

1995-96

NATIONAL HEALTH LAW  
MOOT COURT COMPETITION

---

---

TRANSCRIPT OF RECORD

Docket No. 95-3045

---

---

SUPREME COURT OF THE UNITED STATES

October Term, 1995

---

---

WORLDWIDE HEALTH, INCORPORATED,

Petitioner,

v.

KATHERINE WEBSTER HAMMOND,

Respondent.

---

---

SPONSORS:

Southern Illinois University School of Law

Southern Illinois University School of Medicine,  
Department of Medical Humanities

American College of Legal Medicine

**IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF PACIFICA**

<b>KATHERINE WEBSTER HAMMOND,</b>	)	
<b>Plaintiff</b>	)	
	)	<b>Civil No. 92-1895</b>
<b>v.</b>	)	
	)	
<b>DR. WAYNE EARL MOSS, M.D., and</b>	)	
<b>WORLDWIDE HEALTH,</b>	)	
<b>INCORPORATED,</b>	)	
<b>Defendants</b>	)	

**MEMORANDUM OPINION AND ORDER**

**EVA M. PATTERSON, District Judge.**

This case is before the court on the defendant WorldWide's motion to dismiss Count II of the plaintiff's complaint and on its motion for summary judgment on Count III.

**I. FACTS**

Katherine Hammond, thirty-six years old, is a resident of the State of Atlantis. However, she works some twenty miles from her home in the State of Pacifica. She is an employee of Jennings and Associates (Jennings), a corporation organized under the laws of Pacifica. Hammond is a participant in WorldWide Health, Inc. (WorldWide), a health maintenance organization (HMO) organized under the laws of Delaware and doing business in the State of Pacifica. The plaintiff's membership in WorldWide is a benefit provided through Jennings. The plaintiff concedes this benefit is part of a qualified employee welfare benefit plan as defined by the Employee Retirement Income Security Act (ERISA) (29 U.S.C. § 1001 et seq.). Pursuant to the terms of WorldWide's plan with Jennings, the plaintiff selected Dr. Wayne Moss, M.D. as her primary care physician from a list of independent primary care physicians with whom WorldWide contracted to provide medical care for plan members. Dr. Moss is a resident of and practices medicine in the State of Pacifica, where he is licensed.

On April 21, 1992, the plaintiff filed this suit against the defendants. The complaint alleges that in February 1990, the plaintiff discovered a lump in her left breast during a routine self-examination. Dr. Moss examined her three days later and told her there was nothing to worry about. He said she simply had fibrocystic breast disease. He did not order a mammogram, a magnetic resonance imaging (MRI) test, or any other diagnostic test.

Approximately one year later, in January 1991, the plaintiff returned to Dr. Moss for her annual physical examination. She complained that the lump had increased in size and she was beginning to experience breast and chest pain. Dr. Moss examined her and again assured her there was nothing to worry about. He did not order a mammogram, MRI, or any other diagnostic test.

During the next several months, the plaintiff experienced increasing pain as the lump grew in size. In late April 1991, she saw a physician not associated with WorldWide who diagnosed metastatic breast cancer. The plaintiff then contacted Dr. Anna Chang, an oncologist selected by WorldWide to provide oncology care to members. Dr. Chang confirmed the diagnosis of metastatic breast cancer. The plaintiff underwent a radical mastectomy and radiation treatments.

Over the course of the next eight months, the plaintiff underwent four cycles of low-dose chemotherapy (LDC). However, her disease did not respond to this treatment. Thus Dr. Chang recommended high dose chemotherapy with autologous bone marrow transplantation (HDC/ABMT). Dr. Chang told the plaintiff HDC/ABMT was her best chance for any type of long-term survival.

The high doses of chemotherapy administered during this procedure are nearly lethal. The chemicals destroy not only the cancer but most of the patient's bone marrow as well. Therefore, before these high doses are administered, doctors extract bone marrow from the patient and freeze it. After HDC is complete, the patient's bone marrow is returned to her body. The procedure generally requires 10-14 days in the hospital, usually in intensive care, and full-time medical attention. The cost of the procedure is in excess of \$200,000.

