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MIXED ELIGIBILITY-TREATMENT DECISIONS BY HMO PHYSICIANS ARE NOT SUBJECT TO A FIDUCIARY DUTY UNDER ERISA

In a case arising from a patient's claim that her HMO denied her timely care in an effort to contain costs, the Supreme Court held that a physician practicing in a medical group that owned and was under contract with a HMO to provide medical services to plan patients does not owe those patients a fiduciary duty under the Employee Retirement Income Security Act of 1974 ("ERISA") when making treatment decisions. *Herdrich v. Pegram*, No. 98-1949, 2000 WL 743301 (U.S. June 21, 2000). Justice David H. Souter wrote for the unanimous Supreme Court, which reversed the ruling by the United States Court of Appeals for the Seventh Circuit. The Seventh Circuit previously held that financial incentives received by physicians providing services under a managed care plan can rise to the level of a breach of fiduciary duty where physicians delay or withhold proper care to plan beneficiaries for the sole purpose of increasing their compensation.

Factual Background. *Herdrich* stemmed from a physician's decision to delay a diagnostic test for an HMO patient, which allegedly resulted in the patient's suffering a ruptured appendix and peritonitis. The patient, Cynthia Herdrich, was a participant in a pre-paid health insurance plan sponsored by her husband's employer. The plan was operated by Health Alliance Medical Plans, Inc., based in Champaign, Illinois ("HAMP"). Carle Clinic Association, P.C., a large multi-specialty physician group, also based in Champaign ("Carle"), was the sole shareholder of HAMP, and Carle physicians from locations in Champaign and other places in the central Illinois region provided medical services to plan participants under a provider agreement with HAMP.

In March 1991, Herdrich sought treatment for abdominal

pain from Lori Pegram, M.D., a Carle physician. During a further examination, six days after the initial visit, Dr. Pegram discovered an inflamed mass in Herdrich's abdomen. Dr. Pegram did not order an ultrasound at a local hospital, but rather scheduled the procedure for eight days later at a facility staffed by Carle physicians in Champaign, Illinois, fifty miles away. During this delay, Herdrich's appendix ruptured, causing peritonitis.

Procedural Background. Herdrich originally filed a two-count complaint in the Circuit Court of Illinois against Dr. Pegram, HAMP and Carle for negligence. She later added counts III and IV, alleging state-law fraud. In response, the defendants contended that ERISA preempted counts III and IV and successfully removed the case to federal court. The federal District Court then dismissed count IV, but allowed Herdrich to amend count III in order to clearly set forth a basis for proceeding under ERISA. Herdrich's amended third count asserted that the provision of health care services in the context of the financial incentive system in place between HAMP and its owner, Carle, under which supplemental medical expense payments received by Carle from HAMP were related to the amount of profit generated by HAMP each year, entailed a limited or inherent breach of an ERISA fiduciary duty. Specifically, Herdrich alleged that the terms of the Carle plan created an incentive to make decisions in the physicians' interest, as opposed to the best interests of the plan participants. The District Court dismissed the amended count III for failing to satisfactorily establish a claim for breach of fiduciary duty under ERISA because Herdrich had failed to show how either Dr. Pegram or Carle functioned as a "fiduciary" as that term is understood under ERISA. The remaining counts for professional negligence were tried before a jury, and Herdrich received a verdict against Carle in her favor and $35,000 in compensatory damages. Herdrich then appealed the District Court's dismissal of her amended count III to the Seventh Circuit Court of Appeals.

Upon review, the Court of Appeals reversed the District Court's dismissal of Herdrich's claim for breach of ERISA fiduciary duty. The court held that Ms. Herdrich alleged facts that, if proven true, could demonstrate that the defendants breached their fiduciary duty to plan participants.

First, the court determined the degree of discretionary authority or control the defendants maintained over the management or administration of the plan and categorized

them as "fiduciaries" in accordance with ERISA. It believed Ms. Herdrich satisfactorily alleged that the Carle physicians, in addition to providing medical care, functioned as "administrators" of the HAMP plan faced with the task of determining the extent of coverage for health care claims, which categorized them as plan fiduciaries under ERISA.

