

# SACRIFICING PATIENTS FOR PROFITS: PHYSICIAN INCENTIVES TO LIMIT CARE AND ERISA FIDUCIARY DUTY

## I. INTRODUCTION

The problem of the rising cost of health care in the United States has been well documented.<sup>1</sup> In the coming years, the aging American population, technological advancement, and rising public expectations of health care will all contribute to continuing increases in medical costs.<sup>2</sup> As a result, increased attention has been focused on the proper allocation of limited health care resources<sup>3</sup> and the proper decisionmakers for those allocations.<sup>4</sup> In an attempt to limit the rise of health care costs and encourage cost-conscious decisionmaking, many Managed Care Organizations (“MCOs”)<sup>5</sup> have instituted plans giving physicians a role in rationing health care by creating financial incentives for them to limit care.<sup>6</sup>

A physician’s appointed role of gatekeeper<sup>7</sup> contrasts with a physician’s

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1. Health care spending in the United States outpaces that of other industrialized countries. “Health care now accounts for about 12% of the gross national product (GNP) of the United States and is expected to climb to 16% by the year 2000.” Daniel P. Sulmasy, *Physicians, Cost Control, and Ethics*, 116 ANNALS INTERNAL MED. 920 (1992) (footnotes omitted).

2. See David Mechanic, *Professional Judgment and the Rationing of Medical Care*, 140 U. PA. L. REV. 1713 (1992). If health care costs continue to rise at the current rate, they will reach nearly one-third of the GNP by the year 2030. See Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297 (1994).

3. Although the rising costs of health care have focused attention on the allocation of health care and services, this problem is certainly not a new concern. “No nation is wealthy enough to supply all the care that is technically feasible and desirable; no nation can provide ‘presidential medicine’ for all its citizens.” Victor R. Fuchs, *The “Rationing” of Medical Care*, 311 NEW ENG. J. MED. 1572 (1984).

4. The person or entity who makes decisions concerning allocation of health care services in an individual case serves as a gatekeeper. The gatekeeper enforces allocation decisions by allowing or denying access to services by individual patients. The physician, patient, health care payer, or third party, alone or in combination, may play the role of gatekeeper. See David Orentlicher, *Paying Physicians More To Do Less: Financial Incentives To Limit Care*, 30 U. RICH. L. REV. 155, 165-73 (1996).

5. MCOs include Health Maintenance Organizations [hereinafter HMOs], Preferred Provider Organizations [hereinafter PPOs], and a variety of other health care providers. Like traditional insurance, managed care plans offer a range of medical services to their insureds, who pay a monthly rate. The common feature of all managed care delivery systems is that they control the cost of health care by exerting either direct or indirect control over the delivery of services. See E. Haavi Morreim, *Diverse and Perverse Incentives of Managed Care: Bringing Patients into Alignment*, WIDENER L. SYMP. J., Spring 1996, at 89.

6. These plans vary widely. See *infra* note 36.

7. The term “gatekeeper” refers to the physician’s role in determining the amount and type of

traditional ethical role of caregiver, solely responsible to the patient and the patient's best interests.<sup>8</sup> A physician who receives financial incentives to limit patient care plays dual roles of caregiver and gatekeeper, thus facing a conflict of interest. In the role of caregiver, a physician remains bound by the traditional ethical duty to provide quality patient care. As a gatekeeper, however, a physician is motivated by a desire to limit patient care by making fewer referrals to specialists, ordering fewer laboratory tests, and eliminating expensive tests and treatments.<sup>9</sup> This conflict between a physician's ethical responsibility to patients and financial self-interest endangers patients by potentially denying them rightful access to life-saving medical interventions.<sup>10</sup>

Cynthia Herdrich is one such patient whose physician's financial self-interest displaced her medical needs.<sup>11</sup> On March 1, 1991, Herdrich experienced pain in her groin and went to her physician, Lori Pegram.<sup>12</sup> Six days later, at a second exam, Dr. Pegram discovered an inflamed mass in Herdrich's abdomen.<sup>13</sup> Herdrich's health plan required patients in "non-emergency" situations to receive care from facilities owned by the plan.<sup>14</sup> Herdrich's health plan classified her condition as a "non-emergency," and required her to wait eight days for an ultrasound at a plan-owned facility fifty miles from her neighborhood hospital.<sup>15</sup> While Herdrich was waiting for this procedure, her appendix ruptured, causing a life-threatening condition called peritonitis and necessitating surgery.<sup>16</sup>

Herdrich filed a medical negligence suit in Illinois state court against her

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health care offered. Commonly, MCOs require insured patients to obtain a referral from their primary-care physician in order to qualify for certain diagnostic tests, treatment options, or care from a specialist.

8. See Norman G. Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED. 1573 (1984) ("[P]hysicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations.").

9. A conservative formulation of traditional medical ethics would not allow any competing interests to interfere with the physicians' complete allegiance to their patients' best interests. Under this view, physicians have a duty to provide the best possible health care without regard for any competing considerations, especially physicians' self-interest.

10. Impaired medical decisionmaking affects patients in two ways. First, individual patients may suffer if they are incorrectly denied medical services by a gatekeeping physician acting in his or her financial self-interest. Second, when individual patients are denied care, all patients may suffer from a reduction in the general standard of care.

11. See *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), cert. granted, 120 S.Ct. 10 (U.S. Sept. 28, 1999)(No. 98-2043).

12. See *id.* at 365 n.1.

13. See *id.*

14. See *id.* at 374.

15. See *id.*

16. See *id.*

physician, Dr. Pegram, and her health plan provider, Carle Clinic Association (“Carle”).<sup>17</sup> She later amended her complaint to include two counts of state law fraud against Carle and Health Alliance Medical Plans, Inc. (“HAMP”),<sup>18</sup> an HMO which contracted with Carle to provide medical services to its members.<sup>19</sup> The defendants successfully argued that the Employee Retirement Income Security Act (“ERISA”) preempted the fraud claims, and removed the action to federal court.<sup>20</sup> The federal district judge granted summary judgment on one count,<sup>21</sup> and granted Herdrich leave to amend her complaint to state a cause of action under ERISA.<sup>22</sup> Herdrich’s amended complaint alleged that defendants breached their fiduciary duty to the beneficiaries of the plan by providing inadequate health care to beneficiaries and profiting in the amount of unpaid supplemental medical expense payments.<sup>23</sup>

The district court dismissed Herdrich’s ERISA-based complaint for failure to state a claim.<sup>24</sup> Herdrich’s medical negligence claims against Dr.

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17. *See id.* at 365.