Because of the cost of HDC/ABMT and because WorldWide requires pre-certification for any hospital treatment, the hospital where the procedure was to be performed sought pre-certification from WorldWide on January 30, 1992. Thirty days later, on March 1, 1992, the plaintiff and the hospital received letters from Dr. Howard Berkstein, a medical director at WorldWide, denying pre-certification on the basis that the procedure is experimental and therefore is not covered by the plan. Section IV(b)(3) of the plan provided by WorldWide specifies that the HMO "will not authorize or pay benefits for any charges incurred for or related to any treatment, procedure, drug or drug usage which is not recognized as accepted medical practice or not recognized by WorldWide, including those given or performed solely for research purposes, those not in accordance with standards of good medical practice, and those that are experimental or investigational in nature." This section is included in the handbook distributed by WorldWide to plan participants.

The plaintiff's family, friends, and congregation then held several fund-raisers for her and raised \$100,000. The hospital accepted the money in partial payment and administered the treatment.

The plaintiff filed this suit against the defendants, and alleged jurisdiction in this court pursuant to 28 U.S.C. § 1332. Count I of the complaint is against Dr. Moss, and alleges he negligently failed to diagnose the plaintiff's breast cancer. This negligent failure to diagnose allegedly caused the plaintiff's condition to metastasize to stage IV cancer, and necessitated the mastectomy and radiation, LDC, and HDC/ABMT treatments. This count of the complaint is not at issue today, and remains pending against Dr. Moss.

Count II of the complaint is against WorldWide, and alleges WorldWide is vicariously liable for Dr. Moss' negligent failure to diagnose the plaintiff's breast cancer. Count III of the complaint, also against WorldWide, alleges the HMO wrongfully denied the plaintiff benefits (coverage of the HDC/ABMT) it was obligated to provide under the plan.

WorldWide has filed a Rule 12(b)(6) (Fed. R. Civ. P. 12(b)(6)) motion to dismiss Count II of the complaint contending it failed to state a cause of action under ERISA. WorldWide argues ERISA preempts the plaintiff's vicarious liability claim because the claim "relates to" an ERISA plan, 29 U.S.C. § 1144. According to WorldWide, there is under ERISA no recognized cause of action for the vicarious liability of an HMO for the negligence of an independent physician selected to provide medical services to plan participants. For purposes of this motion, the parties have stipulated that under the law of the State of Pacifica, principles of apparent and/or ostensible agency constitute a legally valid predicate for application of vicarious liability.

WorldWide also moves for summary judgment as to Count III of the plaintiff's complaint. WorldWide contends the plaintiff is not entitled to relief as a matter of law because she failed to pursue WorldWide's grievance procedure after her claim was denied. The parties have stipulated that the plaintiff did not pursue WorldWide's grievance procedure after she received the letter denying her claim.

According to WorldWide's summary judgment motion, and the terms of the plan, the initial decision to deny treatment is made by a medical director, a physician who practices in the particular specialty involved. In this case, Dr. Howard Berkstein, a licensed oncologist who works for WorldWide as one of several medical directors, made the decision to deny HDC/ABMT to the plaintiff.

Under the terms of the grievance procedure set forth in the benefit handbook distributed by WorldWide to plan participants, the plaintiff's next step would have been to file a written grievance with the Medical Review Panel. This panel consists of one general practice physician and two upper-level management employees at WorldWide. The relevant portions of Section X(a)(2) of WorldWide's grievance procedure are excerpted here.

In the event a participant shall have a complaint about any medical or administrative decision connected with services provided by the plan, he or she shall file a written

grievance and submit it to the Medical Review Panel (Panel). Written grievances must be received by the Panel within 90 days from the date of the event giving rise to the participant's grievance.

The Panel shall meet within 30 days of receiving the participant's written grievance and evaluate it. \*\*\* If the participant's grievance regards a decision involving medical necessity, standards of care, or the experimental nature of treatment, then the Panel shall defer to the decision of the medical director who rendered the decision provided, however, the medical director's decision must be in accordance with the terms and conditions of the plan.

The Panel shall render a decision within 60 days of receiving the written grievance, and shall promptly notify the participant of its decision. This decision shall be binding.

Dr. Berkstein's affidavit states he reviewed the plaintiff's medical file and the drug protocol recommended by the plaintiff's oncologist. He also examined Food and Drug Administration regulations, Medicare reimbursement laws and regulations, and recent medical literature in the area. On the basis of this information, as well as his professional opinion as an oncologist, Dr. Berkstein determined that HDC/ABMT for metastatic breast cancer is experimental in nature.

