HERDRICH V. PEGRAM: ERISA FIDUCIARY LIABILITY AND PHYSICIAN INCENTIVES TO DENY CARE

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INTRODUCTION

Health care in America has become "dangerously expensive."[1] In 1993, President Clinton warned that:

> [m]illions of Americans are just a pink slip away from losing their health insurance, and just one serious illness away from losing all their savings. . . . [O]n any given day, over 37 million Americans . . . have no health insurance at all. And in spite of all this, our medical bills are growing at over twice the rate of inflation, and the United States spends over a third more of its income on health care than any other nation on earth. And the gap is growing, causing our companies in global competition severe disadvantage.[2]

This explosion in the cost of health care makes it increasingly clear that we can no longer afford all medically beneficial care, and that we must find tools to control costs.[3]

In this environment of ever-increasing costs, Health Maintenance Organizations ("HMOs") and their cost-saving practices have flourished.[4] Studies have found that HMOs cost between ten and forty percent less than traditional "fee for service"[5] plans,[6] and the public has responded by consistently

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1. *See* Arnold S. Relman, *Foreword* to MARC A. RODWIN, MEDICINE, MONEY, AND MORALS (1993).

2. President William J. Clinton, Address to Congress on Health Care (Sept. 22, 1993), *in* BARRY R. FURROW ET AL., HEALTH CARE LAW 718 (3d ed. 1997).

3. *See* David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 156 (1996).

4. *See* Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219 (1997).

5. "Fee for service" refers to a method of pay whereby a patient or third-party payor pays for each individual service provided. *See* RODWIN, *supra* note 1,

voting for cost containment with its pocketbook.[7] The use of physician financial incentives has proven vital to the success of HMOs in controlling costs.[8] Because physicians play such an integral role in health care delivery, cost containment is impossible unless they make it an essential factor in their decision making.[9] In fact, physician incentives are probably the only effective way to make physicians cost-conscious.[10]

Despite their vital role in the battle for cost containment, physician incentives have come under attack.[11] Critics argue that physician financial incentives should be limited or even prohibited because of their perceived negative impact on quality of care.[12] Only recently have these concerns reached the courts, and, for the most part, such concerns have not led to liability.[13] One recent decision, however, may signal the death knell for physician incentives. In *Herdrich v. Pegram*[14] the Seventh Circuit Court of Appeals allowed the plaintiff to pursue her claim for breach of fiduciary duty under the Employee Retirement Security Income Act ("ERISA")[15] against a health care plan, based solely on the plan's use of physician incentives.[16] If not overturned, this case may very well prevent HMOs from utilizing physician incentives without incurring liability under ERISA.[17]

This casenote argues that the federal courts should not impose ERISA fiduciary liability on health care plans based solely on the plan's use of physician incentives. Instead, federal courts should impose fiduciary liability on health plans only when a plan fails to disclose the use of physician incen-

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at 2. Notice that the "fee for service" system gives physicians a substantial financial interest in increasing the amount of care provided. *See id.*

6. *See* Barry R. Furrow, *Litigation Over Quality in Managed Care: Individual Malpractice/Negligence Claims in Arbitration and Litigation*, *in* MANAGED CARE LIABILITY 18 (David L. Leitner ed., 1997).

7. *See* Orentlicher, *supra* note 3, at 157.

8. *See id.* at 164. These financial incentives include capitation, bonuses, and fee withholds. For a description of these techniques, see *infra* Part I of this casenote.

9. *See id.*

10. *See id.*

11. *See* Noah, *supra* note 4, at 1220–21.

12. *See* Orentlicher, *supra* note 3.

13. *See infra* note 44 and accompanying text.

14. 154 F.3d 362 (7th Cir. 1998), *cert. granted*, 120 S. Ct. 10 (1999).

15. 29 U.S.C. §§ 1001–1461 (1994).

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

17. See David G. Savage, *Cost-Cutting Consequences*, 86 A.B.A. J. 30 (2000).

tives. Part I of this paper examines the use of physician incentives in the managed care setting. Part II analyzes the ERISA breach of fiduciary duty claim in the context of a health care plan's use of physician incentives. Part III provides a discussion of the facts in *Herdrich* and the court's reasoning. Part IV critiques the *Herdrich* court's analysis. Ultimately, this casenote concludes that *Herdrich* should be overturned.

I. MANAGED CARE USE OF COST-CONTAINMENT TECHNIQUES

As the cost of health care continues to rise,[18] the health care industry has seen a shift to "managed care."[19] The term managed care describes a variety of organizations that attempt to control the costs of health care services through techniques designed to limit access to specialists and hospitalization services.[20] In the early 1970s, managed care and HMOs achieved a special status when Congress passed the Health Maintenance Organization Act of 1973 ("the Act").[21] The Act provided start-up money and set service standards which, if met, would entitle an HMO to mandate that employers offer an HMO health care option to their employees if any HMO requested that the employer do so.[22] By 1993, more than twenty percent of the U.S. population had enrolled in an HMO. Managed care, however, has not been without its critics.[23] Many argue that the cost-saving techniques employed by managed care organiza-

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18. *See* Timothy J. Hauser & James D. Jameson, U.S. INDUSTRIAL OUTLOOK, 1993, U.S. DEP'T OF COMMERCE 42-1 (1993) (estimating expenditures on health care to be 14% of gross domestic product).

19. *See* FURROW ET AL., *supra* note 2, at 520.

20. *See* Noah, *supra* note 4, at 1219. Examples of "managed care" include: the health maintenance organization ("HMO"), which is an organization that fully integrates the insurance and provider aspects of health care delivery; the preferred provider organization ("PPO"), which is a less integrated version of an HMO, in which physicians often maintain independent practices; and the physician hospital organization ("PHO"), which is an entity comprised of a hospital and its affiliated physicians that offers centralized management, but a less integrated structure than an HMO. *See id.* at 1224 n.22, 1223–26.

21. Pub. L. No. 93-222, 87 Stat. 931 (1973) (codified at 42 U.S.C. § 300e (1994)).

22. *See* 42 U.S.C. § 300e (1994).

23. *See, e.g.*, Ruth Macklin, *The Ethics of Managed Care*, *in* 10 TRENDS IN HEALTH CARE LAW & ETHICS 63 (1995). *See generally* Herdrich v. Pegram, 154 F.3d 362, 375 (7th Cir. 1998).

tions result in a reduced quality of care.[24] This part examines the operation of these cost containment techniques—specifically, physician incentives to limit care—and also discusses recent attempts to hold HMOs liable for the use of such techniques.

A. The Operation of the Physician Incentive

Managed care organizations utilize a variety of different methods for encouraging cost-conscious decision making by doctors. The two primary methods are called "capitation" and "salary."[25] While they have different names, both methods operate in basically the same manner. With capitation, the physician receives a fixed amount of money for each patient, regardless of the actual treatment cost for that patient.[26] With a "salary" method, the HMO either employs a full-time staff or contracts with a group of physicians to provide medical services to plan participants for a fixed salary.[27] Essentially, both the capitation and salary methods force physicians to bear a portion of the financial risk for providing health care.[28] A physician receives no additional compensation for spending more time or resources on a patient.[29] Under a capitation scheme, the only way a physician can increase her pay is to see more patients.[30] A physician paid according to the salary method has no way to increase her pay. Thus, both methods create personal incentives to limit the amount of health care provided to each patient, because no additional compensation can be earned by providing additional care.[31]

While capitation and salary arrangements give physicians incentives to limit the amount of time spent with patients, these methods do not encourage doctors to limit their use of ancillary health care services like diagnostic tests, referrals, and experimental treatments. To restrain physicians' use of these

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24. *See* Macklin, *supra* note 23, at 63–64.
25. *See* Orentlicher, *supra* note 3, at 158.
26. *See id.*
27. *See id.* at 159.
28. *See* RODWIN, *supra* note 1, at 140.
29. *See id.*
30. *See* Andrew Ruskin, *Capitation: The Legal Implications of Using Capitation to Affect Physician Decision-Making Processes*, 13 J. CONTEMP. HEALTH L. & POL'Y 391 (1997).
31. *See* Orentlicher, *supra* note 3, at 159.

ancillary services, managed care organizations also utilize tools like bonuses or fee withholds.[32] In a bonus arrangement, the health care plan sets aside a pool of funds to pay for ancillary services.[33] Unspent funds go to physicians who are frugal in their use of ancillary services.[34] In a fee withhold system, the health care plan reduces a portion of the physician's capitated payment and uses the withheld amount to fund a pool for ancillary services.[35] Unspent funds are returned to physicians in proportion to their use of ancillary services.[36] Under both arrangements, physicians realize they can increase their compensation by reducing their use of ancillary services.[37]

B. HMO Tort Liability for Use of Physician Incentives

In recent years, critics have started to complain that the use of physician incentives by HMOs has resulted in a decline in the quality of care.[38] Despite these concerns, very few state courts have had the opportunity to examine the liability of a managed care organization for using physician incentives.[39] In *Bush v. Dake*,[40] however, one court addressed this very issue. In *Bush*, the plaintiff alleged that her doctor was negligent in failing to perform a simple test that delayed the detection of her cervical cancer.[41] The plaintiff attempted to hold the health care plan liable by claiming the plan's use of physician incentives caused her deficient treatment.[42] In the end, the court held that there was enough evidence to allow the claim to

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32. *See id.* at 160.
33. *See id.*
34. *See* RODWIN, *supra* note 1, at 140.
35. *See* Orentlicher, *supra* note 3, at 160.
36. *See id.*
37. *See* RODWIN, *supra* note 1, at 140.
38. *See generally* Herdrich v. Pegram, 154 F.3d 362, 375 (7th Cir. 1998). *See also, e.g.*, Macklin, *supra* note 23.
39. *See* Noah, *supra* note 4, at 1237. The small number of cases examining this issue is probably due in part to the fact that many tort claims against HMOs are preempted by ERISA. *See* Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355 (1994).
40. No. 86-25767 Nm-2, slip op. (Mich. Cir. Ct. Saginaw Cty. Apr. 27, 1989), *reprinted in* FURROW ET AL., *supra* note 2, at 292.
41. *See id.* at 293.
42. *See id.*

proceed to the jury.[43] The *Bush* court, however, appears to be alone in its holding. Without more, most courts refuse to recognize a claim against an HMO based on its use of physician incentives alone.[44] The Seventh Circuit's decision in *Herdrich*, however, may have opened the door to a new form of liability for HMOs.