18. *See id.* at 366. Count III, the first of the fraud causes of action, alleged that Carle failed to disclose material facts relating to the ownership of HAMP and failed to disclose “that the compensation of plan physicians was increased to the extent that they did not order diagnostic tests, utilized facilities owned by the physicians, and did not make emergency or consultation referrals.” *Id.* at 366 n.2. Count III alleged a violation of the Illinois Consumer Fraud Act, 815 ILL. COMP. STAT. 505/1 et seq. *See Herdrich*, 154 F.3d at 366 n.2. “Count IV alleged that HAMP breached its duty of good faith and fair dealing by increasing its profits and the profits of its contracted physicians through minimizing the use of diagnostic tests, emergency consultation referrals, and facilities not owned by such physicians, all to the detriment of plan beneficiaries.” *Id.*

19. The court did not clearly define the relationships between Carle Clinic Association, HAMP, and a third defendant, Carle Health Insurance Management Co., Inc. *See id.* at 363. It is apparent, however, that some or all of the physicians who formed Carle Clinic Association owned all three of the companies, and that together these three companies offered and provided medical services. It can be gathered from the opinion that “(1) HAMP is an HMO that was owned and controlled by the physicians comprising the Carle Clinic, (2) that HAMP had a contract with Carle pursuant to which Carle’s physicians were to provide covered medical services to HAMP members, and (3) that Dr. Pegram, plaintiff’s treating physician, was employed by Carle.” Daly D.E. Temchine, *Seventh Circuit’s ERISA Fiduciary Duty Ruling Is Example of Judicial Activism*, 7 HEALTH L. REP. 1421 (1998).

20. *See Herdrich*, 154 F.3d at 366. ERISA, enacted by Congress in 1974, governs all benefit plans sponsored by employers. In the area of employee benefits, ERISA broadly preempts state law. *See* 29 U.S.C. § 1144(a) (1994). Because Herdrich’s health coverage was part of an employee benefit plan sponsored by her husband’s employer, State Farm Insurance Company, the coverage was subject to ERISA.

21. The district court “granted summary judgment against Herdrich on Count IV ‘to the extent [she] relies on § 502(a)(3)(B) [of ERISA] as a basis for monetary relief, as opposed to equitable relief.’” 154 F.3d at 366.

22. *See id.*

23. *See id.*

24. *See id.* at 367. The parties agreed to have their case assigned to a magistrate judge. The magistrate recommended dismissal of the amended Count III because it did not identify how the defendants were fiduciaries with respect to the plan. *See id.* The judge denied Herdrich’s Rule 72

Pegram and Carle Clinic Association went to trial, and a jury awarded Herdrich \$35,000 in compensatory damages.<sup>25</sup> Herdrich appealed the dismissal of her ERISA-based claim.<sup>26</sup>

The United States Court of Appeals for the Seventh Circuit reversed the district court's dismissal of Herdrich's ERISA claim, holding that Herdrich properly stated a claim by alleging that "the defendants' incentive system depleted plan resources so as to benefit physicians who, coincidentally, administered the Plan, possibly to the detriment of their patients."<sup>27</sup> This decision is the first to hold that physician incentives to limit care constitute a breach of fiduciary duty under ERISA.<sup>28</sup>

The breach of fiduciary duty recognized by the *Herdrich* court creates a powerful tool for ensuring that MCOs will not sacrifice patient care in their pursuit of profit maximization. This judicial response protects the public from physician incentives that threaten the quality of medical care, while compensating plaintiffs injured as a result of these profit-maximization schemes. Further, this response effectuates the legislative purpose of ERISA to protect participants and beneficiaries under employer-sponsored programs from inefficient or dishonest plan administration.<sup>29</sup> Finally, while state medical malpractice law compensates patients injured by flawed medical decisions, currently no law compensates patients injured by flawed decision-making processes.

This Note explores the possibilities of an ERISA breach of fiduciary duty cause of action to control the use of physician incentives in managed care. Part II argues that physician incentives create ethical questions, cause conflicts of interest, and compromise patient care. Part III contends that a successful ERISA claim for breach of fiduciary duty, as in *Herdrich*, ensures

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objection to the magistrate's recommendation, but gave her leave to replead her ERISA claim. Herdrich did not replead, but instead stood on Count III as amended. *See id.*

25. *See id.*

26. *See id.*

27. *Id.* at 380. The Court of Appeals remanded to the federal district court for a trial on the merits. *See id.* Judge Flaum dissented and filed an opinion in which he disagreed with the majority's handling of the case in several respects but added:

I would not rule out the possibility that the imposition of incentives to limit care could support a claim of breach of fiduciary duty when there is a serious flaw in the manner in which the incentive arrangement is established or a significant limitation on the ability of plan sponsors to obtain alternative arrangements in the market.

*Id.* at 384 (Flaum, J., dissenting).

28. *Herdrich* is the first case to hold that a scheme of physician incentives, in and of itself, may constitute a breach of fiduciary duty. It is not, however, the first to find a violation of ERISA in connection with physician incentives. *See infra* notes 83-96 and accompanying text.

29. *See* Howard Shapiro et al., *ERISA Preemption: To Infinity and Beyond and Back Again? (A Historical Review of Supreme Court Jurisprudence)*, 58 LA. L. REV. 997 (1998).

that MCOs remain accountable to their participants and beneficiaries in controlling medical costs.

## II. PHYSICIAN INCENTIVES

The use of physician incentives emerged as a cost-saving innovation of the managed care industry.<sup>30</sup> Before the advent of managed care, fee-for-service medicine comprised the norm. In fee-for-service, patients, through a private indemnity insurer or the government, pay physicians for each service provided. The fee-for-service system offers patients freedom to select physicians and treatment options, while providing physicians complete control over clinical decisions and costs.<sup>31</sup> Meanwhile, the private insurer or the government has little or no control over patient care decisions.<sup>32</sup> The fee-for-service system contributed to the rise in health care expenditures because neither the insured patient nor the physician has incentives to limit costs.<sup>33</sup> In fact, because physicians receive payment regardless of the necessity of each service, the fee-for-service system motivates physicians to provide more care than medically necessary.<sup>34</sup>

Managed care in the United States arose in the 1970s in response to

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30. The dramatic growth of managed care has forced important changes in the economic structure of the health care industry. See generally *MANAGED CARE AND CHANGING HEALTH CARE MARKETS* (Michael A. Morrisey ed., 1998). Price competition has led to a restructuring of the market.

[M]ore and more physicians are practicing in large groups rather than singly, and are often associated with hospitals which, in turn, are becoming a part of large hospital systems. These integrated health care systems are competing with one another on price and quality to a greater degree than ever before in the United States.

John W. Pollard, *Quality in Managed Care: A Medical Perspective*, in *ACHIEVING QUALITY IN MANAGED CARE: THE ROLE OF LAW* 21, 23 (John D. Blum ed., 1997).