The plaintiff opposed WorldWide's summary judgment motion, arguing it would have been futile for her to pursue the grievance procedure, which the plaintiff contends was "wholly lacking" in any "meaningful standards" for determining whether a treatment, procedure, drug or drug usage is experimental. She filed an affidavit to that effect. She also filed two other affidavits contradicting WorldWide's conclusion that HDC/ABMT is experimental. Dr. Chang's affidavit states that she prescribed HDC/ABMT because the plaintiff's cancer had not responded well to LDC and radiation. Dr. Chang stated she believed HDC/ABMT was the plaintiff's only chance for survival. She indicated it had been imperative to proceed quickly with the procedure because the plaintiff's condition was deteriorating rapidly. Dr. Chang has prescribed HDC/ABMT for two other female patients also suffering from stage IV metastatic breast cancer. In her opinion, the procedure is no longer experimental.

The plaintiff also filed an affidavit from Dr. Henry Ryland, a board certified oncologist who specializes in the treatment of breast cancer. Dr. Ryland indicated that although studies investigating the efficacy of HDC/ABMT in stage IV metastatic breast cancer are continuing at several research hospitals throughout the country, the procedure is widely prescribed. He stated that HDC/ABMT is no longer an experimental treatment. Dr. Ryland opined that the medical community is in agreement that HDC/ABMT is more effective than LDC in the treatment of stage IV metastatic breast cancer.

The plaintiff also filed portions of her deposition of Dr. Jane Norton, M.D., the Vice President for Medical Quality Assurance at WorldWide. In her deposition, Dr. Norton stated that WorldWide has consistently taken the position that HDC/ABMT for metastatic breast cancer is experimental in nature. According to Dr. Norton, the most recent decision to this effect, prior to the plaintiff's request, was upheld by the Medical Review Panel in December, 1990. Further Dr. Norton explained that the Medical Review Panel has reversed benefit denials, referring specifically to a decision by the Panel in June, 1991 that a laparoscopic cholecystectomy procedure previously found to be experimental by a WorldWide medical director was no longer experimental and would be covered by the plan.

## II. ANALYSIS

### ***Preemption***

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a). According to a decision by the United States Supreme Court, Congress intended the phrase "relate to" in its broadest sense. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, (1983). A law "relates to" a benefit plan if it has a connection with, or reference to, such a plan. *Id.* at 96-97. Even indirect state action bearing on such plans may be preempted by ERISA. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). Thus resolution of the preemption issue depends on whether the plaintiff's claim in Count II relates to the benefit plan WorldWide provides to Jennings employees.

There can be no doubt that the plaintiff's vicarious liability claim clearly relates to WorldWide's plan. To prevail on the merits, the plaintiff will have to prove Dr. Moss acted as an agent of WorldWide.<sup>1</sup> She cannot establish this crucial element of her case without an examination of and reference to the benefit plan and what it provides to participants, including the quality of care promised by promotional materials.

There are also public policy considerations necessitating preemption. For example, if preemption is denied, both the health care provider (the physician) and the HMO will have to carry liability insurance for the acts of the provider. This will result in higher costs to plan beneficiaries. *Ricci v. Goberman*, 840 F. Supp. 316, 317-18 (D.N.J. 1993).

In short, the circumstances of the plaintiff's medical treatment by Dr. Moss under WorldWide's plan is part and parcel of her claim. The vicarious liability claim clearly "relates to" the benefit plan and is preempted by ERISA.

---

<sup>1</sup> The Supreme Court of Pacifica has adopted section 429 of the Restatement (Second) of Torts as the law of the state in this area.

The plaintiff's complaint in Count II does not allege any federal claims under ERISA, and thus it fails to state a cause of action for which relief may be granted. Count II of the plaintiff's complaint is dismissed.<sup>2</sup>

### **Denial of Benefits Claim**

WorldWide contends it is entitled to summary judgment as a matter of law as to Count III of the plaintiff's complaint because she failed to pursue the plan's internal grievance procedures after WorldWide declined to authorize the HDC/ABMT. It is well-settled that an employee's failure to exhaust administrative remedies precludes her from bringing an ERISA action after benefits have been denied. *Tolle v. Carroll Touch, Inc.*, 813 F. Supp. 1368 (C.D. Ill. 1993); *Kennedy v. Empire Blue Cross and Blue Shield*, 796 F. Supp. 764 (S.D. N.Y. 1992), *aff'd* 989 F.2d 588 (2d Cir. 1993); *Garland v. General Felt Indus., Inc.*, 777 F. Supp. 948 (N.D. Ga. 1991); *see generally, Myers v. Bethlehem Shipbuilding Corp.*, 303 U.S. 41, 50-51 (1938).