II. ERISA FIDUCIARY LAW IN THE HEALTH CARE CONTEXT

The Seventh Circuit's decision in *Herdrich* represents a shift away from courts' traditional rejection of tort recovery based on physician incentives alone. In fact, *Herdrich* removed the discussion of physician incentives from the field of traditional tort law to the field of ERISA fiduciary law, and became the first case that allowed a plaintiff to state a claim under ERISA, based solely on a health care plan's use of financial incentives to limit care.[45] To understand *Herdrich*, however, one must first have a firm grasp of ERISA fiduciary law and its application to an HMO's use of physician incentives.

The following discussion of ERISA will examine the ERISA breach of fiduciary duty claim within the context of a health plan's use of physician incentives to limit care. Section A provides a brief overview of ERISA. Section B explains which health care plans are subject to the requirements of ERISA. Section C examines who, within the setting of a health care plan, qualifies as a fiduciary. Section D discusses the scope of the fiduciary duty. Finally, Section E analyzes the act of using physician incentives to understand whether it qualifies as a breach of fiduciary duty.

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43. *See id.* at 294. The case apparently settled out of court before trial. *See id.*

44. *See, e.g.*, Pulvers v. Kaiser Found. Health Plan, 160 Cal. Rptr. 392 (Cal. Ct. App. 1979) (noting that the HMO Act of 1973 required the use of cost-containment measures, but refusing to find liability based on the use of such financial incentives); Madsen v. Park Nicolet Med. Ctr., 419 N.W.2d 511 (Minn. Ct. App. 1988), *rev'd on other grounds*, 431 N.W.2d 855 (Minn. 1988) (affirming the trial court's refusal to permit testimony regarding physician incentives because it was irrelevant and prejudicial); McClellan v. Health Maintenance Org., 604 A.2d 1053 (Pa. Super. Ct. 1992) (arguing that any decision to limit cost-containment methods is one of policy which should be left to the legislature).

45. *See* Herdrich v. Pegram, 154 F.3d 362, 383 (7th Cir. 1998) (Flaum, J., dissenting).

A. *Overview of ERISA*

Congress enacted ERISA[46] to regulate employee benefit plans and to protect the funds invested in those plans for the benefit of participants and their beneficiaries.[47] Essentially, ERISA is a statutory scheme that regulates all private employee benefit plans, including both pension plans and welfare plans.[48]

To ensure uniformity, ERISA provides that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."[49] The operative words in the statute are "relate to."[50] The Supreme Court has stated Congress used the words "relate to" "in their broad sense, rejecting more limiting pre-emption language that would have made the clause 'applicable only to state laws relating to the specific subjects covered by ERISA.'"[51] For example, courts have found many state law negligence claims against HMOs to be preempted by ERISA.[52]

For the purposes of this paper, ERISA's most important provisions are those imposing fiduciary[53] responsibility re-

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46. 29 U.S.C. §§ 1001–1461 (1994).

47. *See id.* § 1302.

48. *See* District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 127 (1992).

49. 29 U.S.C. § 1144(a).

50. *See* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138 (1990).

51. *Id.* (quoting Library of Congress v. Shaw, 478 U.S. 310 (1986)). *But see* New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins., 514 U.S. 645 (1995) (rejecting too expansive a reading of the "relates to" language).

52. *See* Nealy v. U.S. Healthcare HMO, 844 F. Supp. 966 (S.D.N.Y. 1994) (finding preemption by ERISA of plaintiff's attempt to hold HMO liable under several common law tort claims); Ricci v. Gooberman, 840 F. Supp. 316 (D.N.J. 1993). *But see* FURROW ET AL., *supra* note 2, at 304 (noting that several cases have tried to limit ERISA preemption by holding state law claims to have little or nothing to do with the administration of a pension plan or its benefits).

53. The term "fiduciary," as used in this paper, refers to an ERISA "fiduciary" as defined at 29 U.S.C. § 1002(21)(A) (1994), unless otherwise noted.

> [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, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Id.

quirements that apply to both pension and welfare plans.[54] ERISA subjects fiduciaries that breach their duties to a variety of punishments, including the obligation to make good to the plan any losses resulting from the breach.[55] ERISA allows any plan beneficiary, participant, or fiduciary to bring a civil action for appropriate relief.[56] Courts generally describe the test of determining fiduciary status as "functional."[57] Using this functional test, courts ask whether the person or firm has or exercises any of the functions described in § 1002(21)(A).[58] Several courts have found administrators of health plans, including HMOs, to be fiduciaries within the meaning of the statute.[59]

B. Which Health Care Plans Must Comply with ERISA?

With this brief overview in mind, we can now turn to an examination of an ERISA claim for breach of fiduciary duty based on the use of physician incentives. The threshold issue for any ERISA claim becomes whether the plan is regulated by ERISA. As noted above,[60] ERISA applies to both "employee pension benefit plans" and "employee welfare benefit plans."[61] The statute defines a "welfare plan" as "any plan, fund, or program which was . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or oth-

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54. *See* 29 U.S.C. § 1104 (1994 & Supp. III 1998).

55. *See id.* § 1109(a) (1994).

56. *See id.* § 1132(a)(2)–(3). In *Varity Corp. v. Howe*, 516 U.S. 489 (1996), the Supreme Court held that a participant or beneficiary may proceed under § 1132(a)(3) to obtain individual "'*appropriate*' equitable relief." *See id.* at 515. Previously, the Court used the term "equitable" to indicate that participants and beneficiaries may seek traditional injunctive remedies and the monetary remedies of disgorgement and restitution rather than legal damages. *See* Mertens v. Hewitt Assoc., 508 U.S. 248, 253 (1993). Courts take this pronouncement to mean that participants and beneficiaries are not entitled to recover compensatory damages. *See* Varity Corp. v. Howe, 36 F.3d 746 (8th Cir. 1994), *aff'd*, 516 U.S. 489 (1996).

57. *See* Robert N. Eccles, *Fiduciary Litigation Under ERISA*, 415 PLI/TAX 9, 14 (1998).

58. *See id.*

59. *See, e.g.*, IT Corp. v. General Am. Life Ins. Co., 107 F.3d 1415 (9th Cir. 1997); Weiss v. Cigna Healthcare, 972 F. Supp. 748 (S.D.N.Y. 1997).

60. *See supra* text accompanying note 48.

61. *See* District of Columbia v. Greater Wash. Bd. Of Trade, 506 U.S. 125, 127 (1992).

erwise, medical, surgical, or hospital care or benefits."[62] To determine whether a plan is covered by ERISA, courts generally apply the test delineated by the Supreme Court in *Fort Halifax Packing Co. v. Coyne*.[63] In *Fort Halifax*, the Court defined an ERISA plan as one that requires some administrative scheme for it to operate.[64] Therefore, a health plan is governed by ERISA when an employer establishes an employee benefits plan that (1) requires an administrative scheme; and (2) provides benefits described by ERISA. Most employer-sponsored health care plans satisfy these requirements.[65]

C. *Who is a Fiduciary in the Health Care Context?*

ERISA allows plan participants and beneficiaries to bring an action against plan *fiduciaries* for breach of fiduciary duty.[66] Thus, the next step in the analysis of an ERISA breach of fiduciary duty claim must be to ask who, within the health plan, is a fiduciary. This question can be broken down into two parts. First, what are the tests for determining ERISA fiduciary status? Second, who, within a health care plan, qualifies as a fiduciary?

1. Tests for ERISA Fiduciary Status

Since nonfiduciaries are not liable for monetary damages even when they knowingly participate in a breach of fiduciary duty,[67] a finding of fiduciary status is a prerequisite for imposing fiduciary liability.[68] ERISA states that a person is a fiduciary if he (1) exercises discretionary authority or control with regard to management of plan assets, (2) renders investment

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62. 29 U.S.C. § 1002(1) (1994).

63. 482 U.S. 1 (1987).

64. *See id.* at 12–19.

65. Employer-sponsored health plans take on many different forms. It is conceivable that a plan might be so small as not to require an administrative scheme. Therefore, one cannot say that "all" employer-sponsored health plans necessarily are governed by ERISA.

66. *See* 29 U.S.C. § 1132(a) (1994).

67. *See* Mertens v. Hewitt Assoc., 508 U.S. 248 (1993). The Supreme Court has also severely restricted the equitable relief available against a nonfiduciary. *See* Reich v. Rowe, 20 F.3d 25 (1st Cir. 1994) (citing the *Mertens* decision as limiting relief available to a nonfiduciary).

