



CSU
College of Law Library

2002

The Serpent in the Garden of Eden: A Look at the Impact of Physician Financial Incentive Programs and a Reconsideration of Herdrich v. Pegram

Amy L. Cralam

Follow this and additional works at: <https://engagedscholarship.csuohio.edu/jlh>



Part of the [Health Law and Policy Commons](#), and the [Insurance Law Commons](#)

[How does access to this work benefit you? Let us know!](#)

Recommended Citation

Amy L. Cralam, Serpent in the Garden of Eden: A Look at the Impact of Physician Financial Incentive Programs and a Reconsideration of Herdrich v. Pegram, 16 J.L. & Health 289 (2001-2002)

This Article is brought to you for free and open access by the Journals at EngagedScholarship@CSU. It has been accepted for inclusion in Journal of Law and Health by an authorized editor of EngagedScholarship@CSU. For more information, please contact library.es@csuohio.edu.

THE SERPENT IN THE GARDEN OF EDEN:¹ A LOOK AT THE
IMPACT OF PHYSICIAN FINANCIAL INCENTIVE PROGRAMS
AND A RECONSIDERATION OF *HERDRICH v. PEGRAM*²

AMY L. CRALAM³

I.	INTRODUCTION	290
II.	STATEMENT OF THE CASE.....	293
	A. <i>The Facts</i>	293
	B. <i>United States District Court for the Central District of Illinois</i>	296
	C. <i>Seventh Circuit Court of Appeals</i>	298
	1. The Majority Opinion.....	298
	2. The Dissenting Opinion.....	299
	D. <i>United States Supreme Court</i>	301
III.	BACKGROUND.....	303
	A. <i>The Health Management Organization</i>	303
	1. Historical Background and Function of HMOs....	303
	2. Types of HMOs	306
	a. <i>The Staff Model</i>	306
	b. <i>The IPA Model</i>	307
	c. <i>The Group Model</i>	308
	3. Controlling Costs and Cost Containment	308
	a. <i>Utilization Review</i>	308
	b. <i>Panel Selection</i>	309
	c. <i>Direct Physician Financial Incentives</i>	310
	i. Salary.....	311
	ii. Capitation	311
	iii. Bonus	312
	iv. Profit Sharing	313
	d. <i>The Use of Direct Financial Incentives By HMOs</i>	313

¹Genesis 3:1-19.

²*Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), *reh'g denied*, 170 F.3d 683 (7th Cir. 1999), *rev'd*, 530 U.S. 211 (2000) (*per curiam*).

³J.D., *magna cum laude*, 2002, Hamline University School of Law. The author would like to thank her husband Jared for inspiring her to write this article and her family for all of their support. She would also like to thank Colin Johnson for all of his insight and assistance with this Article.

e.	<i>Cases Discussing the Use of Financial Incentives</i>	314
B.	<i>The Effect of ERISA on Managed Care</i>	317
1.	ERISA Preemption	317
2.	Fiduciary Duty Under ERISA	319
3.	The “Savings Clause” and Common-Law Claims	320
IV.	ANALYSIS	322
A.	<i>The Fiduciary Duty</i>	322
1.	The ERISA Standard	322
a.	<i>A Fiduciary Under ERISA</i>	323
b.	<i>The Role of Utilization Review</i>	324
i.	Control of the Claims Process	324
ii.	Liability and Utilization Review	325
c.	<i>Mixed Eligibility Decisions and Fiduciary Duties</i>	326
B.	<i>Physician Financial Incentive Agreements Can Rise To A Breach</i>	329
1.	Carle’s Bonus Distribution	329
2.	The Effect of Incentive Arrangements on Patient Care: Creating a System of Dual Loyalties	330
a.	<i>“ERISA Tolerates Some Conflict of Interest”</i>	330
b.	<i>A Lack of Accurate Data</i>	332
c.	<i>The Physician Response and Patient Trust</i>	333
d.	<i>The Role of the Market Forces Argument</i>	334
C.	<i>Solutions</i>	335
1.	Remand <i>Herdrich v. Pegram</i>	335
2.	Amending ERISA	337
a.	<i>Acknowledgement of a Fiduciary Relationship</i>	337
b.	<i>Expansion of the “Savings Clause”</i>	338
3.	Full Disclosure of Incentive Agreements	338
V.	CONCLUSION	339

I. INTRODUCTION

When you are sick, you call your doctor. As the patient, you believe that your doctor will examine you and make a decision on the best course of treatment for you.

You trust that your medical interests are at the forefront of their mind. Simply stated, this is the age old patient-doctor relationship.

However, modern health care systems have blurred this otherwise straightforward relationship.⁴ More money is spent on health care per person in the United States than anywhere else in the world, and each year the costs grow higher.⁵ Americans spend greater than \$1 trillion annually on medical care forcing the use of cost containment programs in order to curb these costs.⁶ Thus came the birth of the Health Management Organization (HMO). HMOs use financial incentives to prompt physicians to recognize the cost consequences of their treatment decisions and thus reduce the amount of care subject to insurance reimbursement.⁷ Financial incentives place physicians in a tempting situation by encouraging them to order less treatment and reap greater financial reward.⁸ Financial incentive programs have taken the place of the “serpent of temptation” in a modern day medical Garden of Eden.⁹

The cutting of costs comes with a price to the patient. Sixty-one percent of managed care patients surveyed stated they were very or somewhat worried that if they became sick, their insurer would be more concerned about saving money than about their medical care.¹⁰ In addition, many of the methods of cost-containment

⁴RAND ROSENBLATT ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 545 (1997) (arguing that “[w]hat makes managed care such an important development is its effects on the longstanding series of relationships within the health care system and its redistribution of power among the health care players.”).