Second, the court reasoned that, although incentives to limit costs do not alone constitute a breach of fiduciary duty, such incentives can rise to the level of breach when, as Herdrich alleged, they cause physicians to delay or withhold treatment for the purpose of increasing their financial reward. The court found that the Carle physicians had an incentive both to deny coverage and to restrict treatment in an effort to ensure sizable annual bonuses.

Third, the court agreed with Herdrich's claim that the alleged breach resulted in a loss to the plan because it denied participants needed medical care to which they were entitled. Accordingly, the Seventh Circuit remanded the case to the District Court to determine if the defendants did violate their fiduciary duty as administrators to act exclusively in the best interests of plan beneficiaries and participants.

The Supreme Court's Analysis

The critical issue in *Herdrich*, according to the Supreme Court, was not whether HMO structures that offer participating physicians incentives to limit costs can constitute a breach of ERISA fiduciary duty (as the Seventh Circuit concluded they can), but whether treatment decisions made by physicians practicing under such structures are fiduciary decisions under ERISA. The Court held that such treatment decisions, which were referred to as "mixed treatment-eligibility" decisions because they involve an analysis of the appropriate level of medical care and whether the plan will cover such care, are not subject to an ERISA fiduciary duty in large part because they differ in their basic nature from traditional fiduciary decisions. Additionally, the Court explained that a finding that the existence of cost-cutting incentives that influence treatment decisions can amount to a breach of fiduciary duty would effectively mean the end of the for-profit HMO, which is a result likely not intended by Congress. The Court also explained that the application of the fiduciary standard to individual treatment decisions made under a care-rationing incentive structure, rather than to the existence of the structure itself, would essentially make HMOs guarantors of

successful treatment.

Court Refuses to Differentiate Between Incentive Structures

Before discussing the fiduciary requirements under ERISA, the Court briefly addressed Herdrich's claim that reviewing the decisions made by Carle physicians would not open the door to similar claims about other HMO structures. Specifically, Herdrich argued that the particular incentive structure in place, which she claimed rewarded physicians annually for limiting care throughout the year, differed from the cost-saving mechanisms employed by other HMOs, so that a finding that the Carle physicians breached a fiduciary duty under ERISA would not apply to other physicians who participate in HMOs.

The Court, however, concluded that it would not identify some HMO structures as "good" and others as "bad." According to the Court, "no HMO organization could survive without some incentive connecting physician reward with treatment rationing." Further, any legal principle that draws a line between good and bad HMOs translates into a judgment about "socially acceptable medical risk." The Court was not comfortable making such judgments, and proceeded on the understanding that the mixed treatment-eligibility decisions contained in Herdrich's complaint could not be subject to a claim that they violate fiduciary standards unless all such decisions made by all HMOs through their physicians, regardless of whether the physicians are owners or employees, are judged by the same standards.

Mixed Treatment-Eligibility Decisions Are Not Fiduciary Obligations Under ERISA

ERISA imposes certain obligations on employee welfare benefit plan fiduciaries. According to the ERISA law, a fiduciary is somebody acting in the capacity of manager, administrator or financial advisor to an employee welfare benefit plan. *See* 29 U.S.C. §§ 1002(21)(A)(i)-(iii). An employee welfare benefit plan is defined, albeit circularly, as "any plan, fund, or program…to the extent that such plan, fund, or program was established…for the purpose of providing…through the purchase of insurance or otherwise…medical, surgical, or hospital care or benefits." The Court interpreted this definition, as applied to a managed care context, to mean that, when an employer contracts with a HMO to provide health care benefits to its

employees, the documents that create the HMO are not an ERISA plan, but the agreement between the HMO and the employers provide elements of an ERISA plan by setting out rules under which employee-beneficiaries will be entitled to receive care. The Court then concluded that, although Carle was not an ERISA fiduciary simply because it administers or exercises discretionary authority over the operations of its own HMO, it could be an ERISA fiduciary if it administers the medical plan to beneficiaries.