68. *See* Bruce D. Pingree, *Fiduciary Issues in Welfare Plans, in* ERISA FIDUCIARY LAW 87 (Susan P. Serota ed., 1995).

advice for a fee with respect to plan funds, or (3) has any discretionary authority in the administration of the plan.[69] Some positions are, without question, fiduciary positions under ERISA.[70] These positions include plan administrators[71] and plan trustees who by the very nature of the position, have "discretionary authority" within the meaning of § 1002(21)(A).[72] Courts generally state that the test for determining fiduciary status is "functional."[73] The question, therefore, is whether the person or group performs any of the functions listed in § 1002(21)(A)—that is, whether the person or group has "discretionary authority" over plan asset management or plan administration.[74] Some courts have used this functional approach to hold that individuals within a corporation who perform the functions making the corporation a fiduciary are individually liable as fiduciaries.[75] In *Confer v. Custom Engineering*,[76] however, the Third Circuit limited individual liability for officers of a fiduciary corporation, so long as the individual acted within the corporate structure.[77]

While the functional test is very broad, there are limits on who qualifies as an ERISA fiduciary. The language of § 1002(21)(A) limits fiduciary status by stating that a person is a fiduciary "to the extent" she performs one of the listed functions.[78] Courts often find that people may be fiduciaries when they do certain things, but that they are entitled to act in their own interest when they do others.[79] Persons having "purely ministerial" functions—like applying rules determining eligibility for benefits or making recommendations to others for decisions with respect to plan administration—are not fiduciaries.[80] More specifically, attorneys and accountants performing their professional functions for the plan ordinarily are not con-

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69. *See* 29 U.S.C. § 1002(21)(A) (1994).
70. *See* Eccles, *supra* note 57, at 13.
71. For the statutory definition, see 29 U.S.C. § 1002(16)(A) (1994).
72. *See* 29 C.F.R. § 2509.75-8 at D-3 (1999).
73. *See* Eccles, *supra* note 57, at 14; discussion *supra* Part II.A.
74. *See* Eccles, *supra* note 57, at 14; Acosta v. Pacific Ent., 950 F.2d 611, 617–18 (9th Cir. 1995).
75. *See, e.g.*, Leigh v. Engle, 727 F.2d 113, 135 (7th Cir. 1984).
76. 952 F.2d 34 (3d Cir. 1991).
77. *See id.* at 37–38.
78. *See* 29 U.S.C. § 1002(21)(A) (1994).
79. *See* Eccles, *supra* note 57, at 19–20 (citing cases).
80. *See* 29 C.F.R. § 2509.75-8 at D-2 (1999).

sidered fiduciaries because they lack the requisite authority over plan administration.[81]

2. Who, Within the Context of a Health Care Plan, is a Fiduciary?

After examining some of the principles for determining fiduciary status, the next inquiry becomes: who, within the context of a health care plan, is a fiduciary? This section will examine the three primary players in a health care plan—the health care plan itself, the physician organization responsible for delivering care, and the individual physician who provides the care—to understand which players should be deemed fiduciaries under ERISA.

a. The Health Care Plan

The health care plan as a corporate entity seems to be the player that most easily fits the test of an ERISA fiduciary. While the term "health care plan" is broad, it is meant to describe the various corporate structures that have emerged over the past decade in response to the move toward delivering integrated health care.[82] These structures include HMOs, Preferred Provider Organizations ("PPOs"),[83] Physician Hospital Organizations ("PHOs"),[84] and other integrated delivery systems that act as both insurers and health care providers.[85] Many courts have held that because these structures "exercise[] discretionary control over the administration of the plan and for the payment of benefits,"[86] they are fiduciaries under ERISA.[87] Since health care plans can take many forms,[88] one

81. *See* Yesta v. Baima, 837 F.2d 380, 385 (9th Cir. 1988).

82. *See* DONALD K. FREEBORN & CLYDE R. POPE, PROMISE AND PERFORMANCE IN MANAGED CARE: THE PREPAID GROUP PRACTICE MODEL 2–6 (1994); Physician Payment Review Comm'n, *Annual Report to Congress* (1995), *reprinted in* FURROW ET AL., *supra* note 2, at 521–24.

83. *See supra* note 20.

84. *See supra* note 20.

85. *See* FURROW ET AL., *supra* note 2, at 520; Noah, *supra* note 4, at 1223.

86. Morales v. Health Plus, 954 F. Supp. 464, 468 (D.P.R. 1997).

87. *See* O'Reilly v. Ceuleers, 912 F.2d 1383, 1385 (11th Cir. 1990) (holding the defendant HMO to be a fiduciary under ERISA because it exercised discretionary control of the plan and over the payment of benefits); Weiss v. Cigna Health Care, 972 F. Supp. 748, 751 (S.D.N.Y. 1997) (stating that an HMO is an ERISA fiduciary when it exercises discretion over administration of plan).

must examine whether the plan exercises discretion over plan administration and payment of benefits. Still, most health care plans probably exercise the requisite discretion,[89] and should therefore be deemed ERISA fiduciaries.

b. The Physician Organization Providing Care to Plan Participants

Whether a physician organization is an ERISA fiduciary is less clear. Many health plans contract with physician organizations to provide office-based primary care.[90] The scope of the physician organization's duties will vary by the contract, but generally these organizations negotiate contracts with insurers, consolidate practice management functions, and better utilize expensive medical technology.[91] Within the setting of a health care plan, the primary role of the physician organization is to provide a network of doctors who provide care to the patients.[92]

Based on these notions of the purpose and role of the physician organization, such organizations would rarely have discretion over the administration of a plan or over the payment of benefits. The organization may provide information to the plan in connection with its prospective utilization review of hospital admissions and specialist referrals.[93] But this activity should be considered "purely ministerial,"[94] in that the physician organization is simply following the rules set by the plan rather than exercising its own discretion.[95]

While it is possible that a physician organization might, by way of its contractual relationship with the health plan, be given discretionary authority over plan administration and

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88. *See* 29 U.S.C. § 1002 (1994).

89. *See supra* notes 60–61 and accompanying text.

90. *See* Noah, *supra* note 4, at 1223.

91. *See* FURROW ET AL., *supra* note 2, at 522–23.

92. *See* CHARLES G. BENDA & FAY A. ROZOVSKY, MANAGED CARE AND THE LAW: LIABILITY AND RISK MANAGEMENT–A PRACTICAL GUIDE § 2.4.1 (1996).

93. *See* Linda V. Tiano, *The Legal Implications of HMO Cost Containment Measures*, 14 SETON HALL LEGIS. J. 79, 80 (1990) (noting that as a cost-saving technique HMOs often review doctors' decisions to use expensive medical interventions).

94. *See* 29 C.F.R. § 2509.75-8 (1999).

95. *See id.* (stating that persons following rules and procedures set by others are not ERISA fiduciaries).

payment of claims, such a situation is probably the exception. Even in such a circumstance, ERISA fiduciary status is limited to those actions in which the person or group is acting in a discretionary capacity.[96] The physician organization may act as a fiduciary when making administrative decisions regarding the health plan, but not when making medical or business decisions that relate to the management of the physician organization.[97] The fiduciary status of physician organizations, therefore, is a fact-intensive issue that must be decided on a case-by-case basis.[98]

c. *The Physician*

The status of a physician as an ERISA fiduciary is somewhat unclear, but the better answer appears to be that a physician is not an ERISA fiduciary. Recall that courts holding a health plan to be an ERISA fiduciary have based their conclusion on the fact that the health plan "exercises discretionary control over the administration of the plan and for the payment of benefits."[99] The physician's primary role within a health plan is to provide medical care directly to plan participants.[100] Certainly, an argument could be made that a physician exercises a substantial amount of discretion when making these medical decisions and that this discretion should make a physician an ERISA fiduciary. In a managed care arrangement, however, the health plan ultimately maintains control over

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96. *See supra* notes 78–80 and accompanying text.

97. A person is a fiduciary only to the extent he or she has discretion over plan management or administration. *See* 29 C.F.R. § 2509.75-8 (1999). A person is not considered a fiduciary when he or she makes decisions based on policies, interpretations and rules established by others. *See id.* The contention here is that medical and business decisions made by physician organizations are distinct from decisions involving plan management or administration. These medical and business decisions relate to the management of the physician organization, not the management or administration of the health plan.

98. The determination of whether a person or organization is a fiduciary is a very fact-intensive question susceptible to different interpretations and conclusions. *See* Pingree, *supra* note 68, at 88.

99. Morales v. Health Plus, 954 F. Supp. 464, 468 (D.P.R. 1997). *See also* O'Reilly v. Ceuleers, 912 F.2d 1383, 1385 (11th Cir. 1990) (holding the defendant HMO to be a fiduciary under ERISA because it exercised discretionary control of the plan and over the payment of benefits); Weiss v. Cigna Health Care, 972 F. Supp. 748, 751 (S.D.N.Y. 1997) (stating that an HMO is an ERISA fiduciary when it exercises discretion over administration of plan).

100. *See* Noah, *supra* note 4, at 1223.

management of the plan and over many of the physician's decisions.[101] Since fiduciary status requires control and discretion,[102] and since ultimate control remains with the health plan,[103] a physician would not seem to be an ERISA fiduciary.

Two additional arguments can be made against a physician being deemed an ERISA fiduciary. First, physicians—like attorneys and accountants—should not be considered fiduciaries when only performing professional functions, because they lack ultimate authority with regard to plan administration.[104] Second, the fact that the law imposes independent fiduciary duties on a physician in the form of malpractice liability[105] argues against the need to impose ERISA fiduciary duties. These arguments both recognize that the physician's exercise of professional medical discretion is distinct from decisions made with regard to the health care plan. In effect, the physician has an express contract with the health plan and an implicit contract with the patient.[106] Certainly, an argument can be made that a physician exercises discretion when making medical decisions. But those decisions are exactly that—medical. They relate to the physician's contract with the patient wherein he exercises independent medical judgment, and for which he is already subject to liability for malpractice. Furthermore, no reported decision holds that a treating physician may be considered an ERISA fiduciary. Because the physician's medical decisions are distinct from the exercise of any administrative discretion, this appears to be the better answer.

D. The Fiduciary Duty

The next step in analyzing the ERISA breach of fiduciary duty claim in the context of a health care plan's use of physician incentives is to examine the nature of the fiduciary duty. This section will examine two of the fiduciary duties imposed by ERISA. The first duty is to act "solely in the interest" of beneficiaries. The second is the duty of disclosure.

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101. *See* RODWIN, *supra* note 1, at 139.
102. *See* 29 C.F.R. § 2509.75-8 (1999).
103. *See* RODWIN, *supra* note 1, at 139.
104. *See* 29 C.F.R. § 2509.75-5 (1999).
105. *See* FURROW ET AL., *supra* note 2, at 360.
106. *See id.* at 361.