One exception to the exhaustion rule states that a participant need not exhaust her administrative remedies if to do so would be futile. This exception requires the participant show that it is certain her claim will be denied on appeal, and not merely that she doubts the appeal will result in a more favorable determination. *Smith v. Blue Cross & Blue Shield United*, 959 F.2d 655, 659 (7th Cir. 1992). There is no evidence in the record to suggest that utilization of WorldWide's grievance procedure would have been futile. I agree with WorldWide that the plaintiff should have exhausted her administrative remedies before coming to court, and her failure to do so precludes the allegations raised in Count III.

### **III. CONCLUSIONS**

Count II of the plaintiff's complaint "relates to" the benefit plan provided by WorldWide and is therefore preempted by ERISA. However, because the Count fails to state a cause of action under ERISA, the defendant's motion to dismiss is granted. The defendant's motion for summary judgment as to Count III is granted, because the plaintiff failed to exhaust her administrative remedies under the plan before filing the suit.

The court, finding no just reason for delay, pursuant to Rule 54(b) (Fed. R. Civ. P. 54(b)), hereby directs entry of a final judgment for WorldWide on Counts II and III.

### **IT IS SO ORDERED**

---

<sup>2</sup> The court recognizes this leaves the plaintiff without a remedy against WorldWide. Several courts have held a claim is still preempted under ERISA even if the plaintiff is left without a remedy. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. den.* 113 S. Ct. 812 (1992); *Lister v. Stark*, 890 F.2d 941 (7th Cir. 1989), *cert. den.* 498 U.S. 1011 (1990); *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6 (2d Cir. 1992).

**Date: January 4, 1994**

\_\_\_\_\_  
/s/ Eva M. Patterson  
DISTRICT JUDGE

**IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF PACIFICA**

<b>KATHERINE WEBSTER HAMMOND,</b>	)	
<b>Plaintiff</b>	)	
	)	<b>Civil No. 92-1895</b>
<b>v.</b>	)	
	)	
<b>DR. WAYNE EARL MOSS, M.D., and</b>	)	
<b>WORLDWIDE HEALTH,</b>	)	
<b>INCORPORATED,</b>	)	
<b>Defendants</b>	)	

**JUDGMENT**

This matter coming before the court on defendant WorldWide's motion to dismiss Count II and for summary judgment on Count III of plaintiff's complaint, it is hereby ordered and adjudged that Count II is dismissed for failure to state a cause of action, that summary judgment is entered for defendant WorldWide on Count III because of plaintiff's failure to exhaust her remedies, and that plaintiff take nothing as to defendant WorldWide.

**Date: January 4, 1994**

          /s/ Richard Powers            
CLERK OF THE COURT

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE TWELFTH CIRCUIT**

No. 94-2467

**KATHERINE WEBSTER HAMMOND,**

**Plaintiff-Appellant,**

**v.**

**WORLDWIDE HEALTH,  
INCORPORATED,**

**Defendant-Appellee.**

---

Appeal from the United States District Court  
for the Middle District of Pacifica  
Civil No. 92-1895 -- **Eva M. Patterson**, District Judge

---

Argued January 10, 1995 -- Decided February 23, 1995.

**Before NOWERS, Chief Judge, GRAVEL and BRYCE, Circuit Judges.**

**NOWERS, Chief Judge.** This diversity action comes before the court on appeal from the district court's judgment dismissing Count II of the plaintiff's complaint against the defendant and granting summary judgment for the defendant on Count III of the complaint. The district court's judgment is reversed.

**I. FACTS**

The district court's opinion adequately sets forth the facts of this case. We merely summarize them here as necessary for our analysis.

The plaintiff filed a three-count complaint against the defendants in federal district court. Only the counts of the complaint against WorldWide are involved in this appeal. Count II of the complaint alleged WorldWide, a health maintenance organization (HMO) incorporated in Delaware, provided health benefits to the plaintiff through her employer. Dr. Moss was the primary care physician the plaintiff selected from a directory of such physicians provided by WorldWide to plan participants. She alleges he failed to diagnose a cancerous tumor in her left breast. The cancer metastasized to other organs, necessitating a radical mastectomy, chemotherapy, and radiation treatments. The plaintiff contends WorldWide is vicariously liable for Dr. Moss' alleged negligence.