31. See Ryan Steven Johnson, Note, *ERISA Doctor in the House? The Duty To Disclose Physician Incentives to Limit Health Care*, 82 MINN. L. REV. 1631, 1635 (1998).

32. The private insurer or the government exerts some degree of control by limiting the scope of the policy to exclude such things as "mental health, dentistry, outpatient prescription drugs, and podiatry." Mechanic, *supra* note 2, at 1715.

33. In fee-for-service medicine, physicians and patients have exclusive control over the choice of medical options, while the payer has exclusive responsibility for its costs. Consumption of medical services remains completely independent from and unaffected by consideration of costs. Thus, fee-for-service medicine is a free-for-all, in which patients' access to care is determined solely by their insurance coverage, and it is impossible to implement broader societal judgments about the proper allocation of health care spending. See Orentlicher, *supra* note 4, at 158.

34. In traditional fee-for-service medicine, as in managed care, a conflict may exist between the best interests of the patient and the physician's financial self-interest. In the case of fee-for-service medicine, however, limiting cost is usually not a factor in the decisionmaking of either the patient or the physician. As a result, although patients may receive more care than is medically necessary, they are unlikely to be refused medically beneficial services. Thus, it is the payer (usually the insurer or the government) who is most likely to suffer from the physician's conflict of interest.

growing concerns about the fee-for-service system and escalating medical expenditures.<sup>35</sup> Although MCOs exist in a number of forms, each offers a hybrid package of health insurance and health care delivery.<sup>36</sup> Because the payment and delivery of health care are linked, the MCO can control costs by exerting direct or indirect control over patient care alternatives.<sup>37</sup> For example, MCOs may limit costs by restricting a patient's choice of physicians, specialist consultations and diagnostic and treatment options.<sup>38</sup>

Although it is a fairly recent innovation, managed care has quickly grown to dominate the health care industry. In 1997, an estimated seventy-three percent of American workers received their health care through some type of managed care system.<sup>39</sup> Enrollment in HMOs increases at a rate of ten to fifteen percent annually.<sup>40</sup> Further, approximately sixty percent of physicians received at least a portion of their income from a contractual relationship with an HMO.<sup>41</sup> The omnipresence of managed care has fundamentally impacted the structure, institutions, and costs of health care.<sup>42</sup>

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35. See, e.g., Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 400-01 (1996); Allison Faber Walsh, Comment, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 213 (1997). Managed care has seen dramatic growth in the past 15 years. In 1985, only 7.5% of insured workers received their medical coverage through a managed care organization. See Michael A. Morrissey, *Introduction*, in MANAGED CARE AND CHANGING HEALTH CARE MARKETS, *supra* note 30, at 1. By 1995, that number had jumped to 73%. See *id.*

36. Managed care includes a variety of combinations of insurer and provider. HMOs are health care plans that provide a range of health care benefits for a fixed, prepaid premium. An HMO that owns hospitals and clinics and employs health care professionals is called a staff-model HMO. A PPO is a health plan that contracts with a network of hospitals, physicians and other health care providers to furnish a comprehensive package of benefits. When plan members use a provider outside of the network, the plan reimburses only a portion of their costs. While HMOs and PPOs are currently the most common incarnations of MCOs, the managed care industry has created many other organizational forms in an attempt to contain costs by effective management and risk-shifting. See generally Orentlicher, *supra* note 4. Recently there has been a dramatic increase in the number of employers who contract directly with health care providers in physician practice networks. See Linda H. Lamel, *Significance of Risk in Direct Contracts with Health Providers*, in ACHIEVING QUALITY IN MANAGED CARE: THE ROLE OF LAW, *supra* note 30, at 79.

37. See Morreim, *supra* note 5, at 89 (defining "managed care" as "a health care delivery system that attempts to control the cost of care by controlling the provision of services").

38. The restriction of services may be through rule-based decisionmaking where, for instance, only the least expensive of several treatment options is available for a given condition; through utilization review, where an agent of the MCO must preapprove patient services or through cost-conscious decisionmaking by the primary-care physician who determines the range of options open to a given patient. See generally Frankel, *supra* note 2.

39. See Johnson, *supra* note 31, at 1638.

40. See Orentlicher, *supra* note 4, at 157.

41. See *id.*

42. See *supra* note 28. While managed care has focused attention on health care rationing, payment decisions of government programs also significantly influence the allocation of health services. For example, in the post-war period, "[n]ew medical care financing made available by

MCOs limit costs by controlling access to services at three levels: administration, physician, and patient. At the administrative level, MCOs often limit costs through rule-based decisionmaking.<sup>43</sup> At the physician level, MCOs limit costs by enabling primary-care physicians to play gatekeeping roles in determining which services should be available to patients.<sup>44</sup> At the patient level, MCOs limit costs by encouraging patients to limit their own care through co-payments.<sup>45</sup> At each level, MCOs encourage cost-conscious decisionmaking through financial incentives and risk-shifting. At the physician level, three primary forms of financial incentives limit care—capitation, salary, and withholding agreements.<sup>46</sup>

Capitation shifts the risks involved in health insurance from the MCO to physicians or physician groups by compensating them a single predetermined amount per patient per time period, regardless of the amount or type of care actually provided.<sup>47</sup> Depending on the agreement, primary-care physicians may assume costs of referrals, laboratory tests, and hospital services.<sup>48</sup> Physicians profit in a capitation arrangement by minimizing the

Medicare, Medicaid, and other government programs altered the supply of services. These programs were biased toward the reimbursement of technical procedures, in contrast to providing cognitive and counseling services characteristic of primary care.” Mechanic, *supra* note 2, at 1717.

43. For example, two drugs are available for patients with myocardial infarction who need thrombolytic therapy. One, called tissue plasminogen-activator [hereinafter tPA] seems to be slightly more effective but costs ten times as much as the alternative, streptokinase. See Morreim, *supra* note 5, at 112 n.73. Thus, one MCO allows the use of tPA “to dissolve blood clots only in patients who have large anterior myocardial infarctions and are under 75.” *Id.* (quoting Ken Terry, *Technology: The Biggest Health-Care Cost-Driver of All*, MED. ECON., Mar. 21, 1994, at 124, 132).

44. Many observers favor physician gatekeeping over rule-based decisionmaking because it allows physicians to make determinations based on their patients’ unique circumstances. In addition, no systematic set of rules can cover every conceivable patient scenario, so rule-based decisionmaking can at best be somewhat limited in scope. See Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 713 (1994) (noting that physician-based rationing of health care “permits the denial of marginally beneficial treatment only where doing so is consistent with the prevailing standard of care and thus does not constitute malpractice”).