1. Solely in the Interest

The first duty that may apply to the health care context is the duty to act "solely in the interest" of the plan participant. Section 1104(a) requires that ERISA fiduciaries "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to [plan] participants . . . and defraying reasonable expenses of administering the plan."[107] Courts interpret this section to impose a duty of undivided loyalty to plan participants on ERISA fiduciaries.[108] Generally, this duty is used to deal with situations where the fiduciary acts in her own personal interest.[109]

This duty, however, is not completely unqualified. Some courts have held that a fiduciary's actions may create a benefit for the fiduciary so long as the action was in the best interests of the plan.[110] In *Donovan v. Bierwith*,[111] the Second Circuit stated that a fiduciary may take action that benefits his own interests so long as the action is also in the best interests of the plan.[112]

2. Duty of Disclosure

The second duty ERISA imposes on fiduciaries is the duty of disclosure. Much confusion exists among the courts as to the source and the scope of this duty.[113] The first branch of this duty is to avoid affirmative misrepresentations. In *Varity Corp. v. Howe*,[114] the Supreme Court held that § 1104(a)'s duty to act "solely in the interest of [plan] participants" is inconsistent with lying to a participant.[115] The Court, therefore, con-

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107. 29 U.S.C. § 1104(a) (1994).

108. *See* Eccles, *supra* note 57, at 28 (quoting Eaves v. Penn, 587 F.2d 453, 457 (10th Cir. 1978)).

109. *See, e.g.*, Wright v. Nimmons, 641 F. Supp. 1391, 1408 (S.D. Tex. 1986) (noting that fiduciary consistently treated plan assets as if they were his own).

110. *See* Donovan v. Walton, 609 F. Supp. 1221, 1245 (S.D. Fla. 1985), *aff'd sub nom.* Brock v. Walton, 794 F.2d 586, 588 (11th Cir. 1986).

111. 680 F.2d 263 (2d Cir. 1982).

112. *See id.* at 271.

113. *See* Ethan Lipsig et al., *Fiduciary Disclosure Obligations*, *in* ERISA FIDUCIARY LAW, *supra* note 68, at 154 (Supp. 1998).

114. 516 U.S. 489 (1996).

115. *Id.* at 506.

cluded that a fiduciary has a duty not to make misrepresentations about the plan.[116]

Some courts have extended this duty to create a second branch: a duty of *affirmative* disclosure. The D.C. Circuit has held that when a beneficiary contacts the fiduciary about his status and options within the plan, the fiduciary has an obligation to provide complete and correct material information.[117] The Third Circuit has also found an affirmative duty to disclose in certain circumstances.[118] The court held that when the fiduciary has notice that a failure to disclose will cause harm to a plan participant, the fiduciary has a duty to convey "complete and accurate information material to the beneficiary's circumstance."[119] In another case, the Third Circuit went even further in holding that a specific request by a participant is not necessary to find that the fiduciary had a duty to disclose information material to the participant's situation.[120] The court made clear that a fiduciary has an affirmative duty to disclose material information even in the absence of an inquiry by a beneficiary.[121] Not all circuits, however, have adopted this expansive view of the duty of disclosure. In *Pocchia v. NYNEX Corp.*,[122] the court rejected the argument that a fiduciary is obligated to make voluntary disclosures to beneficiaries absent an inquiry.[123] The ultimate scope of this duty, therefore, is somewhat unclear.

E. Does a Health Plan Breach its Fiduciary Duty When it Uses Physician Incentives to Deny Care?

The final step in this analysis must be an examination of whether a health plan's use of physician incentives constitutes a breach of the fiduciary duties outlined above. Each duty will be examined separately, beginning with the duty to act solely in the interest of plan beneficiaries.

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116. *See id.*

117. *See* Eddy v. Colonial Life Ins., 919 F.2d 747, 751 (D.C. Cir. 1990).

118. *See* Bixler v. Central Pa. Teamsters Health & Welfare Fund, 12 F.3d 1292 (3d Cir. 1993).

119. *Id.* at 1300.

120. *See* Jordan v. Federal Express Corp., 116 F.3d 1005, 1016 (3d Cir. 1997).

121. *See* Lipsig et al., *supra* note 113, at 169.

122. 81 F.3d 275 (2d Cir. 1996).

123. *See id.* at 278.

1. Duty to Act Solely in the Interests of Beneficiaries

Does a health plan's use of physician incentives to deny care constitute a breach of ERISA's fiduciary duty to act "solely in the interest" of plan participants?[124] The short answer is "probably not," and the reasoning is twofold: (1) when using physician incentives, a health plan is likely acting in accordance with the interests of plan participants; and (2) congressional approval for the use of physician incentives argues against the conclusion that an ERISA fiduciary breaches her duty when utilizing such incentives.

a. Use of Physician Incentives is Likely in the Interest of Plan Participants

Under § 1104(a), a fiduciary breaches her duty when she does not act "solely in interest" of a plan participant. Fiduciaries, however, may benefit from a decision so long as the decision is made in the best interest of plan participants.[125] Ultimately, a health plan's use of physician incentives is in the best interest of plan participants. There are two reasons for this conclusion. First, physician incentives reduce health care costs, which ultimately benefits plan participants. Second, economic forces ensure that the interests of a health plan and those of participants are not in conflict with one another.

With regard to reducing health care costs, physician incentives are most likely in the best interest of plan participants because these incentives have effectively contained the exponential increases in health care costs[126] seen during past two decades.[127] A recent study conducted by the University of Minnesota Medical School found that patients enrolled in a prepaid health plan utilizing physician incentives in the form of fee "withholds" used significantly less care while receiving care

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124. Notice that this question limits the inquiry to looking at the health plan's actions. Since a physicians organization and the individual physician are probably not ERISA fiduciaries, *see supra* Part II.C, these parties have no fiduciary duty under ERISA and cannot be responsible for the decision to employ a physician incentive scheme.

125. *See supra* Part II.D.1.

126. For a description of this increase in costs and the causes of the increase, see Orentlicher, *supra* note 3, at 156–57.

127. *See* Noah, *supra* note 4, at 1227–28.

of equivalent or better quality than a plan not using incentives.[128] One commentator argues that use of physician incentives is the best method for lowering health care costs, because incentives operate as an effective cost-containment tool while still providing some degree of physician autonomy and individualized patient care.[129] Ultimately, cost-containment through physician incentives is in the interest of ERISA plan participants who benefit from lower health care costs when less of their overall compensation package goes to health care and instead is paid as salary. One might even argue that when a health plan fails to employ any type of physician incentive arrangement, the plan breaches its duty to act in the interest of plan participants because plan participants will eventually see more of their income go toward covering the costs of health care.

With regard to the second argument, several courts have reasoned that the interests of health plans are actually the same as those of plan participants. The Seventh Circuit Court of Appeals has argued that the companies that sponsor ERISA welfare benefit plans are, in reality, "customers" who choose which group insurance policies they will use.[130] The court noted that these corporate employers want to see their employees' claims granted, because they want their employees satisfied with their benefits. Moreover, employers have the sophistication and bargaining power necessary to take their business elsewhere if the benefit provider consistently denies claims or provides a substandard product.[131] The court concluded that no conflict of interest existed between the benefit provider and the plan participant, because a benefit provider has an interest in providing quality service.[132]

Judge Easterbrook has made a similar argument in the health care context:

> A[n] . . . [HMO] offers, for a fixed fee, as much medical care as the patient needs. Providers using traditional fee-for-service methods, by contrast, charge for each procedure.

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128. *See* 140 CONG. REC. 5148–53 (1994).

129. *See* Orentlicher, *supra* note 3, at 174.

130. *See* Mers v. Mariott Int'l Grp. Accidental Death & Dismem. Plan, 144 F.3d 1014, 1021 (7th Cir. 1998).

131. *See id.*

132. *See id.*

> Each method creates an unfortunate incentive: a physician receiving a fee for each service has an incentive to run up the bill by furnishing unnecessary care, and an HMO has an incentive to skimp on care . . . in order to save costs. Each incentive encounters countervailing forces: patients, or insurers on their behalf, resist paying the bills for unnecessary services, and HMOs must afford adequate care if they are to attract patients. HMOs also have a reason to deliver excellent preventive medicine. Prevention may reduce the need for costly services later. Competition among the many providers of health care, and between the principal methods of charging for that care, affords additional protection to consumers.[133]

In light of these arguments, one can see that when a health plan decides to implement a physician incentives arrangement, the plan acts with the knowledge that it must provide high quality care at a competitive price so that it can survive. The interests of quality care at a competitive price are also the interests of plan participants. Therefore, when the plan implements a physician incentives program, it acts in the interest of plan participants and beneficiaries, and does not, therefore, breach its fiduciary duty under § 1104(a)(1).

b. Congressional Approval of Physician Incentives

When a person reads ERISA, she will not find the words "capitation," "withhold," or "physician incentives." When Congress passed ERISA in 1974, nothing in the legislative history indicated that ERISA could impose liability on health care plans for using physician incentives.[134] Subsequently, however, Congress has repeatedly approved the use of physician incentives and other cost-containment measures in the health care setting. This congressional approval argues strongly against the imposition of ERISA fiduciary liability on health plans for the use of these incentives.

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133. Anderson v. Humana, Inc., 24 F.3d 889, 890 (7th Cir. 1994).

134. *See* Jack F. Monahan & Michael Willis, *Special Legal Status for HMOs: Cost Containment Catalyst or Marketplace Impediment?*, 18 STETSON L. REV. 353, 360 (1989) (noting that HMOs were almost nonexistent in the early 1970s).

In 1973, Congress passed the Health Maintenance Organization Act.[135] The Act provided start-up capital and set service standards which, if followed, entitled an HMO to require that employers offer an HMO health care option to their employees.[136] Congress's intent in passing the HMO Act was to encourage the development of less costly and more efficient systems of providing care.[137] In § 300e(c)(2)(D) of the HMO Act, Congress explicitly approved the use of physician incentives by stating that an HMO may "make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians."[138] The Health Care Financing Administration has issued regulations requiring HMOs to "have effective procedures to monitor utilization and to control cost of basic and supplemental health services and to achieve utilization goals, which may include mechanisms such as risk sharing, *financial incentives*, or other provisions agreed to by providers."[139] Clearly, the federal government approves of the use of physician incentives by health care plans.

Congress, however, has acted to meet some of the concerns surrounding the use of physician incentives. Section 9313(c) of the Omnibus Budget Reconciliation Act of 1986 ("OBRA '86")[140] prohibited health care organizations with Medicare or Medicaid contracts from knowingly making incentive payments to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries.[141] Congress extended the im-

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135. Pub. L. No. 93-222, 87 Stat. 931 (1973) (codified at 42 U.S.C § 300e (1994)).