WorldWide moved to dismiss this count contending the state law claim is preempted by ERISA and fails to state a cause of action under ERISA, 29 U.S.C. § 1144. The district court

found ERISA preempted the claim and granted WorldWide's motion to dismiss pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure, Fed. R. Civ. P. 12(b)(6).

Count III of the complaint alleges the HMO wrongfully denied precertification for high dose chemotherapy with autologous bone marrow transplantation (HDC/ABMT), a procedure prescribed by the plaintiff's oncologist, Dr. Chang, as plaintiff's best chance for long-term survival. WorldWide refused to authorize the procedure because it concluded the procedure was experimental and thus excluded from the plan's coverage.

WorldWide moved for summary judgment on Count III of the complaint on the ground that the plaintiff failed to exhaust her administrative remedies before filing suit. The district court granted the motion.

## II. ANALYSIS

### ***Preemption***

Congress enacted ERISA to promote the interests of employees and their beneficiaries in employee benefit plans. *Shaw v. Delta Air Lines*, 463 U.S. 85, 90 (1983); 29 U.S.C. § 1001. The preemption provision found in section 1144(a) is broad because Congress intended to establish pension plan regulation as exclusively a federal concern. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). The intent was "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 142 (1990). ERISA also avoids the potential for conflict in substantive law and the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. *Id.*

Looking to Congressional intent to define the term, the Court has repeatedly held a law "relates to" a benefit plan if it has some connection with, or reference to, covered employee benefit plans. *Shaw*, 463 U.S. at 96-97. Even indirect state action bearing on private pensions may "encroach upon" the area of exclusive federal concern. *Alessi*, 451 U.S. at 525.

However, the statute itself makes clear that it does not apply to all state laws. For example, ERISA does not apply to any "generally applicable criminal law of a state." 29 U.S.C. § 1144(b)(4). Additionally, ERISA does not "exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A).

The Court, in its decision in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), indicated that ERISA plans are often sued for "run-of-the-mill" state-law

civil claims, such as torts committed by an ERISA plan. Although these suits affect and involve ERISA plans, the Court suggested they are not preempted by ERISA. *Id.* at 833.<sup>3</sup>

These decisions lead us to the conclusion that the plaintiff's medical malpractice claim based on vicarious liability, a "run-of-the-mill" state law claim, is not preempted by ERISA. First, the complaint against WorldWide seeks damages for the medical malpractice allegedly committed by Dr. Moss. This count of the complaint does not allege WorldWide denied benefits to the plaintiff and she does not seek to recover any benefits under the plan. The allegations of the complaint rely on principles of professional malpractice, not on WorldWide's obligations under the plan.

Second, nothing in the plaintiff's state tort action affects the scheme created by ERISA or its purpose. ERISA does not preempt state common law claims which are not premised on a violation of duties imposed by ERISA.

Nor does a determination of medical malpractice require an examination of the plan to decide whether the service promised was the service provided. Instead, the court will have to examine evidence of what transpired between Dr. Moss and the plaintiff, and make an assessment of whether in providing medical care or giving professional advice Dr. Moss possessed and utilized the knowledge, skill, and care usually had and exercised by physicians in his community or medical specialty. The court will also have to determine if principles of apparent or ostensible agency would apply to make Dr. Moss an agent of WorldWide.

Finally, the plaintiff brought this lawsuit on her own behalf, not on behalf of the plan. The outcome of the claim made in Count II will not affect the plan. And any damages the plaintiff recovers she will receive personally; the plan will not receive any moneys. *See Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994).

The claim made in Count II of the plaintiff's complaint is a traditional negligence and malpractice claim, traditionally covered by state law. We decline to interpret ERISA as preempting the claim in the absence of evidence of Congressional intent to do so. Count II of the plaintiff's complaint is not preempted by ERISA. The district court is reversed.

---

<sup>3</sup> The Third Circuit's decision in *Painters of Philadelphia District Council No. 21 Welfare Fund v. Price Waterhouse*, 879 F.2d 1146 (3d Cir. 1989), held that ERISA did not preempt an action against an employee welfare fund's former auditor. "[S]tate law has traditionally prescribed the standards of professional liability and, in the absence of clear indicia in the act or legislative history, we are reluctant to ascribe to Congress an intention to intrude in this area. Far from their being clear indicia of an intent to create an implied professional malpractice cause of action under ERISA, there is not a scintilla of evidence that Congress had this in its mind \*\*\*." *Id.* at 1152-53.

