

*Pegram v Herdrich:*  
**Implications for Consumer Protections in Managed Care**

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This Report, prepared for the Substance Abuse and Mental Health Services Administration,<sup>1</sup> provides a brief overview of the United States Supreme Court's landmark decision in *Pegram v Herdrich* (hereinafter referred to as *Herdrich*).<sup>2</sup> This report begins with a brief overview of the debate in the courts over how to distinguish between legal challenges to the conduct of managed care companies in which all state remedies are preempted by ERISA and those that may proceed under state law. It then summarizes the facts of the *Herdrich* case and the Court's holding. The report concludes with a discussion of the implications of the decision for federal and state consumer protection legislation.

A point of caution should be raised. The *Herdrich* decision is so new, and its implications so potentially far-reaching, that legal scholars, policy makers, lawyers, and judges undoubtedly will be pondering and debating its meaning and reach for years. However, in light of the enormous attention now focused on managed care accountability, the decision will attract a great deal of attention. Consequently, at least a preliminary analysis is warranted.

## **1. Overview of ERISA**

Enacted in 1974, the Employee Retirement Income Security Act (ERISA) establishes federal requirements for employer-sponsored pension and benefit plans. The United States Department of Labor estimates that 125 million persons (72% of the workforce and two-thirds of the non-elderly population) are covered by an ERISA group benefit plan.<sup>3</sup>

ERISA establishes certain "content" requirements for pensions. However, in the case of other benefits (such as health and disability benefits), ERISA contains few substantive requirements. As a result, employers have near-total discretion over the structure of their health plans, including the benefits they offer and the organizational and delivery arrangements they provide for.

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<sup>1</sup> The Department of Health and Human Services has reviewed and approved policy related information within this document, but has not verified the accuracy of data or analysis presented within this document. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS) or the U.S. Department of Health and Human Services.

<sup>2</sup> 120 S. Ct. 2143 (2000); slip op. dated June 12<sup>th</sup>, 2000. Hereinafter, all references are to the Slip Opinion.

<sup>3</sup> Phyllis C. Borzi, "ERISA and Health Plans: A Primer on ERISA Requirements and a Discussion of Proposals for Change" (D.C. Bar Association, June, 2000).

Despite this broad discretion over the design and content of health benefits, ERISA plan administrators (including entities that operate the health component of an employee benefit plan) are subject to a “fiduciary standard” obligating them to administer the plan solely in the interest of the plan’s beneficiaries.<sup>4</sup> ERISA defines a “fiduciary” as anyone who exercises discretion or control over the plan’s assets or administration.<sup>5</sup> Under such a standard, coverage decisions by managed care company employees or contractors would appear to involve the type of discretionary decision-making over the disposition of plan assets that triggers the fiduciary obligation. However, where benefits are found to be improperly denied or withheld, ERISA limits recovery to the value of the benefits claimed and does not permit damages for the economic or non-economic losses generally associated with a personal injury; state law remedies that would permit such damages (under theories of fraud, bad faith breach of contract, or negligence in insurance coverage-decision making, for example) all would be superceded by ERISA’s sweeping “preemption” rule.<sup>6</sup>

Because it represents the merger of coverage and health care, managed care makes distinguishing between coverage decision-making and medical treatment particularly difficult. In recent years, courts increasingly have determined that when managed care companies act either directly or through their network physicians as health *care* corporations, principles of both corporate and vicarious liability that have applied to hospitals for some 40 years<sup>7</sup> also may apply to them. As a result, a health maintenance organization (HMO) that injures a member through substandard medical conduct (either through its physicians’/agents’ negligence or its own direct failure to safeguard members from incompetent providers or an inadequate standard of care) may be liable under state law for damages.<sup>8</sup>

These HMO negligence cases typically have arisen in the context of individuals who are not covered by ERISA (e.g., federal and state employees or Medicaid beneficiaries). In the case of ERISA plan members, courts have drawn a distinction between cases that allege injury as a result of a coverage decision and those that challenge the quality of care.<sup>9</sup> Where a claim is determined to be one for coverage, the claim is considered to “arise under” ERISA and all state remedies are preempted.<sup>10</sup> In these instances, the company’s breach of its ERISA fiduciary duties would give the individual the right to recover the benefit due, but no more. On the other hand, where the claim is determined to amount to a challenge to the quality of care received, courts have ruled that state medical liability laws continue to apply.<sup>11</sup>

States that have attempted to create remedies for negligent or injurious coverage decision-making by insurers have seen their laws preempted under ERISA.<sup>12</sup> Congress is currently debating

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<sup>4</sup> 29 U.S.C. §1104(a)(1).