136. *See* Monahan & Wills, *supra* note 134, at 356.

137. *See id.* at 360–61 (construing the intent of the Act using 1973 U.S.C.C.A.N. 3033).

138. 42 U.S.C. § 300e(c)(2)(D) (1994). At least two courts have cited this section in holding that use of physician incentives cannot serve as the basis for health care plan liability. *See* Weiss v. Cigna Healthcare, 972 F. Supp. 748, 753 (S.D.N.Y. 1997); Pulvers v. Kaiser Found. Health Plan, 160 Cal. Rptr. 392, 394 (Cal. Ct. App. 1980).

139. 42 C.F.R. § 417.103(b) (1999) (emphasis added).

140. Pub. L. No. 99-509, 100 Stat. 1874 (codified as amended in scattered sections of 42 U.S.C.).

141. *See* 57 Fed. Reg. 59,024 (1992) (codified at 42 C.F.R. pts. 417, 434, 1003).

plementation date for these provisions several times.[142] Ultimately, the Omnibus Budget Reconciliation Act of 1990 ("OBRA '90")[143] repealed the prohibition of all physician incentives arrangements in prepaid health care plans and enacted requirements for regulating these incentives.[144] Under these requirements, a health care plan that provides care to Medicaid or Medicare patients may not make "specific" payments "directly or indirectly" to a physician "as an inducement to reduce or limit medically necessary services."[145] This statute, however, does not prohibit capitation payments, withholds, or bonuses because these arrangements are not considered "specific payments" made to physicians "as an inducement to reduce or limit medically necessary services."[146] Therefore, while Congress has taken some steps to regulate the use of physician incentives, the fact that Congress has refused to ban them outright provides some evidence that the federal government still approves of their use.

2. The Duty of Disclosure

While a health plan should not be found to have breached its fiduciary duty based solely on its use of physician incentives, a health plan probably should be held liable for a failure to disclose the existence of physician incentives. This conclusion is the product of two factors: (1) due to the conflict of interest created by the health plan using physician incentives, basic principles of fiduciary law require disclosure of the conflict so the plan participant can make informed decisions; and (2) imposing fiduciary liability for nondisclosure is consistent with Congress's treatment of physician incentives to deny care.

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142. *See id.*

143. Pub. L. No. 101-508, 104 Stat. 1388 (codified as amended in scattered sections of 42 U.S.C.).

144. *See* 57 Fed. Reg. 59,024 (1992) (codified at 42 C.F.R. pts. 417, 434, 1003). For the restrictions on HMO use of physician incentives, see 42 U.S.C. § 1395mm(i)(8)(A)(i) (1994).

145. 42 U.S.C. § 1395mm(i)(8)(A)(i) (1994).

146. 61 Fed. Reg. 13,430, 13446–48 (1996) (codified at 42 C.F.R. pts. 417, 434, 1003).

a. Plan Participant Welfare

While physician incentives offer an effective method of reducing the costs of health care, these incentives also present significant dangers. Because these incentives give physicians a personal economic interest in limiting care, many doctors may delay treatment or omit expensive testing to the detriment of their patients.[147] Still, fiduciary law has long acknowledged that not all conflicts of interest are avoidable.[148] To overcome this conflict of interest, the fiduciary should disclose the conflict and allow the beneficiary to determine whether he wants to continue the relationship.[149]

In the context of a health plan's decision to utilize physician incentives that create a conflict of interest for plan physicians, the plan should disclose the conflict to beneficiaries and allow them to decide whether to continue the relationship with the physician. Since the health care plan creates a conflict of interest that could have dangerous implications for plan beneficiaries, the plan—as a fiduciary—must act to remedy the conflict.

The Eighth Circuit Court of Appeals came to this exact conclusion in *Shea v. Esensten*.[150] In *Shea*, the court stated that a fiduciary health plan's use of physician incentives is a material piece of information critical to allowing the patient to make educated decisions about his medical treatment.[151] The court concluded that the plan's failure to disclose the existence of the incentives could constitute a breach of an ERISA fiduciary's duty to speak out if it "knows that silence might be harmful."[152]

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147. *See* Orentlicher, *supra* note 3, at 161.

148. *See* Haavi Morreim, *Benefits Decisions in ERISA Plans: Diminishing Deference to Fiduciaries and an Emerging Problem for Provider-Sponsored Organizations*, 64 TENN. L. REV. 511, 549 (1998).

149. *See id.*

150. 107 F.3d 625 (8th Cir. 1997).

151. *See id.* at 628.

152. *Id.* (citing Restatement (Second) of Trusts § 173 cmt. d (1959)). For a criticism of the *Shea* decision, see *Weiss v. Cigna Healthcare*, 972 F. Supp. 748, 753–55 (S.D.N.Y. 1997) (refusing to impose an affirmative duty of disclosure on ERISA fiduciaries).

b. Disclosure is Consistent with Congressional Treatment of Physician Incentives

As noted above, Congress approves of the use of physician incentives as a means for reducing the cost of health care. However, realizing the potential dangers presented by such incentives, regulations now require HMOs treating Medicare patients to disclose the use of physician incentives.[153] HMOs must now disclose to Medicare beneficiaries both their use of incentives and the type of incentives used.[154]

While this congressionally-imposed duty does not apply to health plans not treating Medicare patients, and while ERISA does not impose an affirmative duty of disclosure on fiduciaries, liability based on nondisclosure is consistent with Congress's treatment of physician incentives. Congress refuses to ban the use of financial incentives (presumably because of their benefits), but requires some health plans to disclose their use to plan beneficiaries (presumably because of their dangers). Encouraging ERISA fiduciaries to disclose financial incentives to participants by imposing liability for nondisclosure is consistent with congressional intent.

3. Is the Use of Physician Incentives a Breach of ERISA's Fiduciary Duty?

In summary, the answer to the above question is both "no" and "yes"—depending on the duty examined. As for the duty to "act solely in the interest of plan beneficiaries," the cost savings achieved through the use of physician incentives and the congruence of interests between the health care plan and plan participants argue for the conclusion that a health plan's use of physician incentives does not in and of itself constitute a breach of this fiduciary duty. Congress's approval of the use of physician incentives and its reluctance to ban such incentives also argue strongly against reading ERISA to impose liability on health plans merely for using incentives. To find that ERISA imposes liability for the use of physician incentives truly would be "tantamount to a claim" that physician incen-

153. *See* 42 C.F.R. § 417.479 (1999).
154. *See id.*

tives are "inherently illegal."[155] In light of the above-cited statutes and regulations, such a claim would seem untenable.

An analysis of the duty of disclosure, however, requires a different conclusion. Physician incentive arrangements present inherent dangers; federal courts should interpret ERISA to impose liability on health plan fiduciaries for a failure to disclose their use of such incentives. This interpretation remedies the conflict of interest inherent in the use of physician incentives, and is consistent with Congress's treatment of physician incentives by health care plans.

III. *HERDRICH V. PEGRAM*

While most state courts reject the notion that physician incentives can provide a foundation for a claim against health care plans,[156] and while persuasive arguments can be made against such claims,[157] a recent decision by the Seventh Circuit appears to have opened the door to HMO liability under ERISA. This Part first examines the facts of the case, then the court's reasoning, and concludes with a discussion of the dissent.

A. Facts

On March 7, 1991, Dr. Lori Pegram discovered a six-by-eight centimeter "mass" in Cynthia Herdrich's abdomen.[158] Even though the mass was inflamed, Dr. Pegram asked Herdrich to wait eight days before receiving an ultrasound to determine the exact nature of the mass.[159] During this time, Herdrich's "mass" (later determined to be an inflamed appendix) ruptured, resulting in the onset of a serious infection.[160]

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155. *See* Weiss v. Cigna Healthcare, 972 F. Supp. 748, 753 (S.D.N.Y. 1997).

156. *See* Madsen v. Park Nicolet Med. Ctr., 419 N.W.2d 511 (Minn. Ct. App. 1988), *rev'd on other grounds*, 431 N.W.2d 855 (Minn. 1988) (affirming the trial court's refusal to permit testimony regarding physician incentives because it was irrelevant and prejudicial); McClellan v. Health Maintenance Org., 604 A.2d 1053 (Pa. Super. Ct. 1992) (arguing that any decision to limit cost-containment methods is one of policy that should be left to the legislature).

157. *See supra* Part II.D.

158. *See* Herdrich v. Pegram, 154 F.3d 362, 365 (7th Cir. 1998), *cert. granted*, 120 S. Ct. 10 (1999).

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

160. *See id.* at 365–66.

