This would most likely require congressional action, which might take one of two forms. Congress could revise ERISA outright to make clear that mixed determinations should be treated as fiduciary decisions. Alternatively, through a "patient's bill of rights" or similar legislation, Congress could independently create restrictions or impose duties that would give patients a cause of action for breach of fiduciary duty.[89]

State legislatures may also enact statutes offering plan participants more extensive protection than ERISA affords.[90] Again, however, the authority of states to do so is unresolved. It is possible that ERISA would be held to preempt such efforts.

C. CONTRACTUAL ALTERNATIVES

A final option relies neither on the courts nor legislative action. Parties to a managed care plan may simply include a provision explicitly making mixed decisions subject to fiduciary obligations, thus contracting around the limited protection of ERISA as interpreted by *Pegram*. Litigation regarding such a contractual provision would give rise to a state-law contract claim, but probably would not generate a corresponding ERISA claim, as private parties cannot expand the scope of federal legislation or create federal-question jurisdiction by contract.[91] Of course, it may be argued that MCOs would have little incentive to agree to such a provision, thereby increasing their potential liability. It is entirely possible, however, that either market forces, in the form of demand by plan participants, or external pressures, such as the threat of a "patient's bill of rights" or other similar legislation, might induce MCOs to

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88 Other discussions have thoroughly addressed potential legislative alternatives. *See, e.g.*, David A. Hyman, *Regulating Managed Care: What's Wrong With a Patient Bill of Rights*, 73 S. CAL. L. REV. 221 (2000); Jacobson & Pomfret, *supra* note 1; Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution*, 65 MO. L. REV. 405 (2000); June M. Sullivan, *Overcoming the ERISA Barrier to Recovery Against HMOs: Current Trends and Legislation*, 4 QUINNIPIAC HEALTH L.J. 245 (2001).

89 For example, the House version of the "Patient's Bill of Rights" in 1999 would have capped treating physicians' financial risk-bearing and prohibited physicians from receiving payments "as an inducement to reduce or limit medically necessary services." 42 U.S.C.A. § 1395mm(i)(8)(A)(i) (West Supp. 2001) (Medicare provision cross-referenced in proposed Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2990, 106th Cong. § 1133 (1999)). We offer no position as to the merits of this specific proposal, but provide it as an indication of Congress's capacity to enact restrictions of this type.

90 *Cf.* Bloche & Jacobson, *supra* note 67, at 2776 (2000) ("Although the Justices embraced rationing as national policy and construed *federal* law to permit financial rewards to physicians for limiting care, ambiguous language in *Pegram* invites litigants to argue that *state* law can impose myriad constraints on medical cost control programs.") (emphasis added).

91 *See* Ins. Corp. of Ireland v. Compagnie des Bauxites de Guinee, 456 U.S. 694, 702 (1982) ("[N]o action of the parties can confer subject-matter jurisdiction upon a federal court."). Moreover, adding language explicitly stating that mixed decisions involve "administration of the Plan" or some other such reference to ERISA's language is similarly unlikely to create a fiduciary duty under ERISA. *See* Mabe v. G.C. Servs. Ltd. P'ship, 32 F.3d 86, 88 n.2 (4th Cir. 1994) ("A private contract cannot create federal question jurisdiction simply by reciting a federal statutory standard."); Oliver v. Trunkline Gas Co., 796 F.2d 86, 89-90 (5th Cir. 1986) ("We are aware of no case in which any court, let alone the Supreme Court, has held that a *private* contract can give rise to federal-question jurisdiction simply by 'incorporating' some federal regulatory standard that would not have been binding on the parties by its own force.").

agree to such terms. MCOs would not want to risk losing business or operating under even harsher regulations.

This option also has its own attractive elements from the managed care industry's perspective. One of managed care's shortcomings has been its failure to involve the public in the desirable goal of reducing healthcare costs. Instead of attempting to involve the public in its decision making processes, the managed care industry has essentially forced these changes on subscribers. The predictable result has been the much-noted managed care backlash. The managed care industry might do well to rethink this strategy and to develop mechanisms and processes to obtain public support for the managed care model.

The failure to involve the public extends to managed care's failure to communicate well with its subscribers. A recent study found that communication between managed care organizations and their members is poor.[92] The authors conclude as follows:

> Not enough information is disclosed or requested, and the information that is disclosed is not particularly clear, helpful, or accessible. . . . Denial letters rarely explain who made the decision, the reason for the decision, what sources of evidence were considered, what coverage policies were applied, or anything about the process of making that decision.[93]

For managed care to succeed over the long term, the public must begin to accept the need for cost controls generally and to trust individual MCOs to impose and monitor those controls responsibly. To achieve this, MCOs could embrace implementation of a patient advisory board with meaningful oversight of cost-containment strategies, along with the availability of a patients' rights advocate. One positive step toward this approach is the expanding use of independent grievance review mechanisms to review denied or delayed care.[94] It behooves the industry to take responsibility for consumers confused by the product they purchased, as well as patients injured by poorly implemented cost-containment programs.

A full delineation and examination of mechanisms the managed care industry might use to engage the public is beyond the scope of this article. Even assuming adoption of one or more such mechanisms, public involvement may not be a panacea for the perceived shortcomings of the managed care model. Our point, rather, is that managed care will probably not succeed unless it gains greater public acceptance as a legitimate means of providing healthcare services at a reasonable cost. Taking steps to seek public buy-in to the concept does not reflect a change in the underlying care delivery approach as much as it represents a new dimension in how that strategy is implemented.

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92 Sara J. Singer & Linda A. Bergthold, *Prospects for Improved Decision Making About Medical Necessity*, HEALTH AFF., Jan./Feb. 2001, at 200, 204.

93 *Id.*

94 *See, e.g.*, Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335, 352 (2000) (noting that complaints and disputes are often resolved more quickly through independent grievance review).

V. CONCLUSION

Only time will tell whether the Supreme Court's opinion in *Pegram* marked a beginning or an end. At first blush, the opinion appears to grant managed care a huge victory and to foreclose nearly any breach-of-fiduciary-duty suits against either MCOs or their administrative or medical employees, at least under ERISA. In our view, the Court's holding was unfortunate. The fiduciary concept could have provided a useful framework for resolving the inevitable and intractable conflicts between individuals and groups that arise under managed care. But if the federal courtroom door has closed, the state courthouses remain open, as do the federal and state Capitols. Indeed, *Pegram*'s rather blunt response to sophisticated problems regarding managed care's inherent tradeoffs might only call more attention to the need for a thorough and balanced governmental response to these issues, in which case the decision may well spur, rather than impede, necessary reform.