<sup>5</sup> 29 U.S.C. §1002(21).

<sup>6</sup> Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, New York, NY; 1997; 1999-2000 Supplement).

<sup>7</sup> See, e.g., *Darling v Charleston Community Memorial Hospital*, 211 N.E.2d 253 (Ill. 1965); *Jackson v Power*, 743 P.2d 1376 (Alaska 1987).

<sup>8</sup> See, e.g., *Boyd v Albert Einstein Medical Center*, 547 A.2d 1229 (Pa.Super. 1988); *Petrovitch v Share Health Plan of Illinois, Inc.*, 719 N.E.2d 756 (Ill. 1999); and *Jones v Chicago HMO Ltd. Of Ill.*, 730 N.E.2d 1119 (Ill. 2000).

<sup>9</sup> *Dukes v U.S. Healthcare, Inc.*, 57 F.3d 350 (3<sup>rd</sup> Cir. 1995); *In re U.S. Healthcare, Inc.*, 193 F. 3d 151 (3<sup>rd</sup> Cir. 1999); *Pappas v Asbel*, 724 A.2d 889 (Pa. 1998), *vacated and remanded by U.S. Healthcare Systems of Pennsylvania, Inc. v. Pennsylvania Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000).

<sup>10</sup> See, e.g., *Corcoran v United HealthCare, Inc.*, 965 F.2d 1321 (5<sup>th</sup> Cir. 1992), *cert. denied* 506 U.S. 1033 (1992).

<sup>11</sup> See, e.g., *Shannon v McNulty*, 718 A.2d 828 (Pa.Super. 1998).

<sup>12</sup> See, e.g., *Corporate Health v Texas Department of Insurance*, 12 F. Supp. 597 (S.D. Tx. 1998).

managed care legislation that would address the issue of injuries, although the House and Senate approaches differ significantly.<sup>13</sup>

## 2. The facts of the *Herdrich* case and the decision

The *Herdrich* case sits at this complex nexus of ERISA preemption, state medical liability law, and managed care.

Cynthia Herdrich, insured through her husband's ERISA-covered employee health plan, was a member of the Carle Clinic, a physician-owned HMO. Herdrich sought care for lower abdominal pain. Rather than immediately securing an ultrasound diagnosis at a local hospital, Dr. Lori Pegram decided to order the test through a distant Carle Clinic-owned diagnostic facility that could not perform the procedure for 8 days. Herdrich's appendix ruptured before the 8 days passed and she developed peritonitis.

Herdrich sued both Pegram and Carle in state court for medical malpractice;<sup>14</sup> she also sued the Clinic for state law fraud. The essence of her case was medical negligence against the physician and fraudulent and improper denial of benefits by the company, in which the physician was a part-owner and which paid physicians through incentive arrangements.

After her state fraud count was dismissed on the basis of the ERISA preemption principles discussed above,<sup>15</sup> Herdrich amended her complaint to charge the Carle Clinic with a violation of ERISA's fiduciary duty requirements in its use of physician financial incentives. The trial court dismissed her claim of breach of fiduciary duty, holding that the HMO's financial incentive structure did not constitute the type of practice that amounts to the exercise of a fiduciary duty. On appeal, however, the United States Court of Appeals for the 7<sup>th</sup> Circuit held that such an incentive arrangement did indeed constitute the type of activity that fell within the Clinic's "fiduciary" practices within the meaning of ERISA. The court of appeals further held that the use of such an incentive arrangement in the case of a physician-owned HMO amounted to a breach of its fiduciary obligation, because the existence of the incentive arrangement arguably led to a decision to delay and deny care, thereby creating an improper conflict of interest between the physician-owners of the plan and their patients.<sup>16</sup> After a rehearing on the case, the court of appeals reaffirmed its decision and the Supreme Court granted the defendants' request to hear the case.