The ERISA statute provides that fiduciaries shall discharge their duties with respect to a plan "solely in the interest of the plan participants" and "for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." Although this fiduciary duty is rooted in the common law of trusts, the Court stated that, unlike the common law trustee, an ERISA fiduciary may have financial interests adverse to beneficiaries. Nonetheless, as the Court pointed out, ERISA does require that the fiduciary with competing interests serve only one interest at a time, and serve the interests of the beneficiaries when making fiduciary decisions.

As the Court articulated, the threshold question when addressing a claim of breach of ERISA fiduciary duty stemming from action taken by an individual employed to provide services under a plan focuses not on the effect of the decision on a beneficiary's interest, but whether that individual was performing a fiduciary function when taking that action. The Court read Herdrich's complaint not to concern administrative decisions concerning "pure eligibility," such as determinations about the plan's coverage of a particular condition or medical treatment, which properly are categorized as fiduciary decisions under ERISA. Instead, Herdrich's complaint addressed "mixed treatment-eligibility" decisions, which combine eligibility considerations with physicians' judgments about reasonable medical treatment. For example, Herdrich pointed to the following decisions as fiduciary in character: when to use diagnostic tests; when to seek outside consultations; when to make referrals to facilities that are not affiliated with Carle; what is the proper standard of care; what is the nature of a proposed course of treatment; and the emergency character of a medical condition. Such decisions, according to the Court, are "inextricably mixed" and cannot serve as the basis for an alleged fiduciary breach.

Congress did not intend HMOs to be considered fiduciaries

when making mixed treatment-eligibility decisions through their physicians, according to the Court. Fiduciary duties generally entail making decisions related to managing assets and distributing property to beneficiaries. Mixed treatment-eligibility decisions bear only a "limited resemblance" to the customary business of traditional trustees. Traditional trustees administer a medical trust by distributing money to buy medical care, whereas physicians making mixed eligibility-treatment decisions, such as Carle physicians, consume the money as well. Similarly, traditional trustees do not make treatment decisions, whereas treatment determinations are what distinguish mixed eligibility-treatment decisions from pure eligibility determinations. When Congress addressed the subject of fiduciary responsibilities under ERISA, it focused on the financial decisions made by a fiduciary. The Court expressed doubt that Congress considered mixed treatment-eligibility decisions when it provided that decisions related to administering a plan were fiduciary decisions.

Negative Consequences Would Follow From Herdrich's Claim

The Court worried that applying the ERISA fiduciary standard to HMO structures that provide incentives for rationing care (as Herdrich suggested), rather than to individual treatment or mixed treatment-eligibility decisions that injure patients, would allow plan beneficiaries to recover simply upon demonstrating that the incentive scheme would generally affect mixed decisions. Since the remedy for such a finding would be the return of profits to the plan for the benefit of its members, that remedy would amount to the elimination of the for-profit HMO model, and possibly not-for-profit HMOs, as well. Because Congress has promoted the formation of HMO practices for over twenty-seven years, it likely would not support an application of the fiduciary standard that would lead to their demise, according to the Court.

Alternatively, the Court considered the consequences of applying the ERISA fiduciary standard to particular treatment or mixed eligibility decisions, instead of to the HMO structure as a whole. The Court saw a problem with this approach as well: in any case where rationing care yielded a less-than-optimal outcome, patients (and courts) could too easily blame economic incentives for the poor results. Thus, for all practical purposes, such a standard would convert HMOs into guarantors of success.

Medicare/Medicaid, antitrust, fraud and abuse/Stark legislation, Certificate of Need, licensure, corporate practice of medicine and other issues;

- Development of managed care organizations and other strategic health care arrangements;
- Structuring of corporate networks, mergers, affiliations and acquisitions, including purchases and sales of practices and institutions;
- Comprehensive counseling to professional health care associations and medical specialty societies;
- Counseling in connection with implementation of strategic initiatives by health care entities, such as primary care satellite programs, physician recruitment and retention initiatives, and program development in emerging areas such as home health and outpatient mental health;
- Tax-exempt and taxable financing (both as borrowers' and underwriters' counsel); and
- Development of innovative responses to Medicaid and other publicly sponsored managed care initiatives.

