Granted

No. 98-1949

IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF WASHINGTON LEGAL FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether a health maintenance organization ("HMO") and its physicians breach a fiduciary duty under section 404(a)(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1104(a)(1), by implementing a managed care program in which the physicians receive financial incentives to provide medical care to the HMO's enrollees in a cost-effective manner.

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INTEREST OF THE *AMICUS CURIAE*

The Washington Legal Foundation (WLF) is a non-profit public interest law and policy center with supporters nationwide, including many in Illinois.[1] While WLF engages in litigation and participates in administrative proceedings in a variety of areas, WLF devotes a substantial

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[1] Pursuant to Supreme Court Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amicus*, contributed monetarily to the preparation and submission of this brief.

portion of its resources to advancing the interests of the free-enterprise system and to ensuring that economic development is not impeded by excessive litigation. To that end, WLF has appeared before this Court as well as other federal and state courts in cases raising tort liability issues arising under the Employee Retirement Income Security Act of 1974 ("ERISA"). *See, e.g., Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). WLF also has appeared in cases touching upon the effects of tort liability on the ability of health care providers to deliver quality service to the American public. *See, e.g., Rotella v. Wood,* No. 98-896 (decision pending, U.S. S. Ct.); *Medtronic, Inc. v. Lohr,* 518 U.S. 470 (1996).

WLF is concerned by the proliferation of suits against health maintenance organizations and their fiduciaries being brought pursuant to ERISA. WLF believes that such suits have the potential -- particularly when, as here, they are directed at physicians' individual treatment decisions -- to cause serious disruption to the delivery of quality, affordable health care.

WLF fully agrees with Petitioners both that the appeals court's decision misinterpreted ERISA and that -- by extending ERISA fiduciary responsibilities to encompass cost-containment mechanisms -- it will undermine efforts to ensure that quality health care is widely available at affordable costs. WLF also filed an *amicus curiae* brief in support of the petition for certiorari in this case.

WLF is filing this brief because of its interest in maintaining high-quality health care to all Americans. It has no interest in the outcome of this lawsuit or of any other suits raising similar issues. Because of its lack of direct

economic interests, WLF believes that it can assist the Court by providing a perspective that is distinct from that of any party.

WLF's brief is being filed with the consent of all parties. Copies of the letters of consent have been lodged with the Clerk of the Court.

STATEMENT OF THE CASE

Respondent Cynthia Herdrich received medical treatment from an employee benefit plan established by State Farm Insurance Company (her husband's employer) for its employees and their dependents. The plan provides benefits through a health maintenance organization ("HMO"). Petitioner Lori Pegram, M.D., is the HMO physician who treated Ms. Herdrich. Petitioner Health Alliance Medical Plans, Inc. ("HAMP") operates the HMO. Petitioner Carle Clinic Association ("Carle Clinic") owns HAMP. The physicians who provide services through the HMO own Carle Clinic. Under an agreement between State Farm and HAMP, HAMP received a fixed monthly amount for each participant in the State Farm plan in payment for services the HMO would provide to plan participants.

The Court of Appeals concluded that Carle Clinic and HAMP were fiduciaries under ERISA because they had the right to decide disputed claims of individuals covered by the HMO. *Herdrich v. Pegram*, Pet. App. 14a. Dr. Pegram was a fiduciary because she exercised discretion in rendering care to individuals covered by the HMO. *Id.* The Court of Appeals further found that the financial incentives under which the Petitioners operated as fiduciaries could give rise to a fiduciary breach where, as alleged by the Respondent,

a physician delays or withholds care to benefit herself financially. *Id.* at 20a.

SUMMARY OF ARGUMENT

WLF agrees with Petitioners' position that the Court of Appeals' decision below was incorrect and will have harmful and anomalous effects on the country's health care system if allowed to stand.

The decision below resulted from the application of ERISA's fiduciary provisions to decisions that are not properly governed by ERISA. ERISA's fiduciary provisions regulate the process of paying for benefits provided under an employee welfare benefit plan. ERISA's fiduciary rules do not regulate the benefits that will be provided under the plan nor the medical decisions of doctors for whose services the plans pay.