45. MCOs rarely exploit this option because studies have shown that patients who limit their own care reduce both medically nonbeneficial and beneficial care and wait longer to receive medical attention for health problems. See Morreim, *supra* note 5, at 105. In addition, “copayment . . . deters the poor from seeking care to a greater extent than the affluent, even though poverty is associated with more illness and a greater need for care.” Mechanic, *supra* note 2, at 1719.

46. See Hall, *supra* note 44, at 758-59.

47. See generally Frances H. Miller, *Capitation & Physician Autonomy: Master of the Universe or Just Another Prisoner’s Dilemma? (What Can Britain’s National Health Service Experience Teach Us?)*, 6 HEALTH MATRIX 89 (1996).

48. See *id.* at 94-95. Miller explains:

At the simplest level, physicians can be capitated solely for delivering their own services. In such situations, they usually contract with insurers to provide whatever care (within their medical competence) patients require during a given period of time, in return for a set total fee. A more complex arrangement would capitate a primary-care doctor for *all* physician services needed by a particular patient, whether provided personally or by other professionals.

cost of each individual patient, thereby maximizing the amount by which the capitation payment exceeds the cost of care.<sup>49</sup>

Another physician-level financial incentive, paying physicians a salary, saves costs by motivating physicians to limit care in order to maximize their own free time.<sup>50</sup> Normally each physician maintains a certain number of patients. Physicians therefore have an incentive to minimize the time spent on each patient in order to maximize the amount of time available to pursue other professional or personal interests.<sup>51</sup>

The third physician-level financial incentive, a withholding agreement, often operates in conjunction with capitation and salary to limit patient access to outside services such as specialists, hospital services, and diagnostic and treatment procedures.<sup>52</sup> Such withholding agreements directly reward physicians for providing fewer referrals and other specialized services. In one form of withholding agreement, MCOs create a “risk pool” from a percentage of each physician’s capitation payment; this “risk pool” pays for referrals and other additional services.<sup>53</sup> At the end of the accounting period, participating physicians receive as a bonus a distribution of surplus funds in the risk pool. In some withholding arrangements, physicians must compensate the MCO for any deficit in the risk pool at the end of the accounting period.<sup>54</sup>

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*Id.*

49. Physicians that provide some or all of their services under capitation agreements have incentives to maximize profit in two ways. First, they serve their own financial interests by spending less time and money on individual patients and by restricting access to specialized services. Second, because the MCO compensates the physician a set amount per patient, capitated physicians have an incentive to increase the number of patients covered under the capitation agreements. Each of these incentives may lead to a reduction in the standard of care.

50. Salaried physicians are the hallmark of a staff-model HMO, which is a specific type of MCO that owns hospitals and clinics and employs health care professionals. *See generally* Orentlicher, *supra* note 4. Kaiser Health Care is one example of a staff-model HMO.

51. *See* Orentlicher, *supra* note 4, at 159. Orentlicher explains the differing effects of salary and capitation. Salaried physicians have personal incentives to limit the number of patients they serve in order to increase their free time, while physicians who provide services on a capitation basis have incentive to maximize the number of patients they serve in order to increase their personal income. *See id.*

52. MCOs impose various incentives to limit access to outside services. A capitation agreement that requires capitated physicians to be responsible not only for primary care but also laboratory, specialist, and/or hospital services is one way to minimize use of these benefits. Alternatively, if the MCO is responsible for payment of outside services it may discourage the use of these services by offering financial rewards to primary-care physicians who make fewer referrals and imposing penalties on those who over-utilize specialized care.

53. These withholding agreements typically constitute from 10% to 30% of the physician’s capitation amount, and 20% is most common. *See* Hall, *supra* note 44, at 773-74.

54. Stop-loss protection moderates the risk assumed by physician groups in both capitation and withholding agreement arrangements. Although the form varies, it generally ensures that the physician group will not suffer losses greater than a given amount either for a single patient or across all patients



Many commentators favor physician incentives. Physician incentives to limit care and other cost-cutting techniques instituted by the managed care industry have successfully limited the costs of health care.<sup>55</sup> Many commentators argue that physician incentives are crucial to managing the costs of health care by making physicians responsible for the cost-sensitivity of their decisions.<sup>56</sup> As one commentator asks, “[w]hy should health care providers be exempt from this entirely common and appropriate concern of professionals, service providers and manufacturers?”<sup>57</sup> In addition, physicians have always acted as patients’ access point for available health care alternatives, and thus already function as de facto gatekeepers.<sup>58</sup> Under traditional fee-for-service medicine, physicians receive incentives to become “factitious gatekeepers”<sup>59</sup> because they directly profit from ordering more tests and procedures. Therefore, commentators argue that MCO financial incentives reverse the bias of fee-for-service medicine by eliminating incentives for waste and substituting incentives for thrift.<sup>60</sup>

Additionally, many argue that while physicians are not ideally situated to assume roles as restrictive gatekeepers,<sup>61</sup> they are nonetheless better situated than the alternatives.<sup>62</sup> Presumably, physicians are best situated to make

in a certain time period. Stop-loss protection is required for Medicare and Medicaid providers when the physician or physician group faces “significant financial risk,” as determined by amount and immediacy of risk. *See id.* at 775.

55. One study found that increased enrollment in managed care has led to an overall reduction in the growth of medical spending. *See* DAVID M. CUTLER & LOUISE SHEINER, *MANAGED CARE AND THE GROWTH OF MEDICAL EXPENDITURES* 102 (National Bureau of Econ. Research Working Paper Series No. 6140, 1997). From 1960 to 1990, per capita medical expenditures increased about 5% per year. *See id.* at 3. Since 1992, this rate of expansion has slowed significantly. Medical expenditures increased by 1.5% in 1994, and by 2.1% in 1995. *See id.* at 3-4. The authors theorize that the reduction in costs in the current managed care-dominated health care industry results from three factors. First, MCOs have the necessary leverage to negotiate reductions in the cost of services. *See id.* at 5. Second, by excluding experimental treatments from their range of services, MCOs reduce the growth of medical technology. *See id.* at 6. Finally, the managed care industry has saved money by reducing the quantity of services provided to their beneficiaries by limiting access to specialists, reducing the length of hospital stays and restricting consumption of medical services in other ways. *See id.* at 5-6.

56. *See generally* Orentlicher, *supra* note 4; *see also* Hall, *supra* note 44.

57. Temchine, *supra* note 19, at 1424.

58. *See* Sulmasy, *supra* note 1, at 923. Physicians are de facto gatekeepers because they “actually control the supply and can influence the demand for medical interventions.” *Id.*

59. “[T]hat is, to order unnecessary tests and treatments in order to generate a profit.” *Id.*

60. *See, e.g.,* Temchine, *supra* note 19, at 1424.