Writing for a unanimous Court, Justice Souter stated the question in the case was "whether *treatment decisions made by a health maintenance organization, acting through its physician employees*, are fiduciary

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<sup>13</sup> The Senate would allow individuals who have won the right to a benefit through external review to recover limited damages against a managed care company where the company originally failed to provide the benefit that was granted. The House bill, on the other hand, would allow states to fashion their own remedies for the wrongful denial of coverage, thereby lifting ERISA's preemption provisions with respect to these types of coverage decisions.

<sup>14</sup> Ms. Herdrich won a malpractice claim against Dr. Pegram for \$35,000.

<sup>15</sup> ERISA supercedes all state laws that relate to employee benefit plans unless such laws are "saved" as laws regulating insurance. Federal courts will dismiss claims against health care companies furnishing employer products if they consider the claim against the company to be a "claim for benefits" due under an ERISA plan. See Sara Rosenbaum and Joel Teitelbaum, *Coverage Decisions Versus the Quality of Care: An Analysis of Recent ERISA Judicial Decisions and Their Implications for Employer-Insured Individuals (Issue Brief #8)*, Managed Behavioral Health Care Issue Brief Series, The George Washington University Hirsh Health Law and Policy Program (Washington, DC, April, 2000).

<sup>16</sup> Slip. op., p. 4.

acts within the meaning of [ERISA].”<sup>17</sup> In framing the question this way from the outset, Justice Souter appeared to underscore the Court’s view that the basic issue before it involved the HMO’s conduct as a *medical care provider*, rather than its functions as an insurer making *coverage and payment decisions*.

Justice Souter began his decision with a review of managed care that makes clear that in the view of the Court, physician incentive arrangements are part of the *inherent design structure* of managed care:

Traditionally, medical care in the United States has been provided on a “fee-for-service” basis. \*\*\* In a fee-for-service system, a physician’s financial incentive is to provide more care, not less, so long as payment is forthcoming. The check on this incentive is a physician’s obligation to exercise reasonable medical skill and judgment in the patient’s interest. \*\*\* The defining feature of an HMO is the receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed. \*\*\* Like other risk bearing organizations, HMOs take steps to control costs. \*\*\* These cost controlling measures [Justice Souter identifies several techniques including coverage determinations, practice guidelines, and utilization review] are commonly complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health care services and penalizing them for what may be found to be excessive treatment. \*\*\* Herdrich focuses on the Carle scheme’s provision for a “year-end distribution[.]” \*\*\* *The essence of a HMO is that salaries and profits are limited by the HMO’s fixed membership fees. \*\*\* [W]hatever the HMO, there must be rationing and inducement to ration.*<sup>18</sup>

In commenting on the design of managed care as one that by definition was structured to ration care, Justice Souter made clear that it was the province of Congress, which authorized the use of HMOs in 1973, and not the courts, to determine how far this type of health care structure could go:

Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks, \*\*\* any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk. \*\*\* [S]uch complicated factfinding and such a debatable social judgment are not wisely required of courts. \*\*\* [C]ourts are not in a position to derive a sound legal principle to differentiate an HMO like Carle’s from other HMOs. For that reason, we proceed on the assumption that the decisions listed in Herdrich’s complaint cannot be subject to a claim that they violate fiduciary standards \*\*\*.<sup>19</sup>

Justice Souter next considered what was encompassed in the “ERISA plan”, a crucial issue for distinguishing when a claim arises under ERISA and when it involves conduct that is not reached by the statute. An ERISA plan, wrote Souter, is the written “scheme” that “comprises a set of rules that define the rights of a beneficiary and provide for their enforcement.”<sup>20</sup> He noted that rules governing the “collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan.”<sup>21</sup> As such, the HMO itself was not the “plan”, even though the contract between the employer and the HMO might address certain elements of the ERISA plan, such as coverage and the rules under which a beneficiary will be entitled to care.

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<sup>17</sup> *Id.* at 1 [emphasis added].

<sup>18</sup> *Id.* at 5-8 [emphasis added].

<sup>19</sup> *Id.* at 8-9.

<sup>20</sup> *Id.* at 10.