Unlike fee for service arrangements, where a participant obtains medical services from his or her own doctor and submits the bill to the plan for payment, HMOs embody both the medical services governed by state law and the payment mechanism governed by ERISA. Because HMOs play multiple roles, the nature of an HMO's decision can be mischaracterized, as happened in this case. Properly analyzed, however, ERISA and state law provide a framework for appropriately regulating the multiple functions of HMOs.

To assure that the various functions of HMOs are subject to the correct regulatory regime, courts should distinguish among three types of decisions made in connection with welfare benefit plans governed by ERISA:

(1) plan design decisions made by employers that sponsor the plans, (2) medical decisions made in connection with the treatment of patients covered by the plans, and (3) fiduciary decisions concerning payment for benefits under the plans. Only the last type of decision properly is governed by ERISA.

ARGUMENT

I. THE COURT OF APPEALS FAILED TO DISTINGUISH AMONG PLAN DESIGN, MEDICAL, AND FIDUCIARY DECISIONS AND THEREBY APPLIED THE WRONG REGULATORY SCHEME TO PETITIONERS' ACTIONS

Petitioners explain in their brief that the Court of Appeals incorrectly concluded that Petitioners acted as fiduciaries in establishing and implementing cost-containment measures for the HMO, and that the establishment and use of these measures may give rise to a breach of fiduciary duty under ERISA. The Court of Appeals' conclusions are wrong because they improperly expand the definition of fiduciary and mischaracterize plan design and a treating physician's medical decisions -- which are outside the bounds of ERISA's fiduciary provisions -- as fiduciary acts.

Determining that the decision below was wrong is only part of the task that faces the Court, however. The more difficult chore is providing guidance on whether and when ERISA will apply to actions taken by or attributed to HMOs. To permit HMOs to continue to use cost-containment measures -- one of the reasons for their existence -- it is necessary to distinguish among plan design

decisions left to the discretion of the employer that sponsors the plan, medical decisions involving individual patients governed by state law, and fiduciary plan payment decisions governed by ERISA.

The proper framework for analyzing this type of case requires, at the outset, a determination whether the conduct at issue was non-fiduciary conduct or fiduciary conduct.

"Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). "ERISA's fiduciary duty requirement simply is not implicated where [the plan sponsor], acting as the plan's settlor, makes a decision regarding the form or structure of the plan such as who is entitled to receive plan benefits and in what amounts." *Hughes Aircraft Co. v. Jacobsen*, 119 S. Ct. 755, 763 (1999). *Accord, Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 100 (1995). Thus, decisions concerning the design of the plan, including, for example, the benefits the plan will provide, the method for delivering benefits, and any limits to benefits the plan will pay for, are not fiduciary decisions. With few exceptions,[2] employers are free to design a plan which does not pay for certain treatments or excludes coverage for certain types of illnesses and to enter into other arrangements to control the cost of the plan. These plan design decisions are business decisions that the employer sponsoring the plan makes, taking into

[2] *E.g.*, Women's Health and Cancer Rights Act of 1998, Pub. Law No. 105-277, 112 Stat. 2681-436 (1998) (requiring group health plans to provide coverage for mastectomies and certain related benefits).

consideration the cost of benefits and the needs of its employees.

Medical decisions by treating physicians similarly are not governed by ERISA's fiduciary provisions. A decision concerning the individual treatment of a plan participant is a medical decision requiring a doctor to consider the needs of the patient, not the plan.[3] *See, e.g., Addison v. Whittenberg*, 529 N.E.2d 552, 556 (Ill. 1988). "Physicians, of course, should not allow the exercise of their medical judgment to be corrupted or controlled. Physicians have professional ethical, moral, and legal obligations to provide appropriate medical care to their patients." *Petrovich v. Share Health Plan of Illinois, Inc.*, No. 85726, 1999 WL 773524, at *16 (Ill. Sept. 30, 1999). Whether the plan will pay for the treatment the patient needs is a separate question, which leads to fiduciary decisions.