61. A restrictive gatekeeper participates in restrictive allocations of health care by reducing patient access to specialized services. The phrase “restrictive gatekeeper” comes from Sulmasy, *supra* note 1, at 921.

62. *See supra* notes 44-45 and accompanying text. Alternative restrictive gatekeeping mechanisms include central administrative decisionmaking by the MCO and patient-motivated reduction in services through the use of co-payments. *See* Orentlicher, *supra* note 4, at 172, 188-89. Physicians are well situated to make rationing decisions because they “will know much of the information about the benefits, risks and costs of treatment relevant to making the rationing decisions

diagnostic and treatment judgments because they are most familiar with their individual patients and their patients' unique medical and personal situations.<sup>63</sup> Thus, restricting medical care at the physician level promotes patient care by avoiding imprecise, generalized decisions by administrators unfamiliar with individual patients.<sup>64</sup>

Despite these practical arguments in favor of physician incentives, traditional medical ethics staunchly oppose them.<sup>65</sup> Simply put, traditional ethics dictate that "physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations."<sup>66</sup> The American Medical Association and the American College of Physicians take the position that the patients' interests should remain paramount, and financial incentives should not compromise a physician's ability to advocate for patients.<sup>67</sup> Two principle concerns underlie

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before them." *Id.* at 173.

63. A related argument in favor of physician incentives emphasizes that incentives provide greater clinical autonomy in allowing physicians broader range for their decisionmaking. *See* Miller, *supra* note 47, at 97.

64. *See* Hall, *supra* note 44, at 702-03. While individual physicians ideally are best able to assess the needs of their patients, their medical decisions are influenced by their own personal judgments about their patients and tend to vary widely among physicians. For example, Hall says that "there is reason to believe that physician rationers will tend to favor more articulate, higher-educated patients who are better equipped to voice their demands, and that they will devote disproportionate time to high-visibility 'dread' diseases or those that command their individual research or intellectual interests." *Id.* at 715.

65. *See generally For Our Patients, Not for Profits: A Call to Action*, 278 JAMA 1733 (1997). A large group of Massachusetts physicians and nurses signed an open letter in the Journal of the American Medical Association, affirming five basic tenets, including "[p]ursuit of corporate profit and personal fortune have no place in caregiving," and "[p]otent financial incentives that reward overcare or undercare weaken patient-physician and patient-nurse bonds and should be prohibited." *Id.* at 1733.

66. Levinsky, *supra* note 8, at 1573. Levinsky argues that the physician's duty to his patient as an advocate remains absolute and, therefore, cannot be compromised by any other considerations, including the needs of other patients or society in general. *See id.* at 1573-75.

67. *See* Susan M. Wolf, *Health Care Reform and the Future of Physician Ethics*, HASTINGS CENTER REP., Mar. 1, 1994, at 28, 33. The AMA's Principles of Medical Ethics state "under no circumstances may the physician place his own financial interest above the welfare of his patients. . . . If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit." CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION: INCLUDING THE PRINCIPLES OF MEDICAL ETHICS AND RULES OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, Opinion 8.07 (AMA 1986). Likewise, the American College of Physicians' manual states: "The physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of the patient." Ad Hoc Committee on Medical Ethics, *American College of Physicians, American College of Physicians Ethics Manual Part I: History of Medical Ethics, The Physician and the Patient, The Physician's Relationship to Other Physicians, The Physician and Society*, in 101 ANNALS OF INTERNAL MED. 129, 134 (1984). However, while neither seems to advocate a blanket prohibition on physician incentives, neither clearly delineates the point at which physician incentives compromise physicians' paramount duty to their patients. *See* Gregory D. Jones, Note, *Primum Non Nocere: The Expanding "Honest Services" Mail Fraud Statute and the Physician-Patient Fiduciary Relationship*, 51 VAND. L. REV. 139, 163-65 (1998).

this distrust of physician incentives—damage to the essential trust in physician-patient relationships and jeopardized patient care.

Trust is crucial to the physician-patient relationship because of the disparity of knowledge and dependence inherent in the relationship; physicians act as the exclusive source of expertise and help for sick, vulnerable patients.<sup>68</sup> When physicians function as restrictive gatekeepers as a result of their own self-interest, the trust between physician and patient erodes.<sup>69</sup> Disruption of trust could lead to lower quality care if it dissuades patients from seeking medical attention early or from following the advice of their physicians.

Patient care might suffer in other ways. In Great Britain, where physicians act as restrictive gatekeepers, evidence shows the standard of care declining as physicians justify their cost-cutting decisions by changing their definitions of medically necessary care.<sup>70</sup> As physicians differ in their personal judgments about cost-cutting, the standard of care will vary widely as well.<sup>71</sup> When a physician bears responsibility only to patients, the physician remains free to act as a knowledgeable, skilled, and trustworthy advocate in delivering to the patient the best care available. More importantly, the physician remains free to advocate for the patient when the MCO offers insufficient care.

Recognizing the dangers of physician incentives to limit care, Congress limited physician incentives in health care plans that provide services to Medicare and Medicaid recipients.<sup>72</sup> These controls prohibit “specific payment . . . under the plan to a physician or physician group as an

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68. See Alexander M. Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 734 (1985-86) (“The nature of the material over which the physician has control is both personal and technologically sophisticated, which creates an imbalance between physician and patient”).

69. See Sulmasy, *supra* note 1, at 1922. Sulmasy presents the example of a patient who would benefit from having oxygen at home, but whose physician determines that it is not medically necessary and thus, functions as a restrictive gatekeeper. See *id.* “An honest doctor might say . . . , ‘No, you can’t have oxygen at home because I need the money to send my children to college.’ A less honest physician might say ‘Oxygen won’t help you.’” *Id.* Both of these options create disruption of the physician-patient relationship. See *id.*

70. See Levinsky, *supra* note 8, at 1574. In Britain “physicians ‘seem to seek medical justification for decisions forced on them by resource limits. Doctors gradually redefine standards of care so that they can escape the constant recognition that financial limits compel them to do less than their best.’” *Id.* (quoting H.J. AARON & W.B. SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE* (1984)).

71. The standard of care may vary not only among physicians but among patients as well. See Hall, *supra* note 44.

72. See Omnibus Budget Reconciliation Act of 1990, 42 U.S.C. § 1395mm(i)(8)(A)-(B) (Supp. V 1993). See also Hall, *supra* note 44, at 772-76 (discussing federal regulation of physician incentives under Medicare). These controls do not affect private health plans.

inducement to reduce or limit medically necessary services provided *with respect to a specific individual*.”<sup>73</sup> This element of the limitations only applies to incentives directed at specific payments.<sup>74</sup> Congress broadened the limitation, however, by regulating physician incentives that create “substantial financial risk,”<sup>75</sup> as when a capitation agreement imposes a large risk for many patients spread among few physicians.<sup>76</sup> No similar controls affect private health plans, and no widely recognized cause of action exists for patients who have been injured by excessive physician incentive programs.