<sup>21</sup> *Id.*

Furthermore, he noted, the HMO was not a fiduciary “merely because it administers or exercises discretionary authority over its HMO business.”<sup>22</sup> In the Court’s view, an HMO acts as a fiduciary only when it is engaged in decisions that involve *ERISA* plan administration, and only then is it bound to the fiduciary standard. Souter made clear that an entity that acts as a fiduciary may have “financial interests adverse to beneficiaries” and that *ERISA* requires only that “the fiduciary with two hats wear only one at a time and wear the fiduciary hat when making fiduciary decisions.”<sup>23</sup> As such, it was entirely consistent with *ERISA*’s scheme that a plan could secure services from a company with interests adverse to its members and could entrust such a company with fiduciary obligations. Furthermore, simply because an HMO signs an agreement with an *ERISA*-covered employer, the existence of such an agreement does not turn the HMO into a fiduciary for *all* of its conduct, but rather only for those *specific actions* that a court considers fiduciary acts.

With this background, Justice Souter then concluded that none of Herdrich’s allegations involved a fiduciary breach within the meaning of *ERISA*. Her only complaint was that the Carle Clinic breached its duty by making treatment decisions through its physicians while simultaneously offering incentives to withhold care. This feature of the plan (i.e., the year-end distribution scheme) was one that the “employer as a plan sponsor was free to adopt \*\*\* since an employer’s decision about the content of a plan are not themselves fiduciary acts.”<sup>24</sup>

At this point, the decision reached what may turn out to be the heart of the case for future federal and state legislative reform purposes. Acknowledging that certain HMO activities would constitute “fiduciary” actions while others would not, Justice Souter turned to a discussion of which HMO decisions made through its physicians will be considered fiduciary (and thus covered by *ERISA*) and which fall outside the scope of *ERISA*. Citing the decision in *Dukes v U.S. Healthcare, Inc.*,<sup>25</sup> the first case to delineate the “quality/coverage” distinction, Justice Souter wrote that there are two types of “arguably administrative” acts:

What we will call pure “eligibility decisions” turn on the plan’s coverage of a particular condition or medical procedure for 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? These decisions are often practically inextricable from one another \*\*\*. [A] great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition \*\*\* or whether acupuncture is a covered procedure \*\*\*. The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO’s obligation to provide or pay for that particular procedure at that time in the case. \*\*\* In practical terms these eligibility decisions cannot be untangled from physicians’ judgments about reasonable medical treatment. \*\*\* The eligibility decision and the treatment decision [in this case] were inextricably mixed, as they are in countless medical administrative decisions every day.

The kinds of decisions mentioned in Herdrich’s *ERISA* count and claimed to be fiduciary in character are *just such mixed eligibility and treatment decisions: physicians’ conclusions about when to use diagnostic test; about seeking consultations and making referrals to physicians and facilities other than Carle’s; about the proper*

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<sup>22</sup> *Id.*

<sup>23</sup> *Id.* at 12-13.

<sup>24</sup> *Id.* at 14.

<sup>25</sup> 57 F. 3d 350 (3rd Cir. 1995), cert. denied 116 S. Ct. 564 (1995).

*standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition.*<sup>26</sup>

In this breathtaking paragraph, the Court appears to have removed from the scope of ERISA fiduciary acts—and placed squarely in the center of medical practice itself—the vast bulk of day-to-day decisions made by physicians employed by or under contract to managed care entities that sell their services to ERISA-covered employers. *According to the Court, these are not “coverage” decisions that are covered by the fiduciary provisions of ERISA and thus subject to preemption.* They are instead “mixed eligibility” decisions that amount to treatment itself. And according to the Court, Congress never intended that these types of mixed eligibility decisions be viewed as fiduciary in nature.<sup>27</sup> In the Court’s view, were these decisions to be viewed as fiduciary in nature, it would result in “nothing less than the elimination of the for-profit HMO” since it would outlaw all mixed decision-making in the course of running an HMO. Indeed, it is not clear that non-profit HMOs could survive, even though they had no profit motive *per se*.

The Court then made indisputably clear what it considers to be the proper remedy in a “mixed eligibility” case:

[T]he defense of any HMO [to a claim of fiduciary violation in a mixed eligibility case] would be that its physician did not act out of financial interest but for good medical reasons, the plausibility of which would require reference to standards of reasonable and customary medical practice \*\*\*. That of course is the traditional standard of the common law. \*\*\* *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* \*\*\*.