Fiduciary conduct requires the exercise of discretionary authority or control respecting management of a plan or discretionary authority or responsibility in administration of

[3] As noted in WLF's brief in support of the petition for a writ of certiorari, a physician burdened with ERISA's fiduciary duties in making individual treatment decisions would be required to temper his or her decisions regarding the appropriate treatment for individual patients by taking account of the financial impact a particular treatment recommendation might have on the plan as a whole and on the plan's participants as a group. Thus, a physician/fiduciary could rightly decide under ERISA to withhold expensive treatment from a near-terminal patient to conserve scarce resources for the benefit of the healthier majority of plan participants. These non-medical, financial considerations are the very considerations that the Court of Appeals thought should *not* influence physicians at the treatment level. *Herdrich v. Pegram*, Pet. App. 31a ("doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients.").

the plan. ERISA § 3(21), 29 U.S.C. § 1002(21). The final decision whether an employee benefit plan will pay for a particular treatment or condition generally is a fiduciary decision. *Libbey-Owens-Ford Company v. Blue Cross & Blue Shield*, 982 F.2d 1031, 1035 (6th Cir.), *cert. denied*, 510 U.S. 819 (1993) ("When an insurance company administers claims for an employee welfare benefit plan and has authority to grant or deny the claims, the company is an ERISA 'fiduciary' under 29 U.S.C. § 1002(21)(A)(iii).").

ERISA's fiduciary provisions were designed to address and are well-suited for regulating plan payment decisions. In making a payment decision, a plan fiduciary must consider only the interests of plan participants and beneficiaries, ERISA § 404(a)(1); use plan assets only to pay benefits and defray the plan's administrative costs, ERISA § 404(a)(1)(A); act prudently, ERISA § 404(a)(1)(B); and follow the terms of the plan document, ERISA § 404(a)(1)(D). 29 U.S.C. § 1104(a)(1)(A), (B), (D).

In contrast, these ERISA considerations plainly are not suited to regulate an employer's decisions concerning the type and amount of benefits it will provide to its employees, or a doctor's decisions concerning proper medical treatment.

Under ERISA's regulatory scheme, a plan administrator's decision that the plan will not pay for a benefit that clearly is covered by the terms of the plan could be a breach of fiduciary duty. On the other hand, a plan administrator's decision that the plan will not pay for a benefit that clearly is not covered by the terms of the plan would not constitute a breach of fiduciary duty under ERISA, regardless of whether the benefit is necessary or appropriate for the

patient as a matter of medical judgment. *E.g.*, *Martin v. Blue Cross and Blue Shield of Virginia*, 115 F.3d 1201, 1209 (4th Cir.) (health plan participant not entitled to payment for treatment recommended by her physician but not covered under health plan), *cert. denied,* 522 U.S. 1029 (1997).

Analyzed under this framework, the Court of Appeals should have concluded that there was no fiduciary decision involved in Ms. Herdrich's treatment.

The financial incentives that the Court of Appeals found repugnant were negotiated by State Farm in establishing a benefit plan ("Plan") and deciding to provide benefits under the Plan through an HMO. Pet. App. 93a. Under the Plan's terms, except in the case of an emergency, services must be provided by the HMO's physicians and at the HMO's facilities. Pet. App. 1-2a, 103a. State Farm paid a fixed premium each month for each of its employees covered by the Plan. Pet. App. 98a-99a. All of these features are plan design features that State Farm chose in establishing the Plan for its employees and their dependents. These design features do not give rise to a breach of fiduciary duty. *Hughes Aircraft Co. v. Jacobsen*, 119 S. Ct. at 763.

The bad medical outcome that Ms. Herdrich suffered was caused by Dr. Pegram's medical judgment that Ms. Herdrich's condition did not require emergency treatment and the resulting decision not to send Ms. Herdrich to the emergency room for an immediate sonogram. In making this decision, Dr. Pegram was not making a judgment that the terms of the Plan did not cover emergency room treatment. Indeed, the Plan clearly permits emergency care

at a non-HMO facility when the physician determines that an emergency exists. Pet. App. 107a-108a. Respondent was not denied the emergency care she needed because of a plan payment decision. She was denied emergency care because Dr. Pegram made an erroneous medical judgment concerning her condition. Ms. Herdrich's claim concerning the treatment she received from the HMO and the HMO doctor therefore is subject to state law.