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In addition, the Court pointed out that in a claim for breach under the standard applied by the Seventh Circuit, a HMO could simply argue that its physician's actions were based on medical judgment rather than profit motive. The case would then depend on the appropriate standard of medical care under the circumstances; thus, every claim for breach would essentially boil down to a malpractice claim. The result would be the creation of a new cause of action for malpractice in federal court, which would in many ways duplicate the existing state-court actions. This would cause confusion on several matters, including who may be sued (HMO, physician, or both) and what law would govern (state or federal). Also, the creation of a new federal "fiduciary-malpractice" action could compromise the efficiency of the federal courts with a flood of new litigation. The Court thought it unlikely that Congress intended any of these effects when it defined the ERISA fiduciary' and consequently found the Seventh Circuit's approach unworkable.

Thus, the Court concluded that within a HMO structure that provides financial incentives for rationing care, treatment and mixed eligibility decisions made by physicians are not subject to a fiduciary duty under ERISA.

Fiduciary Duty to Disclose Financial Arrangements

It is important to note that the Court did not address the issue of whether Carle breached a fiduciary duty to disclose the existence of physician incentives that may limit care. Herdrich's original complaint included a similar allegation, but her amended complaint modified the claim to allege a fiduciary obligation to avoid such incentives. Although the Court was not presented with the issue, it indicated in a footnote that "it could be argued that Carle is a fiduciary insofar as it has discretionary authority to administer the plan, and so it is obligated to disclose characteristics of the plan and of those who provide services to the plan, if that information affects beneficiaries' material interests."

At least two judges sitting in different federal circuits have ruled on opposite sides of the issue. The U.S. Court of Appeals for the Eighth Circuit ruled in 1997 that a HMO had a duty under ERISA to disclose physician incentives that affected the quantity of referrals to specialists. *Shea v. Esenstein*, 107 F.3d 625 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997). More recently, however, the U.S. Court of Appeals for the Fifth Circuit held that HMOs do not have a general duty under ERISA to affirmatively disclose

financial compensation arrangements. *Ehlmann v. Kaiser Found. Health Plan of Texas*, 198 F.3d 552 (5th Cir. 2000), *reh'g and reh'g en banc denied*, (5th Cir. Feb. 14, 2000). Until the U.S. Supreme Court agrees to hear a case involving a claim that a HMO breached a fiduciary duty to disclose its financial compensation arrangements, it remains unclear whether or not a description of compensation arrangements, generally, or the existence of financial incentives, specifically, qualifies as information that must be disclosed by an ERISA fiduciary because it "affects beneficiaries' material interests." In the interim, however, many states that have enacted patients' rights legislation have imposed at least minimal financial disclosure requirements on all health plans.

Practical Application

The Supreme Court's opinion may impact claims against HMOs in various ways. The most obvious result is that patients no longer can argue that mixed treatment-eligibility decisions constitute a breach of fiduciary duty under ERISA. Justice Souter's opinion, however, paved the way for states to create new remedies at law. For the past several years, state courts have been reluctant to address malpractice and negligence claims against HMOs that participate in employer-sponsored health plans. Only a few state court judges thus far have allowed such claims. The Court's opinion, which endorsed the view that state courts, not federal courts, are the proper venue for negligence claims against HMOs, may encourage more states to adopt the view that a HMO is a provider of medical care, and if it, or its affiliated physicians, injures a patient, it may be liable for negligence under state law.

The Court's opinion also may have an effect on federal legislation. At numerous points during the opinion, Justice Souter refrained from addressing important issues that were discussed at great length in the Seventh Circuit's opinion, such as whether patients have a right to sue HMOs in state court and whether HMOs have an obligation to disclose incentive structures to participants. The Court indicated instead that the federal judiciary would be acting contrary to the federal legislature, which created HMOs when it adopted the Health Maintenance Organization Act of 1973, if it were to restrict the ability of certain HMOs to operate. The Court's reluctance to speak about important issues can be interpreted as a challenge to Congress to enact federal legislation that clarifies the rights of patients who participate in HMOs.

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