### III. ERISA AND THE CAUSE OF ACTION

#### A. ERISA

Congress enacted the Employee Retirement Income Security Act (“ERISA”) in 1974 primarily to create minimum standards for the protection of employee pension benefits.<sup>77</sup> ERISA applies to all benefit programs of all employers who engage in interstate commerce, including most employer-sponsored health care plans.<sup>78</sup> Congress intended both to protect beneficiaries of employer sponsored plans by improving the financial stability of those plans and to create “a uniform set of federal rules that would ease their administration and minimize unanticipated expenses. State-based claims against benefit plans were thereby preempted in favor of purely federal causes and remedies.”<sup>79</sup>

ERISA broadly preempts state laws, “supersed[ing] any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.”<sup>80</sup> Courts have interpreted this to include claims against MCOs for denial of benefits but not claims against physicians for medical malpractice.<sup>81</sup> For

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73. 42 U.S.C. § 1395mm(i)(8)(A)(i) (emphasis added).

74. See Hall, *supra* note 44, at 775.

75. See 42 U.S.C. § 1395mm(i)(8)(A)(ii).

76. The amount of risk assumed by a physician group in a capitation agreement is a function of the number and type of services which the physicians are responsible for providing, the number of capitated patients, and the number of participating physicians.

77. See Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 189 (1997).

78. See 29 U.S.C. § 1003(a)(1) (1994).

79. E. Haavi Morreim, *Benefits Decisions in ERISA Plans: Diminishing Deference to Fiduciaries and an Emerging Problem for Provider-Sponsored Organizations*, 65 TENN. L. REV. 511, 512 (1998).

80. 29 U.S.C. § 1144(a) (1994).

81. See Robert A. Clifford, *Physician's Liability in a Managed Care Environment*, 10 HEALTH LAW. 5, 8 (1997). There are two reasons that ERISA preempts state law related MCO administration but not physician negligence. First, malpractice claims against physicians are too tenuously related to

example, in *Herdrich*, Cynthia Herdrich received a jury verdict on a state law medical malpractice claim but ERISA preempted her state law fraud claim, forcing her to replead her claim in federal court.<sup>82</sup>

ERISA's broad preemption means that regulation of MCO incentive plans must take place at the federal level. If the ERISA fiduciary duty fails to encompass a prohibition on excessive physician incentives, Congress must implement such a prohibition.

### *B. Existing Duties: The Duty to Inform*

In *Shea v. Esensten*,<sup>83</sup> the Eighth Circuit held that an HMO had a fiduciary duty<sup>84</sup> under ERISA to disclose a physician incentive structure.<sup>85</sup> During an overseas business trip, Patrick Shea was hospitalized with severe chest pains.<sup>86</sup> When he returned home, he made several visits to his family physician, who was aware of Mr. Shea's family history of heart disease.<sup>87</sup> Despite Mr. Shea's warning signs of chest pains, shortness of breath, muscle tingling, and dizziness, his physician said that a "referral to a cardiologist was unnecessary."<sup>88</sup> Mr. Shea even offered to pay for a cardiologist on his own, but his physician persuaded him that the forty-year-old Shea was "too young and did not have enough symptoms to justify a visit to a cardiologist."<sup>89</sup> A few months later, Mr. Shea died of heart failure.<sup>90</sup> In her complaint against the HMO, Mr. Shea's widow alleged a breach of fiduciary duty for the HMO's failure to disclose that it offered financial incentives for physicians to limit care.<sup>91</sup> She further claimed that if their HMO would have informed them of the physician incentives, they would have chosen to seek a

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the employee benefits plan to fall under ERISA. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983). Second, if ERISA preempted state medical malpractice law, MCOs would enjoy a protected status that would be unique in the law, and "never contemplated by Congress." *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Mem'l Hosp.*, 995 F.2d 1179, 1194 (3d Cir. 1993).

82. 154 F.3d 362, 365.

83. 107 F.3d 625 (8th Cir. 1997).

84. For a discussion of fiduciary duty under ERISA, *see infra* notes 103-09.

85. *See* 107 F.3d at 629.

86. *See id.* at 626.

87. *See id.*

88. *Id.*

89. *Id.*

90. *See id.*

91. *See id.* at 627. Mr. Shea's HMO required patients to receive a written referral from their primary-care physician before consulting with a specialist. *See id.* The HMO utilized a cost-saving device whereby "the primary care doctors were rewarded for not making covered referrals to specialists, and were docked a portion of their fees if they made too many." *Id.*

cardiologist on their own.<sup>92</sup>

In holding that Mr. Shea's HMO had a duty to disclose its incentive arrangement the court relied in part on the Supreme Court decision in *Varity Corporation v. Howe*.<sup>93</sup> In *Varity Corporation*, the Supreme Court held that section 404(a)(1) of ERISA, which "requires a 'fiduciary' to 'discharge his duties with respect to a plan solely in the interests of the participants and beneficiaries,'" codifies the common law of trusts' duty of loyalty.<sup>94</sup> The common law of trusts imposes broad disclosure requirements,<sup>95</sup> and the Supreme Court easily could have held that this included the "material fact" of physician incentives. The *Shea* decision has stirred up much debate, but it remains to be seen whether other circuits will follow the Eighth Circuit's lead in imposing upon HMOS a fiduciary duty to disclose financial incentives for physicians.<sup>96</sup>

### C. The Cause of Action

As forward-looking as ERISA was at the time it was written, it does not specifically address the unique problems raised by the managed care industry.<sup>97</sup> At the same time, ERISA preempts state law on fraud and agency as they relate to managed care. The combination of these two factors has left the cost-cutting innovations devised by the managed care industry "ungoverned and ungovernable," denying beneficiaries any protection from the allocation decisions and mechanisms of their health plan and providers.

Congress has not specifically limited physician incentives in private

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92. *See id.*

93. 516 U.S. 489 (1996). *See* 107 F.3d at 628.

94. 516 U.S. at 506 (quoting ERISA § 404(a)(1)). The Supreme Court did not reach the issue of what constitutes the proper scope of the duty of loyalty. *See id.* The Eighth Circuit Court of Appeals decision in *Varity Corp.*, affirmed by the Supreme Court, however, held that "the duty of loyalty requires an ERISA fiduciary to communicate any material facts which could adversely affect a plan member's interests." *Shea*, 107 F.3d at 628 (citing *Howe v. Varity Corp.*, 36 F.3d 746, 754 (8th Cir. 1994)).