In fact, the case presented to the Court of Appeals did not involve any plan administration decision governed by ERISA's fiduciary rules because no plan fiduciary decided whether the Plan would pay for Ms. Herdrich's emergency room treatment.[4] If, notwithstanding Dr. Pegram's medical judgment that emergency treatment was not necessary, Ms. Herdrich had gone to an emergency room, and then presented the bill for emergency treatment to the HMO for payment, the decision whether to pay for the treatment would be a fiduciary decision governed by ERISA. Because

[4] Nor is Respondent in any event likely to recover anything for herself in an ERISA action alleging breach of fiduciary duty. A plan participant may bring two basic types of actions under ERISA: (1) an action for benefits due under a plan (ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)); or (2) an action to restore to the plan any losses the plan suffered as a result of a fiduciary breach (ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2)). A plan participant claiming that an ERISA fiduciary has breached a fiduciary duty to the plan generally may not recover monetary relief for his or her own benefit, however. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 (1985) ("recovery for violation of [an ERISA fiduciary duty] inures to the benefit of the plan as a whole"). A plan participant claiming that an ERISA fiduciary has breached a fiduciary duty to the participant is limited (under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)) to an award of "appropriate equitable relief." *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996).

that did not happen in this case, no fiduciary claim arises from the HMO's treatment of Ms. Herdrich.

II. HMO DECISIONS MUST BE ANALYZED UNDER A FRAMEWORK THAT DISTINGUISHES AMONG PLAN DESIGN, MEDICAL, AND FIDUCIARY DECISIONS SO THAT THE PROPER REGULATORY SCHEME IS APPLIED TO EACH DECISION

HMOs, which were not widely used when ERISA was enacted in 1974, sometimes blur the distinction among the types of decisions made in connection with welfare benefit plans: what benefits are provided under the plan -- a plan design decision; what treatment is provided by a physician employed by the HMO -- a medical decision governed by state law; and whether the HMO will provide or pay for the treatment -- a plan fiduciary decision. The distinctions can become confused because, as in Respondent's case, the same individuals who make individual medical treatment decisions also may decide whether the HMO will provide or pay for a particular treatment. Notwithstanding these multiple roles, the distinctions between the discrete functions are discernible and must be recognized to avoid results like the decision below. Determining in the first instance whether a decision was a plan payment decision governed by ERISA or some other type of decision provides an analytical framework for deciding HMO cases in a manner that applies the proper regulatory scheme to HMO decisions.

A simple example is the application of a lifetime maximum benefit provision. Some plans place a dollar limit on benefits that will be paid by the plan, imposing an annual cap, for example, of $250,000. Including this limitation in

a plan is a plan design decision that is not governed by ERISA. A physician could determine that a plan participant required treatment that exceeds the plan's dollar limits. This decision is a medical decision governed by state law. The plan's decision not to pay for the recommended treatment would be a fiduciary decision. And so long as the denial of payment was consistent with the terms of the plan, the denial would not give rise to a fiduciary breach.

Employee benefit plans that include managed care features often require the plan fiduciary to make a medical decision to determine whether the plan will pay for the benefit. *Corcoran v. United Healthcare*, 965 F.2d 1321, 1331 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992). Thus, in practice, the distinction among plan design, medical judgment, and payment decisions can be murky. While medical decisions made in the context of the doctor-patient relationship are governed by state law and may give rise to a tort claim under state law, medical determinations made in the context of a plan payment decision are subject to ERISA and can give rise only to a claim for benefits due under the terms of the plan. *Id.*[5]

In *Corcoran*, for example, the court distinguished among the utilization review feature (requiring advance approval for hospitalization) that the participant's employer chose to include in the employee benefit plan covering its employees, the recommendation of the participant's doctor that hospitalization was appropriate, and the medical

[5] *See Pryzbowski v. U.S. Healthcare, Inc.*, No. 97-3097 (MTB), 1999 US Dist LEXIS 13907 (D.N.J. Sept. 8, 1999) (distinguishing between quality of medical care and quality of payment decisions; the former is governed by state law, the latter by ERISA).

judgment exercised by the plan fiduciary in determining that the plan would not pay for the hospitalization recommended by the participant's doctor. The plan fiduciary determined that the plan would not pay for the recommended hospitalization, so the participant chose a less aggressive alternative that the plan would pay for. She suffered a bad medical outcome as a result. In essence, the participant made an economic decision to elect treatment that was less desirable than the treatment recommended by her treating physician. Of course, the alternative available to her was to elect the more expensive treatment, and challenge the plan fiduciary's adverse claims decision in a later proceeding. *Id.* at 1323.