This delay in treatment stemmed, in part, from policies adopted by Herdrich's health care plan. Carle Clinic Association ("Carle"), Health Alliance Medical Plans ("HAMP"), and Carle Medical Insurance Management Co. operate the pre-paid health plan that covered Herdrich through her husband's employer.[161] Carle is comprised of physicians who provide care to plan participants.[162] The plan is administered through Carle's subsidiary, HAMP.[163] Plan policy requires that all participants receive medical care from Carle-staffed facilities when suffering from a "nonemergency" condition.[164] Because Dr. Pegram classified Herdrich's condition as "nonemergency," Herdrich was forced to wait eight days before receiving an ultrasound at a Carle facility.[165] Before Herdrich received the ultrasound, however, her appendix ruptured and she was sent to a Carle facility so her appendix could be drained and cleaned.[166]

Soon thereafter, Herdrich filed a complaint against Pegram and Carle alleging professional medical negligence, and against HAMP and Carle alleging state law fraud.[167] The defendants removed the case to federal court, asserting that ERISA preempted the state law fraud claims.[168] The federal district court then allowed Herdrich to amend her state law fraud claims to set forth a basis for proceeding under ERISA.[169] Specifically, Herdrich alleged that defendants breached their fiduciary duty to plan beneficiaries by depriving them of proper medical care and retaining the savings for themselves.[170] Apparently, HAMP utilized a physician incentives program in an effort to limit the cost of providing care.[171] Specifically, HAMP based the physicians' year-end bonuses on the difference between total plan costs and revenues.[172] This "bonus" system[173]

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161. *See id.* at 365.
162. *See id.* at 381.
163. *See id.*
164. *See id.* at 374.
165. *See id.*
166. *See id.*
167. *See id.* at 365.
168. *See id.* at 366.
169. *See id.*
170. *See id.* at 367 n.3.
171. *See id.* at 372.
172. *See id.*
173. *See supra* notes 32–37 and accompanying text.

gave plan physicians a personal financial incentive to make cost-conscious medical decisions.[174]

Soon after Herdrich amended her complaint, defendants moved to dismiss the new ERISA claim for failure to state a claim upon which relief could be granted.[175] The court granted the motion to dismiss, and the case proceeded on the professional medical negligence claim.[176] The jury returned a verdict for Herdrich, awarding her $35,000 in compensatory damages.[177] Herdrich then appealed the dismissal of her ERISA claim for breach of fiduciary duty.[178]

B. The Court's Decision

Perhaps surprisingly, the Seventh Circuit reversed the dismissal, holding that defendants are fiduciaries within the meaning of ERISA, and that defendants' use of a physician incentive program, which gave doctors financial incentives to limit care, could constitute a breach of fiduciary duty under ERISA.[179]

1. Fiduciary Status

The court began its decision with an inquiry into whether Carle and HAMP are "fiduciaries" under ERISA. The court quoted § 1002(21)(A) of ERISA, which states that "a person is a fiduciary with respect to a plan to the extent . . . he exercises any discretionary authority . . . respecting management of such plan . . . or . . . has any discretionary authority . . . in the administration of such plan."[180] The court relied on this language to find that the allegations in Herdrich's complaint were sufficient to find Carle and HAMP to be "fiduciaries."[181] Specifically, the court found that the defendants' (1) right to decide all disputed and non-routine claims under the plan; (2) management of physician referrals including the nature and duration

174. *See Herdrich*, 154 F.3d at 372.
175. *See id.* at 365.
176. *See id.*
177. *See id.* at 367.
178. *See id.*
179. *See id.* at 369–74.
180. *Id.* at 369–70.
181. *See id.* at 370.

of treatment and the extent to which patients are required to use Carle-owned facilities; and (3) control over each and every aspect of the HMO's governance satisfied ERISA's requirement that a fiduciary maintain "discretionary control and authority."[182]

2. Breach of Fiduciary Duty

After concluding that Carle and HAMP were "fiduciaries," the court examined the duties imposed by ERISA, and they concluded that Herdrich had stated a claim for breach of fiduciary duty. The court began by quoting § 1104(a)(1), which states that "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries."[183] The court concluded that under § 1104(a)(1), a fiduciary breaches its duty whenever it acts to benefit its own interest.[184] The court then cited *Shea v. Esensten*[185]—which held that a health plan breached its fiduciary duty by not disclosing to plan beneficiaries the use of physician incentives—as a case that should instruct the court how to handle Herdrich's claim.[186] Finally, the *Herdrich* majority quoted *Ries v. Humana Health Plan, Inc.*,[187] which held that a health plan's "covert profiteering at the expense of insureds" is inconsistent with the duty to act "solely in the interest" of plan beneficiaries.[188]

Considering the duty found in § 1104(a)(1) and the decisions in *Shea* and *Ries*, the court found that Herdrich had stated a claim against Carle and HAMP.[189] Herdrich's complaint alleged that the defendants' incentive scheme "invited and encouraged plan fiduciaries to place their own interests ahead of the interests of plan beneficiaries," and "constituted a breach of the administrators' fiduciary duty."[190]

Realizing the potential impact of its decision, the court noted that this case "does not stand for the proposition that the

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182. *See id.*
183. *Id.* at 371.
184. *See id.*
185. 107 F.3d 625 (8th Cir. 1997).
186. *See Herdrich*, 154 F.3d at 372.
187. 1995 WL 669583 (N.D. Ill. 1995).
188. *Herdrich*, 154 F.3d at 372 (quoting *Ries*, 1995 WL 669583, at *7).
189. *See id.* at 372–73.
190. *Id.* at 372.

existence of incentives *automatically* gives rise to a breach of fiduciary duty."[191] The court claimed to hold that "incentives *can* rise to the level of a breach [of fiduciary duty] where . . . physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses."[192]

C. Dissent

Accepting the majority's assertion that the defendants had created an incentive for physicians to limit treatment through the bonus program, the dissent concluded that the "mere existence of [an] asserted conflict" does not "give[] rise to a cause of action for breach of fiduciary duty under ERISA."[193]

First, the dissent argued that ERISA tolerates some conflicts of interest on the part of fiduciaries.[194] Specifically, the dissent cited the fact that ERISA allows the employer that establishes an employee benefits plan to have one of its own representatives serve as a plan fiduciary, despite the fact that the representative will have loyalties both to the employer and the plan.[195] The dissent understood this tolerance of a conflict of interest to mean that conflicts of interest are not per se unlawful under ERISA.[196]

Second, the dissent argued that the court, in a related context, had recognized that market forces reduce the risk that a fiduciary's conflict of interest will work to the detriment of plan beneficiaries.[197] The dissent cited *Mers v. Marriot International Group Accidental Death & Dismemberment Plan*,[198] where the court found there to be no conflict of interest when an insurer acting as a plan administrator denied a claim that, if it had been paid, would have been paid out of the insurer's assets.[199] The *Mers* court concluded that paying claims was actually in the insurer's best interest, because employers could

191. *Id.* at 373.
192. *Id.*
193. *Id.* at 381 (Flaum, J., dissenting).
194. *See id.*
195. *See id.*
196. *See id.*
197. *See id.*
198. 144 F.3d 1014 (7th Cir. 1998).
199. *See Herdrich*, 154 F.3d at 382 (Flaum, J., dissenting).

take their business elsewhere if employees were unsatisfied.[200] The dissent used this conclusion to argue that Herdrich had not alleged an actionable conflict of interest, because the plan's sponsor would take business elsewhere if HAMP and Carle did not provide quality care.[201]

Third, the dissent argued that the plaintiff's complaint was actually an invitation for the court to make an evaluation of the appropriateness of physician incentives in managed care.[202] Concluding that such an invitation should be rejected, the dissent argued that the legislature was the proper body to make this determination.[203]

Finally, the dissent provided an alternative to the majority's conclusion. Arguing that a health plan's failure to disclose the use of physician incentives should constitute a breach of the health plan's fiduciary duty, the dissent concluded that nondisclosure should represent the limit on ERISA liability for the use of incentives.[204]

IV. CRITIQUE OF THE *HERDRICH* DECISION

By imposing liability for the use of physician incentives, the decision in *Herdrich* may very well mean that HMOs can no longer utilize this effective cost-control tool without incurring liability. The court's decision, therefore, must be closely scrutinized. Before one can critique the court's decision, however, a full understanding of the court's holding is necessary. Then one can analyze the court's handling of the fiduciary status issue and the court's understanding of whether the use of physician incentives constitutes a breach of ERISA's fiduciary duty.

A. What Did the Court Really Hold?

The *Herdrich* court purported to hold that incentives can rise to the level of a breach of fiduciary duty when physicians delay providing necessary treatment for the sole purpose of in-

200. *See id.*
201. *See id.*
202. *See id.* at 383.
203. *See id.*
204. *See id.* at 383–84.

creasing their bonuses.[205] This limited formulation of the holding, however, is inconsistent with the dissent's understanding of the opinion, is inconsistent with the court's subsequent formulations of the holding, and does not comport with the wording in the plaintiff's complaint. The majority opinion should be read to hold that a health plan's use of physician incentives, without more, can constitute a breach of ERISA's fiduciary duty.

The dissent understood the majority to hold that the mere existence of an asserted conflict gives rise to a cause of action for breach of fiduciary duty under ERISA.[206] Recall, however, that the *Herdrich* majority claimed to require more. The majority claimed to require (1) that the physician delay providing necessary treatment or withhold proper care; and (2) that the delay or withhold be due solely to the doctor's interest in increasing her bonus.[207] But what do these requirements actually add to the claim to differentiate it from a mere assertion of a conflict of interest?

As to the first requirement, physician incentives, by definition, can create some delay in care or withholding of care.[208] Thus, if a patient suffers a negative outcome, that outcome can be traced to a health plan's decision to utilize physician incentives, the patient should be able to point to some delay in care or a withholding of care.[209] Therefore, requiring a delay or withholding does little to differentiate the majority's position from the mere assertion of a conflict of interest created by the use of physician incentives.

While the majority also claims to require that the delay or withhold be *due solely to the doctor's interest in increasing her bonus*, this statement is inconsistent with (1) the majority's restatement of the holding and (2) the allegations in plaintiff's complaint.

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205. *See id.* at 373.

206. *See id.* at 381 (Flaum, J., dissenting).

207. *See id.* at 373.

208. *See supra* notes 32–37 and accompanying text.

209. A delay in receiving care or a withholding of care would not be present when the treatment performed is proper, but is performed incorrectly or negligently by the physician. In such a case, the plaintiff would sue based on the acts of the physician alone. No challenge could be made to a health plan's use of physician incentives.

First, near the end of the opinion, the court states that it is reversing and remanding the case for a determination of whether defendants "violated their fiduciary obligations to act *solely in the interest of the Plan participants and beneficiaries.*"[210] The court says, "it does not appear to us that it was in the interest of plan participants for the defendants to deplete the Plan's funds by way of year-end bonus payouts."[211] This formulation of the holding (second version) is inconsistent with the formulation stated in the preceding paragraph (first version). The first version of the holding requires an inquiry into the doctor's state of mind to determine if the doctor delayed or denied care solely because she could increase her bonus by doing so.[212] The second version of the holding abandons any inquiry into the doctor's state of mind, and only requires an examination of the incentive program to determine whether it is inconsistent with the interests of participants and beneficiaries.[213] Because the majority focused most of its discussion on the mere existence of a conflict of interest, without providing any other reference to the doctor's state of mind, the court probably did not intend to add the state of mind requirement.