### ***Denial of Benefits Claim***

The district courts have discretion to decide whether to require the exhaustion of administrative remedies as a prerequisite to bringing a suit under ERISA. *Smith v. Blue Cross & Blue Shield*, 959 F.2d 655, 658 (7th Cir. 1992). The plaintiff contends the district court abused its discretion by requiring her to exhaust her administrative remedies before filing suit against WorldWide for its denial of precertification for the HDC/ABMT procedure. We agree.

The general requirement that a litigant exhaust her administrative remedies before proceeding to court advances Congressional policies underlying ERISA. It minimizes the number of frivolous lawsuits, promotes consistent treatment of claims, provides a non-adversarial dispute resolution process, and decreases the cost and time of claims settlement. *Talamine v. UNUM Life Ins. Co. of America*, 803 F. Supp. 198, 201 (N.D. Ill. 1992). There are, however, three exceptions to the exhaustion prerequisite: (1) when the nonjudicial remedy is clearly shown to be inadequate to prevent irreparable injury, (2) when resort to the nonjudicial remedy would clearly and unambiguously violate statutory or constitutional rights, and (3) when exhaustion would be futile. *Republic Indus., Inc. v. Central Pennsylvania Teamsters Pension Fund*, 693 F.2d 290, 293 (3d Cir. 1982).

The plan WorldWide provided to the plaintiff stated that WorldWide would not authorize any services which it deemed to be experimental or investigational in nature. Had the plaintiff pursued the grievance procedure, the terms of the plan itself required the Medical Review Panel to defer to the decision of the medical director, Dr. Berkstein, unless his decision was not in accord with the terms and provisions of the plan. However, the plan's terms and provisions say the HMO does not have to cover treatments it deems to be experimental.

The problem lies with the language of the plan's provision regarding exclusions, which is strikingly similar to the provision at issue in *Bucci v. Blue Cross-Blue Shield of Connecticut, Inc.*, 764 F. Supp. 728 (D. Conn. 1991). The provision sets forth no objective standard for evaluating whether a treatment is experimental or whether it is recognized as an acceptable medical treatment. Instead, the plan leaves this determination entirely to itself. WorldWide has denied the benefit on the ground that HDC/ABMT is experimental, but it made this determination using standards which were not defined in the plan.

In addition to the *Bucci* court, other courts have refused to rely exclusively on particular third-party classifications where the plan has not explicitly referenced them in defining its experimental procedure exclusion. *See Pirozzi v. Blue Cross-Blue Shield of Virginia*, 741 F. Supp. 586 (E.D. Va. 1990). This position guards against the risk that a plan defendant will opportunistically invoke a self-serving third-party classification in order to avoid liability.

Because the plan required the Medical Review Panel to defer to the decision of Dr. Berkstein, and because the plan itself contained no standards for determining whether a

procedure is experimental, it would have been futile to require the plaintiff to exhaust her administrative remedies. We are not persuaded by WorldWide's argument that Dr. Berkstein in fact relied on objective, third party information to evaluate the plaintiff's claim for benefits.

The district court abused its discretion in requiring her to exhaust her remedies, and in granting summary judgment for WorldWide on Count III. The order granting summary judgment for the defendant is reversed.

### **III. CONCLUSION**

Count II of the plaintiff's complaint, for medical malpractice, is not preempted by ERISA, and therefore the court's order dismissing the court is reversed. The district court abused its discretion in requiring the plaintiff to exhaust her administrative remedies before filing Count III of her complaint, and thus the court's order granting summary judgment for WorldWide is reversed. The district court's judgment is **REVERSED AND REMANDED** for further proceedings consistent with this opinion.

**No. 95-3045**  
**IN THE SUPREME COURT OF THE UNITED STATES**  
**OCTOBER TERM 1995**

**WORLDWIDE HEALTH INCORPORATED,**

**Petitioner,**

**v.**

**KATHERINE WEBSTER HAMMOND,**

**Respondent**

---

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

---

**ORDER GRANTING CERTIORARI**

Upon consideration of the Petition for Certiorari the Court hereby **GRANTS** the petition on the following issues:

1. Whether a claim for medical malpractice against an HMO, premised on a theory of vicarious liability, is preempted by the Employee Retirement Income Security Act.
2. Whether the plaintiff's failure to exhaust her administrative remedies under the health benefits plan should preclude her from maintaining a claim against the HMO for its denial of benefits under the health benefits plan.

**IT IS SO ORDERED.**

**Date: June 26, 1995.**