The court acknowledged that both the treating physician's recommendation of hospitalization and the plan fiduciary's decision that the plan would not pay for the hospitalization because it was unnecessary involved the exercise of medical judgment. But the court recognized that in the fiduciary's case, the exercise of medical judgment was "part and parcel of its mandate to decide what benefits are available under the . . . plan." *Id.* at 1332. Consequently, the court concluded that the participant's claim against the fiduciary for the damages arguably resulting from the claims decision was not a claim for benefits under the plan. *Id.* at 1335-38.

In the case under review, in contrast, the respondent accepted the advice of her treating physician, either because of her faith in the doctor's judgment or because of her unwillingness to bear the economic risk of obtaining an emergency sonogram that might, in the last analysis, have been unnecessary and therefore unreimbursed by the HMO. But whatever the respondent's motive in following the

recommended course of treatment, the appropriate remedy for an erroneous clinical judgment made by the treating physician is the remedy provided by state law.

"Medical necessity" requirements similarly require the plan fiduciary to make a medical decision to determine whether the plan will pay for a benefit. Many plans expressly do not pay for treatment that is not "medically necessary." Whether the determination of medical necessity is subject to ERISA depends on whether it is made by a physician determining a course of treatment for a patient or by a fiduciary deciding whether a plan will pay for a procedure.

Suppose, for example, a participant in an employee benefit plan that provides medical services through an HMO is diagnosed by an HMO doctor as having cancer. The doctor recommends a course of treatment that, in the doctor's view, is medically necessary to address the participant's condition, and rejects another, more expensive treatment that the doctor deems not to be medically necessary. This decision is a medical decision governed by state law. The doctor's decision to recommend the cheaper course of treatment that he or she thought medically necessary was based on a medical judgment, not on whether the HMO would pay for the treatment. If the doctor's recommended course of treatment is not adequate as a matter of medical judgment, the participant may have a malpractice claim against the doctor under state law.

Alternatively, the HMO doctor may recommend a course of treatment that is deemed to be not medically necessary by the HMO fiduciary that decides benefit claims ("Claim Fiduciary"). Because the benefit is not medically

necessary, the HMO will not provide or pay for the treatment. The participant has the right to appeal the Claim Fiduciary's decision and, after exhausting the HMO's administrative procedures, may bring an action in court under ERISA to obtain the benefit. This decision by the Claims Fiduciary, unlike the HMO doctor's medical necessity decision, is a plan payment decision governed by ERISA. The distinction holds true even if the HMO doctor, wearing a different hat, also is the Claims Fiduciary. *Hughes Aircraft Co. v. Jacobsen*, 119 S. Ct. at 763; *Lockheed Corp. v. Spink*, 517 U.S. at 890.

While not presented in this case, a difficult situation arises if a doctor's recommended course of treatment is appropriate, but nonetheless is a treatment that the HMO, under the terms of the plan, does not pay for. In this situation, neither the doctor nor the fiduciary has breached a duty, but the participant may be denied appropriate care if he or she can't afford to pay for the treatment outside of the HMO. While it may be tempting to blur the lines between fiduciary and non-fiduciary conduct to require an HMO to provide medical care that a participant needs, these types of *ad hoc* judgments by courts bring chaos into the system and ultimately increase the cost of benefit plans under the current regulatory schemes.

CONCLUSION

Amicus curiae Washington Legal Foundation respectfully requests the Court to reverse the decision of the Court of Appeals and to direct the dismissal of Respondent's fiduciary breach claim.

Respectfully submitted,

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