Second, Herdrich's complaint does not contain an allegation that the physician delayed treatment solely because of her interest in increasing her bonus.[214] If the court actually wanted the plaintiff to allege that the doctor delayed care solely because of her interest in making a profit, it should have dismissed Herdrich's complaint on the ground that she failed to make the allegation, or should have required her to amend the complaint. Because the court did neither, the majority opinion should be read to allow a breach of fiduciary duty claim only when the claim is based only on an alleged conflict of interest stemming from a health plan's use of physician incentives to limit care.

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210. *Herdrich*, 154 F.3d at 380 (emphasis added).

211. *Id.*

212. *See id.* at 373 (requiring that the physician withhold care for the sole purpose of increasing his bonus).

213. *See id.* at 380.

214. *See id.* at 373.

B. *Critique of the Court's Analysis of the Fiduciary Status Issue*

With a firm understanding of the *Herdrich* court's holding, the analysis can now turn to the first issue for any ERISA breach of fiduciary duty claim: Who, within the health care plan, was a fiduciary? In *Herdrich*, the court did not even consider whether Dr. Pegram was a fiduciary. The majority, however, did conclude that both the plan (HAMP) and the physician organization (Carle) were fiduciaries under ERISA.[215] While this conclusion may result simply from the fact that the court was reviewing a dismissal for failure to state a claim, an ultimate conclusion that Carle was a fiduciary would probably be a mistake.

The potential mistake on this issue is likely the result of confusion over the limited nature of ERISA's fiduciary status. The same group of physicians owned both Carle and HAMP.[216] Carle was the physicians organization, and HAMP was the entity responsible for plan administration.[217] Since HAMP administered the plan,[218] the conclusion that it acted as a fiduciary is probably correct. The conclusion for Carle, however, is less clear. The Carle physicians may have exercised discretionary authority when they set plan policies while acting as the owners of HAMP, but this only leads to the conclusion that HAMP was a fiduciary. ERISA makes a person a fiduciary only to "the extent"[219] he exercises "discretionary authority" over plan administration.[220] When a person does not exercise such discretion, he is not a fiduciary.[221] The Carle physicians, therefore, likely acted as fiduciaries when setting policies for HAMP. But when acting for Carle, the physicians were likely making business decisions related to the operation of the physician organization. They probably did not have discretionary authority[222] and were probably not fiduciaries.

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215. *See id.* at 371.

216. *See id.* at 381 (Flaum, J., dissenting).

217. *See id.*

218. Presumably HAMP set plan policies and handled benefits determinations. The case, however, does not provide an in-depth discussion of the corporate structure.

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

220. *See supra* notes 69–77 and accompanying text.

221. *See id.*

222. *See supra* Part II.C.2.b.

With regard to Dr. Pegram's actions as a physician, she likely did not have any administrative discretion, since her decisions were primarily medical.[223] Therefore, she was probably not a fiduciary. Additionally, no fiduciary liability could be imposed on Dr. Pegram as an employee of Carle, since Carle was probably not a fiduciary and because there is no indication that Dr. Pegram was not acting within the corporate structure.[224] In any event, the *Herdrich* majority did not hold Dr. Pegram to be a fiduciary.[225] This distinction should prove to be important because, as is discussed in Part IV.C.3., the action claimed to be a breach of fiduciary duty—instituting physician incentives—was taken by HAMP acting as a fiduciary, but the action that caused the harm and the loss—having the patient wait for care—was taken by Dr. Pegram, a nonfiduciary.[226]

C. *Critique of the Herdrich Court's Analysis of the Duty/Breach Issue*

With an understanding of who, within a health care plan, should be considered an ERISA fiduciary, we can turn to the final issue: Does the use of physician incentives constitute a breach of ERISA's fiduciary duty? The majority in *Herdrich* held that "incentives can rise to the level of a breach where, as pleaded here, . . . physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses."[227] In so holding, the court made three errors. First, the majority failed to counter, or even discuss, precedent contrary to the court's holding. Second, the court relied on precedent that does not support its conclusion. Third, and most importantly, the court failed to distinguish between the actions of the fiduciary (HAMP) and the nonfiduciary (Dr. Pegram). Because of these errors, the court incorrectly concluded that the health care plan may be held liable for breach of fiduciary duty solely for the use of physician incentives.

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223. *See supra* Part II.C.2.c.

224. *See supra* note 77 and accompanying text for a discussion of individual liability for a member of a corporate fiduciary.

225. *See Herdrich*, 154 F.3d at 369–71.

226. *See id.* at 371–73.

227. *Id.* at 373 (emphasis omitted).

1. Precedent Contrary to the Court's Holding

The decisions of at least two courts force one to question the *Herdrich* court's analysis. In *Weiss v. CIGNA Healthcare*,[228] the plaintiff alleged that CIGNA paid its physicians through "capitation" with "withholds," whereby CIGNA paid doctors a monthly per-patient fee regardless of the amount of care actually provided and then withheld a portion of the payment to be returned only if the doctor had sufficiently low rates of referrals to specialists.[229] This system gave CIGNA doctors an incentive to deny care, and plaintiff claimed this incentive violated CIGNA's fiduciary duties imposed by ERISA § 1104(a)(1).[230] The court rejected plaintiff's claim using two arguments. First, the court reasoned that, to the extent a doctor takes advantage of the financial incentives and withholds necessary care, that doctor's ethical breach is not attributable to CIGNA.[231] The court argued that the profit motive created by CIGNA did not make such violations by physicians "inevitable."[232] Second, the court dismissed plaintiff's contention that CIGNA's use of physician incentives violated ERISA as an assertion tantamount to a claim that such arrangements in managed care are inherently illegal.[233] The court argued that such a claim was refuted by federal law and was better addressed by the legislature than the judiciary.[234] Ultimately, the court dismissed the action for failure to state a claim under ERISA.[235] The *Herdrich* court never mentioned *Weiss*.

In *Maltz v. Aetna Health Plans*,[236] the plaintiff sought a preliminary injunction[237] claiming Aetna had violated its fidu-

228. 972 F. Supp. 748 (S.D.N.Y. 1997).

229. *See id.* at 752.

230. *See id.*

231. *See id.*

232. *See id.* (citation omitted).

233. *See id.* at 753.

234. *See id.* (citing 42 U.S.C. § 300e(c)(2) (1994) and 42 C.F.R. § 417.103(b) (1999)). The argument that federal law (1) encourages the use of physician incentives to limit care as a cost-containment mechanism and (2) argues against the imposition of liability based on such incentives was discussed at Part II.E.I.b *supra*.

235. *See Weiss*, 972 F. Supp. at 753.

236. 114 F.3d 9 (2d Cir. 1997).

237. In reviewing the denial of a preliminary injunction, the court employed an "abuse of discretion standard." *See id.* at 11. While this fact differentiates *Maltz* from *Herdrich*, where the court was using a de novo standard of review, *see*

ciary duty to act solely in the interest of plan participants when it instituted physician incentives in the form of a capitation payment system.[238] The plaintiff argued that, while Aetna could alter its relationship with physicians for the benefit of enrollees, it could not make such significant changes for its own economic benefit.[239] In rejecting the claim, the court pointed to the fact that Aetna notified its doctors and the doctors notified covered patients of the change in compensation.[240] Despite this, Maltz renewed her contract with Aetna.[241] In light of Maltz's knowledge, the court would not hear her complaint that Aetna had violated its fiduciary duty under ERISA.[242] The court also stated that Aetna had a legitimate interest in reducing health care costs that would be frustrated by an injunction.[243] Accordingly, the court affirmed the lower court's denial of a preliminary injunction.[244] The *Herdrich* majority never mentioned *Maltz*.

While the Herdrich majority never addressed *Weiss* and *Maltz*,[245] one might argue that these cases should be distinguished on their facts. The factual differences between *Herdrich*, and *Maltz* and *Weiss* include: (1) the type of incentive arrangement employed by the plans; and (2) the roles played by the defendants in administering the plan. These two distinctions, however, are actually the same, and should make little difference in a court's analysis of whether physician incentives amount to a breach of fiduciary duty.

First, in *Maltz* and *Weiss*, the plans implemented a "capitation" arrangement[246] and a "capitation" with "withholds" ar-

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Herdrich, 154 F.3d at 369, the *Maltz* court noted in its opinion that plaintiff failed to demonstrate a likelihood of success on the merits. *See Maltz*, 114 F.3d at 12. This statement adds strength to the argument that the *Maltz* court would have rejected plaintiff's breach of fiduciary duty claim even under a de novo standard of review. Still, this difference argues for caution when using *Maltz* as precedent.

238. *See Maltz*, 114 F.3d at 10.

239. *See id.* at 11.

240. *See id.* at 12.

241. *See id.*

242. *See id.*

243. *See id.* at 11.

244. *See id.* at 12.

245. Note here that neither case is controlling for the *Herdrich* court. The criticism is that the *Herdrich* majority never even attempted to deal with these holdings.

246. *See Maltz*, 114 F.3d at 10.

rangement,[247] respectively. In *Herdrich*, Carle and HAMP employed a "bonus" arrangement where physicians received the difference between revenues and costs at the year's end.[248] The financial arrangement in each case gave physicians a financial incentive to limit the care given to patients.[249] The arrangements in *Weiss* and *Herdrich* gave physicians the added incentive to limit use of "ancillary services" to increase the amount returned from the "withhold" in *Weiss*, and to decease costs, thereby increasing the year-end bonus in *Herdrich*.[250] While these arrangements operate differently, they have the same result: They give physicians financial incentives to limit care.[251] The type of incentive used should make little difference to the courts' analyses and their application to the facts in *Herdrich*.