What would be the value \*\*\* of having this kind of ERISA fiduciary action? It would simply apply the law already available in state courts \*\*\*. It is true that *in states that do not allow malpractice actions against HMOs* the fiduciary claim would offer a plaintiff a further defendant to be sued for direct liability, and in some cases the HMO might have a deeper pocket than the physician. But we have seen enough to know that ERISA was not enacted out of concern that physicians were too poor to be sued, or in order to federalize malpractice litigation in the name of fiduciary duty for any other reason.

\*\*\* On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state malpractice claim. \*\*\* [W]e know that Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary, nor such a risk to the efficiency of federal courts as a new fiduciary-malpractice jurisdiction would pose in performing such unheard-of fiduciary litigation.<sup>28</sup>

### 3. Discussion

In the course of deciding the meaning of the outer limits of ERISA, the decision contains major implications for state and federal policy and the future of litigation against the managed care industry.

*State policy:* The *Herdrich* opinion does much to clarify the point at which, in a managed care context, ERISA-governed coverage decision-making ends and the quality of medical treatment begins.<sup>29</sup> As the Court noted, in managed care the line between treatment and coverage decisions

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<sup>26</sup> Slip op., pp. 15-17 [emphasis added; footnotes omitted].

<sup>27</sup> *Id.* at 18.

<sup>28</sup> *Id.* at 23-25 [emphasis added].

<sup>29</sup> Sara Rosenbaum, David Frankford, Brad Moore, and Phyllis Borzi, "Who Should Determine When Health Care is Medically Necessary?," 340 NEJM 3 (January 21, 1999).

becomes so blurred that most conduct characterized by the industry as coverage decisions is, as a practical matter, a decision about treatment that falls within the classic purview of the medical profession. For this reason, the Court concluded that the proper legal framework in which to judge such decisions is not ERISA fiduciary law, but rather the law of medical liability, which lies beyond the legal limits of ERISA.

It is interesting to consider what might have been the outcome of *Corcoran v United HealthCare, Inc.*,<sup>30</sup> a landmark ERISA decision that helped set in motion the public demand for managed care reform. In *Corcoran*, the United States Court of Appeals for the 5<sup>th</sup> Circuit held that in substituting outpatient care in for inpatient treatment requested by a personal physician for his high-risk pregnant patient, United Healthcare—through its utilization management medical staff—was not practicing medicine but instead was making a coverage determination. Because this coverage determination was protected by the ERISA preemption shield, United could not be held liable for the death of the newborn.

In terms of the action that led to the litigation, *Corcoran* appears to be precisely the type of “when and how” decision that falls within the Court’s “mixed eligibility” category, and thus would be covered by state liability law. In *Corcoran*, however, the decision-maker was not the patient’s personal physician but instead, the medical personnel who performed utilization management functions for the company and with whom Mrs. Corcoran had no direct relationship. Whether *Herdrich*’s holding regarding medical liability for “mixed eligibility” determinations is limited to decisions made by treating physicians or also reaches the medical judgment of any physician employed by a managed care company remains unanswered. But *Herdrich* does make clear that HMOs can be liable under state malpractice law for the “mixed eligibility” determinations made by treating network physicians on behalf of their patients.

Furthermore, in applying medical liability law to HMOs, *Herdrich* also suggests that a managed care entity could be liable under state law for corporate acts that result in injuries. These acts, whose precedents lie in the law of hospital liability, include conduct such as the failure to select competent practitioners, failure to monitor the practitioners’ conduct, failure to correct errors, and failure to institute standards that ensure the quality of patient care. In this regard, the use of professionally substandard practice and treatment guidelines arguably could subject an HMO to state law liability, even were an employer arguably free under ERISA principles to buy a managed care product that practices substandard care.<sup>31</sup>

*Federal policy:* The *Herdrich* decision has important federal implications. The Court draws a distinction between “pure” and “mixed” eligibility decisions. In applying this formula the Court appears to suggest that most decisions fall into the “mixed” category and furthermore, that any decision that requires medical judgment and not merely the reading of a contract should be viewed as such. Nonetheless, even if most decisions are “mixed,” not all are. Some eligibility decisions would remain “pure” and subject to ERISA while others would not, requiring courts in applying state medical negligence law to such claims to make a case by case determination as to whether the challenged decision is mixed or pure. This is precisely the type of tortured situation in which ERISA

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<sup>30</sup> 965 F. 2d 1321 (5th Cir. 1992), cert. denied 506 U.S. 1033 (1992).