95. *See Johnson*, *supra* note 31, at 1645. Common law typically does not impose an affirmative duty of disclosure on fiduciaries, absent direct inquiry. *Id.* "The common law does recognize, however, an affirmative duty when the trustee possesses superior knowledge of certain information that the beneficiary needs to know to protect her interests." *Id.*

96. Other courts have addressed the extent of ERISA fiduciary duty in the context of physician incentive schemes. In *Maltz v. Aetna Health Plans of New York*, 114 F.3d 9 (2d Cir. 1997), the Second Circuit seemed to accept Shea's rationale in holding that fiduciary duty is not breached when a beneficiary has full knowledge of changes in the incentive structure of her health plan. However, the Southern District of New York expressly rejected *Shea* in *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 755 n.6 (S.D.N.Y. 1997).

97. *See Shapiro*, *supra* note 29. ERISA's preemption provision provides that "[t]he provisions of . . . [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1994).

health care. However, logic and equity justify expanding ERISA's fiduciary duty requirements to impose a duty on MCOs to ensure that physician incentives do not compromise patient care. Further, recognition that physician incentives can amount to a breach of the MCO's fiduciary duty is necessary both to protect the public from ethically questionable practices and to compensate injured plaintiffs.

The extension of liability to MCOs for physician incentive plans is consistent with the legislative intent of ERISA. Through ERISA, Congress intended to protect participants and beneficiaries of employee-sponsored plans from "perceived abuses involving the management of funds accumulated to finance various types of benefit plans."<sup>98</sup> In the era of indemnity insurance and fee-for-service medicine, Congress could not have envisioned the specific provisions required to protect consumers of managed health care from cost-saving innovations that endanger patients and compromise their quality of care. With proper judicial interpretation, however, ERISA's broad definitions of fiduciary<sup>99</sup> and fiduciary duty<sup>100</sup> can adequately effectuate Congressional intent in the context of managed care.

Existing legal mechanisms insufficiently protect patients in managed care from excessive physician incentive programs. State malpractice claims may compensate injured plaintiffs for flawed medical decisions. The flawed decision-making process that endangered these plaintiffs, however, is beyond the grasp of current law. ERISA broadly preempts state fraud and agency law, but ERISA itself contains no provisions specifically protecting health care consumers from MCO abuses.

Opponents of a breach of fiduciary duty cause of action in the context of physician incentives claim either that it is unnecessary or that it prevents MCOs from controlling costs. These arguments are unpersuasive.

Opponents argue that this cause of action is unnecessary because market forces adequately control quality within the managed care industry.<sup>101</sup> Fierce

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98. See Shapiro, *supra* note 29, at 997.

99. See *infra* notes 103-109 and accompanying text.

100. See *infra* notes 110-118 and accompanying text.

101. See *Herdrich v. Pegram*, 154 F.3d 362, 381-82 (7th Cir. 1998) (Flaum, J., dissenting). In the *Herdrich* dissent, Judge Flaum argued that "market forces help reduce the risk that the fiduciary's conflict of interest in making coverage decisions will work to the detriment of the plan and the plan beneficiaries." *Id.* at 381. Judge Flaum further argued that the sponsor of Cynthia Herdrich's plan, State Farm, was an experienced consumer of health benefits, stating:

The defendants do have a financial interest in denying coverage . . . [b]ut State Farm has an interest in ensuring that its employees are satisfied with their fringe benefits, and the defendants have an interest in ensuring that State Farm is satisfied with the defendants' performance in delivering health care to the beneficiaries. In this sense, the interests of the administrator align with the interests of the beneficiaries and the sponsor.

competition in the health care industry will force out MCOs offering poor care, because consumers will choose plans that combine efficient cost control with quality health care. This argument ignores two unique aspects of the current health care system. First, employees often have little or no choice in selecting their health plans. Second, patients seldom have the expertise to know if they are receiving quality care unless the failure to provide adequate care results in injury.

The argument that a breach of fiduciary duty cause of action would prevent MCOs from controlling costs is likewise unpersuasive. First, only excessive, health-endangering physician incentives constitute a breach of fiduciary duty. Such schemes exceed the range of allowable MCO innovation. Second, cost management at other levels of the MCO will be unaffected. Patients benefit when physicians do not bear primary responsibility for cost control, because this enables physicians to focus their loyalty and advocacy solely on their patients.

The breach of fiduciary duty cause of action used in *Herdrich* consists of three required elements: the defendants must be plan fiduciaries, the defendants must have breached their fiduciary duties, and there must be a cognizable loss to the plan.<sup>102</sup> The following section considers each element in turn.

### *1. Managed Care Organizations are ERISA Fiduciaries*

ERISA broadly defines a plan fiduciary,<sup>103</sup> providing that a person or entity is a plan fiduciary “to the extent” that he or she has discretionary authority or control over either plan management or administration.<sup>104</sup> Congress expressed an intent to have “fiduciary” interpreted broadly, and courts have construed it consistent with this intent.<sup>105</sup>

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*Id.* at 382.

102. *See id.* at 369.

103. *See* 29 U.S.C. § 1002(21)(A) (1994). It provides:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . or (iii) he has any discretionary authority or responsibility in the administration of such plan.

*Id.*

104. *See id.* *See also* Robert N. Eccles, *Fiduciary Litigation Under ERISA*, in *PENSION PLAN INVESTMENTS: CONFRONTING TODAY’S ISSUES* 9, 13 (Howard Pianko & A. Richard Susko co-chairs, 1998).

105. *See Herdrich*, 154 F.3d at 370. The court in *Herdrich* recited the following statement of the Chairman of the House Committee on Education and Labor in 1974:

The Committee has adopted the view that the definition of fiduciary is of necessity broad. . . . A



The test for determining whether a given person or entity is a fiduciary with respect to the plan hinges on the person or entity's "actions, [and] not the official designation of his role."<sup>106</sup> The Supreme Court adopted this functional test in *Mertens v. Hewitt Associates*.<sup>107</sup> Under the functional test adopted in *Mertens*, the *Herdrich* Court correctly determined that the MCO was a fiduciary with respect to the plan.<sup>108</sup> Indeed, most MCOs maintain some discretion and control over claims and therefore would be considered fiduciaries.<sup>109</sup>

## 2. Physician Incentives Can Constitute a Breach of Duty

Physician incentives may not only be ethically questionable and unwise,<sup>110</sup> they may also rise to the level of breach of fiduciary duty.<sup>111</sup> To determine when physician incentives cross this fiduciary line, a court must consider the duties of a fiduciary under ERISA.<sup>112</sup> Under ERISA, plan

fiduciary need not be a person with direct access to the assets of the plan. . . . Conduct alone may in appropriate circumstances impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary.