Second, the defendants in *Herdrich* occupied both the role of plan doctors providing care to plan participants and the role of plan administrators making decisions concerning what claims and conditions are covered under the plan.[252] The defendants in *Weiss* and *Maltz*, on the other hand, only occupied the role of plan administrator.[253] Without mentioning or citing *Weiss* or *Maltz*, the *Herdrich* majority seemed to be making something of this difference when it noted:

> [T]he doctors who owned Carle . . . were the very same individuals who served as officers and directors of HAMP, the plan-administering subsidiary of Carle. . . . [I]t is more likely than not that an incentive existed for the Carle doctors to abuse the dual loyalties that they observed in administering the Plan . . . .[254]

The court went on to argue that "the Carle physicians were intimately involved with the financial well-being of the enterprise . . . [and] [d]ue to the dual-loyalties at work, . . . were faced with an incentive to limit costs so as to guarantee a greater kickback."[255]

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247. *See Weiss*, 972 F. Supp. at 752.
248. *See Herdrich*, 154 F.3d at 372.
249. *See supra* notes 25–37 and accompanying text.
250. *See supra* notes 25–37 and accompanying text.
251. *See supra* notes 25–37 and accompanying text.
252. *See Herdrich*, 154 F.3d at 370.
253. *See Maltz*, 114 F.3d at 10; *Weiss*, 972 F. Supp. at 752.
254. *Herdrich*, 154 F.3d at 379.
255. *Id.* (emphasis omitted).

While the *Herdrich* majority inadvertently identified a difference between the facts in *Herdrich* and cases like *Weiss* and *Maltz*, this "difference" boils down to little more than a distinction in the type of physician incentive employed by the plan—the same difference identified above. Essentially, the *Herdrich* court only identified the workings of a physician bonus arrangement. Because the Carle doctors also owned the plan-administering Carle subsidiary, HAMP, they had a financial incentive to limit care so as to reduce plan costs, thereby increasing their year-end bonuses. The doctors had no need to employ a "capitation" or a "withhold" arrangement, because their corporate structure already provided a financial incentive to limit care by way of the year-end bonus. Many health plans use the employee bonus arrangement as an alternative to "capitation" and "withhold" arrangements.[256] Both give physicians incentives to limit care.[257] The type of incentive used should make little difference to a court's analysis of whether a physician incentive amounts to a breach of fiduciary duty.

2. The Precedent Cited by the Court Does Not Support its Conclusion

The *Herdrich* court relied on several cases to support its conclusion that physician incentives can form the basis for an ERISA breach of fiduciary duty claim. These cases, however, do not support the court's ultimate conclusion.

In the primary case relied on by the *Herdrich* majority,[258] *Ries v. Humana Health Plan*,[259] the defendant health care plan required participants to reimburse the plan for the costs of treatment if those costs were recovered by way of a settlement or judgment from the person who caused the injury or disease.[260] Under the terms of the plan, participants were to pay twenty percent of treatment costs, while the plan covered eighty percent.[261] The plan, however, was not actually paying eighty percent of the costs because it was negotiating discounts with physicians and not passing on the savings to plan partici-

256. *See* Orentlicher, *supra* note 3, at 160.
257. *See id.*
258. *See Herdrich*, 154 F.3d at 372.
259. 1995 WL 669583, at *1.
260. *See id.*
261. *See id.* at *3.

pants.[262] The court held that, based on these allegations, the plan had breached its fiduciary duty.[263] The court stated a "fiduciary's covert profiteering at the expense of insureds is inconsistent with its duties of acting 'solely in the interest of the participants and beneficiaries.'"[264] The court also held that the "failure to inform Ries [a participant] of the discounting arrangement transgresses the fiduciary duty of conveying important information and ensuring against misleading plan participants."[265]

The *Herdrich* majority argued that *Ries* supported its conclusion that physician incentives can rise to the level of a breach of fiduciary duty.[266] In reality, *Ries* does not support the *Herdrich* decision, but supports the outcome reached in *Shea v. Esensten*,[267] which surprisingly, the *Herdrich* majority also cited in support of its conclusion.[268] Remember that in *Shea*, the Eighth Circuit held that a health plan utilizing physician incentives has an affirmative duty to disclose those incentives because of the potential harm created by the incentives.[269] As in *Shea*, the *Ries* court's holding rested primarily on the duty of disclosure and the fact that the fiduciary failed to convey important information to plan beneficiaries.[270] The *Ries* court also could point to the fiduciary duty to act in accordance with plan documents when finding that the fiduciary had breached its duty to cover eighty percent of the costs.[271]

In contrast, the *Herdrich* plaintiff did not claim that HAMP or Carle had failed to disclose the use of physician incentives. All the court had before it was a claim that the health plan's act of utilizing physician incentives breached its duty to act "solely in the interest" of plan participants.[272] Important reasons exist—including cost savings, lack of conflict between the plan and participants, and congressional treat-

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262. *See id.*
263. *See id.* at *7.
264. *Id.* (quoting 29 U.S.C. § 1104(a)(1)(A) (1994)).
265. *Id.*
266. *See Herdrich*, 154 F.3d at 372.
267. 107 F.3d 625 (1997). *See supra* notes 150–52 and accompanying text for a discussion of *Shea*.
268. *See Herdrich*, 154 F.3d at 372.
269. *See Shea*, 107 F.3d at 628–29.
270. *See Ries*, 1995 WL 669583, *7.
271. *See id.*
272. *See Herdrich*, 154 F.3d at 371.

ment of the issue—for treating the duty to act "solely in the interest" and the duty of disclosure differently when imposing ERISA fiduciary liability for the use of physician incentives. The majority never addressed any of these differences, but simply assumed that *Ries* and *Shea* supported its holding. As we have seen, *Ries* and *Shea* actually argue for the imposition of fiduciary liability based on nondisclosure of the use of physician incentives, a conclusion that takes into account the important reasons that exist for treating the duty of disclosure and the duty "to act solely in the interest of plan beneficiaries" differently.[273]

3. The *Herdrich* Court's Failure to Differentiate Between Fiduciary and Nonfiduciary Actors

The last, and most egregious, error made by the *Herdrich* court was its failure to distinguish between the actions of HAMP, the fiduciary, and Dr. Pegram, a nonfiduciary. Persons may act as fiduciaries in one capacity while acting as a nonfiduciary in another.[274] HAMP, acting as the plan administrator, was a fiduciary. Dr. Pegram, acting as a physician making medical decisions, was a nonfiduciary.[275] The court in *Weiss* rested its conclusion that physician incentives are not a breach of a health plan's fiduciary duty on this very distinction.[276] The *Weiss* court stated that, "to the extent that a *doctor* takes advantage of financial incentives and withholds necessary care from his or her patients, that doctor's ethical breach is not attributable to *CIGNA*."[277]

Yet, the *Herdrich* court did not recognize this distinction in its discussion. The court stated that instituting a physician incentives arrangement—the act of HAMP—can rise to the level of a breach of fiduciary duty when the "*physicians* delay providing necessary treatment"[278]—the act of Dr. Pegram, a nonfiduciary. Notice that the court merged the acts of the plan fiduciary and the physician nonfiduciary to create a test for determining whether the plan was liable. Under this formula-

273. *See supra* Part II.E.2.
274. *See supra* notes 78–81 and accompanying text.
275. *See supra* Part II.C.2.
276. *See supra* notes 228–35.
277. *Weiss*, 972 F. Supp. at 752 (emphasis added).
278. *Herdrich*, 154 F.3d at 373 (emphasis added).

tion, a health care plan is not liable simply for instituting the incentive arrangement, but becomes liable when a physician, over whom the plan has no direct control, breaches her ethical duty to the patient. In essence, the *Herdrich* court simply confused the actions of the fiduciary HAMP—who can be held liable for breach—and those of the nonfiduciary physician Dr. Pegram—who cannot be held liable for a breach.

The court's confusion leads to three conclusions. First, the *Herdrich* court's confusion adds strength to the argument made in Part IV.A that the court actually created per se fiduciary liability for a health plan's use of physician incentives. The court hopefully did not intend to confuse the actions of the plan fiduciary and the physician nonfiduciary. Its confusion probably stemmed from the fact that the fiduciary and nonfiduciary actors were the same people acting in different roles. Had the *Herdrich* court seen that it was confusing fiduciary and nonfiduciary action when creating a test for fiduciary liability, it would have understood that it was providing a cause of action against a health plan fiduciary solely for the use of physician incentives.[279]

Second, the *Herdrich* court's confusion supports the conclusion that a health plan should not be held liable solely for utilizing physician incentives to deny care. Had the *Herdrich* court seen that it was imposing per se liability on health plans for the use of physician incentives, it presumably would have been forced to face the arguments discussed in Part II.E.

Finally, the court's confusion lends support to the argument that fiduciary liability should be imposed on a plan when it fails to disclose the use of physician incentives. Differentiating between the acts of fiduciaries and nonfiduciaries leads one to conclude that a fiduciary health plan should be held liable for nondisclosure of physician incentive arrangements. While HAMP should not be held liable for the acts of a nonfiduciary physician over whom it has no control and should not be held liable solely for the use of physician incentives, HAMP should be held liable when it creates a potentially dangerous conflict of interest between plan participants and their physicians and then fails to disclose the conflict. This is the holding

279. The second part of the court's test, denial or delay in care by a physician, will always be present when a patient brings a claim of this sort. *See* discussion *supra* Part III.A.

of *Shea v. Esensten*,[280] and should be the standard for courts in the future.

CONCLUSION

The critics are correct. Physician financial incentives present a real danger to the quality of health care. These incentives, however, are a vital weapon in the fight for containing the costs of health care. Therefore, we must balance the dangers and benefits.

In *Herdrich*,[281] the Seventh Circuit balanced the dangers and benefits by disregarding the benefits and establishing a precedent that may very well prevent HMOs from using physician incentives without incurring per se liability under ERISA. This is not the proper result.

The proper approach is the one taken in *Shea*,[282] where the Eighth Circuit imposed liability on an HMO for failing to disclose its use of physician incentives. This approach acknowledges the benefits of physician incentives, but protects the patients by giving them the information they need to protect themselves. The Seventh Circuit, therefore, should revisit the issues it faced in *Herdrich*, and adopt the *Shea* court's analysis. This will lead the court to the proper result.

280. 107 F.3d 625 (1997).
281. 154 F.3d 362 (1998).
282. 107 F.3d 625 (1997).