<sup>31</sup> Compare *Jones v Kodak*, 169 F.3d 1287 (10<sup>th</sup> Cir. 1999) with *In re U.S. Healthcare, Inc.*, 193 F. 3d 151 (3rd Cir. 1999).

litigants now find themselves, although *Herdrich* does seem to send a strong message to come down on the “mixed” side.<sup>32</sup>

Viewed in this way, the approach taken by the House of Representatives, which would permit state law to determine the remedies for coverage-related injuries, would appear to be the approach most consistent with the decision. Under the House bill, in any state that adopted comprehensive managed care liability legislation governing both coverage and medical judgment-based treatment decisions, courts would be relieved from this obligation to continuously parse claims into those that are “pure” and those that are “mixed.” While some would argue that such a move would open the door to a flood of litigation, the expanded use of external appeal systems under the House bill would appear to limit any such likelihood, since under the House bill, any coverage decision involving the exercise of medical judgment would be covered by the external review process.<sup>33</sup>

*Future managed care litigation:* Perhaps the most thought-provoking aspect of the decision is the court’s characterization of the industry itself as one designed to ration care and governed by a number of structural design principles that simply lie beyond the scope of individual legal challenge. In Justice Souter’s view, challenging the structural components of managed care would be like challenging the structure of a hospital. The question is whether the decision should be read to preclude all such litigation.

The answer, we think, is “no”, in part because even this decision has clear limits, and because the decision involves only ERISA. The Court’s discussion of managed care seems to rest on the assumption that it is within the operating norm of the managed care industry to use incentive arrangements. However, as with any industry, were a member of the industry to stray beyond accepted norms and to institute practices that lie outside of what is considered acceptable practice, the analysis offered by the Court would no longer be applicable. For example, were a company to operate under irrational medical practice standards that had no basis in reasonable practice or were a company to actively interfere with the practice of its physicians to the point that they could no longer treat their patients in a medically ethical way, such practices might themselves, if proven, constitute a breach of fiduciary responsibility. Furthermore, industry practices and tactics that lie outside of the norm for managed care might violate other laws, such as the Racketeer Influenced and Corrupt Organization Act, as several lawsuits now pending around the country argue and which specifically has been held applicable to ERISA arrangements.<sup>34</sup> While Congress in authorizing the

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<sup>32</sup> However, at the time of this writing, at least one federal court declined to extend *Herdrich* to a situation in which a beneficiary of an ERISA-covered plan claimed that her managed care company improperly refused to pay for physical therapy treatments prescribed by her treating physician. *Schusteric v United Healthcare Insurance Co. of Illinois*, 2000 WL 1263581 (N.D. Ill. September 5, 2000). While noting that the cases were similar “in that both involved allegedly erroneous determinations by a health insurer that treatment was not medically necessary,” the court characterized Lisa Schusteric’s claim as one to recover benefits due under ERISA §502 and thus outside the scope of *Herdrich*’s holding concerning fiduciary responsibilities under ERISA §1109. *Id.*

<sup>33</sup> The House bill would deny external appeals for claims related to (1) specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment, and (2) decisions regarding whether an individual is covered under the plan. See Phyllis Borzi and Sara Rosenbaum, *Pending Patient Protection Legislation: A Comparative Analysis of Key Provisions of the House and Senate Versions of H.R. 2990*, Prepared for the Kaiser Family Foundation, Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services (Washington, DC, March, 2000).

<sup>34</sup> *Humana, Inc. v Forsyth*, 119 S. Ct. 710 (1999).

establishment of HMOs in 1973<sup>35</sup> certainly sought to promote a specific approach to the organization, financing, and delivery of care, the prepaid group practice structure that existed at the time looked vastly different from what managed care has evolved into. Staff model and exclusive group practice models were the norm; the modern managed care enterprise, with its vast networks of health providers operating under unbelievably complicated financial schemes, was unheard of. Nothing in the HMO statute prohibits the reasonable evolution of managed care. At the same time, where evidence shows that a member of the industry is using operating tactics that lie outside the norm, the *Herdrich* decision would not appear to prohibit litigation against such outliers.

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<sup>35</sup> The Health Maintenance Organization Act of 1973, 42 U.S.C. §300e *et seq.*