*Id.* at 370 (quoting 120 CONG. REC. 3977, 3983 (daily ed. Feb. 25, 1974) (statement of Chairman of the House Committee on Education and Labor), *reprinted in* 2 Legislative History of the Employment Retirement Income Security Act of 1974, at 3309).

106. *See Eccles*, *supra* note 104, at 14 (citing *Acosta v. Pacific Enterprises*, 950 F.2d 611, 618 (9th Cir 1991)).

107. 508 U.S. 248, 262 (1993) ("[ERISA] 'defines 'fiduciary' not in terms of formal trusteeship, but in *functional* terms of control and authority over the plan, . . . thus expanding the universe of persons subject to fiduciary duties.'").

108. *See* 154 F.3d at 371. "Herdrich pleaded that the defendants had the exclusive right to decide all disputed and non-routine claims." *Id.* at 370. Herdrich also pleaded that "[u]nder the Plan, defendants exercise discretionary authority and discretionary control of claims management, property and asset management, and administration of the Plan." *Id.* at 366 n.3. Thus, the defendants in *Herdrich* were fiduciaries concerning claims and plan assets, bringing them under the purview of ERISA in these areas. *See id.* at 370-71.

109. MCOs have been deemed fiduciaries in other, related contexts. *See, e.g., Shea v. Esensten*, 107 F.3d 625, 628-29 (8th Cir. 1997). For a discussion of *Shea*, see *supra* notes 83-96 and accompanying text.

110. *See supra* notes 65-76 and accompanying text.

111. *See Herdrich*, 154 F.3d at 380.

112. 29 U.S.C. § 1104(a)(1) provides in part:

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

fiduciaries must act “solely in the interest of the participants and beneficiaries” and for the “exclusive purpose” of “providing benefits” and “defraying reasonable expenses of administering the plan.”<sup>113</sup> Courts and commentators have labeled this the “exclusive benefit rule.” Courts have interpreted these requirements as a codification of the duty of loyalty imposed by the common law of trusts.<sup>114</sup>

Despite the absolute wording of ERISA, courts have not interpreted the exclusive benefit rule as a blanket prohibition on all conflicting interests.<sup>115</sup> For example, in *Chalmers v. Quaker Oats Company*,<sup>116</sup> the Seventh Circuit held that it did not constitute a conflict of interest for corporate officers to serve on the plan administration committee, despite the fact that the benefits were paid directly from the company’s earnings.<sup>117</sup>

The conflict of interest in *Herdrich* was more significant than in *Chalmers*. In *Chalmers*, although the benefits were paid from the company’s earnings, plan administration decisions did not affect the personal finances of plan administrators.<sup>118</sup> In *Herdrich*, by contrast, the physician incentives created a conflict of interest by juxtaposing the medical interest of the patient with the financial self-interest of the physician. When plan administration decisions, such as when to approve diagnosis, treatment, and referral options, interconnect too closely with the physicians’ self-interest, these decisions violate the exclusive benefit rule.

### 3. *Loss to the Plan*

ERISA allows either a participant or beneficiary of a plan to bring an action against fiduciaries who breach their duty to the plan.<sup>119</sup> Through this

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29 U.S.C. § 1104(a)(1)(A)-(B) (1994).

113. *See id.*

114. *See* *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996); Eccles, *supra* note 104, at 16.

115. *See* Daniel Fischel & John H. Langbein, *ERISA’s Fundamental Contradiction: The Exclusive Benefit Rule* 55 U. CHI. L. REV. 1105, 1107 (1988) (arguing that the exclusive benefit rule should be “on the list of ERISA’s major blunders” because it fails to take into account the complexities of modern pensions and employee welfare benefit programs).

116. 61 F.3d 1340 (7th Cir. 1995).

117. *See id.* at 1344.

118. *Id.*

119. 29 U.S.C. § 1109(a) provides: “[a]ny person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by [ERISA] . . . shall be personally liable to make good to such plan any losses to the plan resulting from each such breach.” 29 U.S.C. § 1109(a) (1994). Furthermore, § 1132(a) allows a civil action to be brought “by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of [ERISA] . . . or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of [ERISA] . . . or the terms of the plan.” 29 U.S.C. § 1132(a). *See also* *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 (1985) (holding

action in equity, the beneficiary may recoup monies expended in violation of ERISA. Because the ERISA fiduciary duties run to the plan and not to the individual beneficiaries,<sup>120</sup> a cause of action brought by a beneficiary is on behalf of the plan. Thus, the plaintiff must show that the violation resulted in a loss to the plan.

When beneficiaries are denied medical benefits because of the breach of fiduciary duty, the plan suffers a loss in the cost of the supplementary medical expenses.<sup>121</sup> Through the sponsor's contract with the MCO, beneficiaries are entitled to receive medical benefits. When those benefits are denied or delayed long enough to cause injury, the plan suffers a loss in the amount of the services that should have been provided. For example, Cynthia Herdrich's plan suffered a loss equivalent to the amount that her MCO would have spent in supplying her with adequate, timely diagnosis and treatment of her appendicitis.<sup>122</sup>

#### IV. CONCLUSION

Physician incentives to limit care may create a powerful tool for MCOs to shift the risks of health care to physicians and decrease health care expenditures. Unfortunately, such incentives place physicians in a conflict between their financial self-interest and the best interests of their patients. This creates a danger that both individual patient care and the standard of care in general will decline. When physician incentives are excessive, the resulting conflict of interest breaches not only an ethical duty, but a legal duty as well.

Participants and beneficiaries of a health care plan governed by ERISA need the protection of a breach of fiduciary duty cause of action against MCOs creating unduly high incentives to limit care. While a state-law medical malpractice claim may compensate the plaintiff for a single erroneous medical decision, the breach of fiduciary duty cause of action protects all participants and beneficiaries from a flawed decision-making process.

The Seventh Circuit correctly recognized this cause of action in *Herdrich*.

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“[t]here can be no disagreement . . . that § [1132(a)] authorizes a beneficiary to bring an action against a fiduciary who has violated § [1109].”

120. See, e.g., *Harsch v. Eisenberg*, 956 F.2d 651, 657 (7th Cir. 1992).

121. See *Herdrich v. Pegram*, 154 F.3d 362, 380 (7th Cir. 1998).

122. See *id.* “[I]n paragraph 13 of her complaint, Herdrich alleges that as a result of the defendants’ actions, the Plan was deprived of the supplemental medical expense payment amounts in controversy. We thus hold that she has alleged with sufficient clarity that the Plan suffered a loss as a result of the defendants’ actions.” *Id.*

That decision established that MCOs constitute fiduciaries with respect to their beneficiaries, that excessive incentives can amount to a breach of their duty, and that individual beneficiaries have a cause of action to recover the loss to the plan. This cause of action provides a powerful tool to protect the public from unchecked experimentation by the managed care industry.

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