⁵HEALTH INS. ASS’N OF AM., *MANAGED CARE: INTEGRATING THE DELIVERY AND FINANCING OF HEALTH CARE, PART B 1* (1996).

⁶See Daniel P. Sulmasy, et al., *Physicians’ Ethical Beliefs About Cost-Control Arrangements*, *ARCHIVES OF INTERNAL MED.*, Mar. 13, 2000, at 649.

⁷Tracy E. Miller & William M. Sage, *Disclosing Physician Financial Incentives*, *JAMA*, Apr. 21, 1999, at 1424.

⁸David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 *U. RICH. L. REV.* 155, 160 (1996) (“[p]hysicians recognize that they can increase their compensation by reducing their use of ancillary services.”).

⁹See *Genesis* 3:1-19 (reciting the biblical story of Adam and Eve and the serpent of temptation: “[t]he snake tricked me into eating it.”).

¹⁰See Miller, *supra* note 7, at 8 (discussing a Kaiser-Harvard study and explaining that “[s]tructured information about incentives might correct public misperceptions arising from negative media coverage, perhaps by presenting the issue in the context of other plan attributes, such as quality improvement initiatives.”).

commonly used are found to be ethically objectionable by physicians themselves.¹¹ The Proverb stands true, "He who pays the piper calls the tune."¹²

This Note will begin by examining the emergence of managed care starting with the "fee-for-service" system and moving to the modern HMO. Section IIIA. of this article explore several types of HMOs, compared with the different types of physician reimbursement mechanisms utilized by HMOs. Physician reimbursement programs often contain direct financial incentives. The main types of financial incentives utilized by HMOs will be discussed. These incentive programs place the physician in a dilemma when attempting to determine a patient's best course of treatment. In addition, Section IIIB. of the background addresses the Employee Retirement Income Security Act (ERISA), focusing on the state action preemption clause and the roadblock that ERISA creates for patients who want to bring claims against their HMO.

The impact of physician incentive programs is at the heart of the recent Supreme Court case *Herdrich v. Pegram*. In *Herdrich*, the patient, Cynthia Herdrich, challenged the use of a common incentive structure that allowed physicians to profit from decreased utilization of expensive medical procedures.¹³ Ms. Herdrich alleged that the use of these incentive programs created a conflict of interest for her treating physician and that conflict of interest caused a misdiagnosis of her appendicitis.¹⁴ The Seventh Circuit Court of Appeals agreed with Ms. Herdrich but was later overruled by the Supreme Court.¹⁵

This article suggests that *Herdrich v. Pegram* was wrongly decided. It will be shown that the case should have been remanded to the District Court for further review. In Section IVA., this article suggests that a fiduciary duty exists between the HMO and it's membership. Even under an ERISA standard a fiduciary duty could be perceived.

In Section IVB., this article establishes that physician financial incentive agreements implemented by an HMO can rise to the level of a breach of fiduciary

¹¹See Sulmasy, *supra* note 6, at 649 (concluding that "[m]any of the methods now commonly used to influence medical decision making are considered ethically objectionable by most midcareer physicians"). In 1991, the authors conducted a survey designed to elicit opinions regarding the medical practice environment and to assess the career satisfaction of physicians who had recently entered the practice. *Id.* at 650. The survey consisted of 102 closed-ended questions that were presented to physicians via telephone interviews. *Id.* Telephone interviews were completed for 1549 physicians creating a response rate of 74 percent. *Id.* at 651.

¹²David D. Griner, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861 (1991) (Proverb).

¹³See Sarah A. Klein, *Supreme Court to Weigh Physician Financial Incentives*, AM. MED. NEWS, Oct. 18, 1999, at 1 (discussing *Herdrich* at the appellate level and introducing the question "[d]o common financial incentives such as withhold pools create a conflict of interest for physicians and a cause of action for injured patients?"). The article further comments on the appellate decision, stating "[o]ne of the concerns . . . about the appellate decision is that it really takes what is pretty much a garden variety medical malpractice case and turns it into a federal case under ERISA." *Id.* at 2.

¹⁴*Id.* at 1.

¹⁵See *Pegram* at 213 (*per curiam*).

duty. The article will show that the bonus distribution utilized by the HMO in *Herdrich* could cause a breach by improperly influencing the physician decision-making process.

This Note will attempt to persuade the reader that the U.S. Supreme Court decision in *Herdrich v. Pegram* was a missed opportunity. “[I]nstead of establishing a clear rule about the legality of financial incentives paid to physicians, the justices found a host of problems with the case itself. . . .”¹⁶ The unanimous Supreme Court decision handed down June 12, 2000, established that neither physicians nor HMOs can be sued under federal benefits law for using cost containment and physician financial incentives to limit care.¹⁷ *Herdrich* was an opportunity for the Court to fully explore the effect that incentive programs used by HMOs have on the patient treatment decisions made by physicians.

In Section IVC., this Note concludes by suggesting that there are three solutions that would assist in preventing a situation like the one in *Herdrich* from happening again: (1) cases like *Herdrich v. Pegram* must be remanded for continued fact-finding regarding the details of the financial motives involved, (2) ERISA must be amended in order to acknowledge a fiduciary relationship between HMO members and the HMO itself, and (3) physician financial arrangements must be disclosed to HMO patient members.

II. STATEMENT OF THE CASE

A. *The Facts*

On March 1, 1991, Cynthia Herdrich, was experiencing pain in the middle area of her groin.¹⁸ Ms. Herdrich was examined by Carle Clinic Association (Carle) physician, Dr. Lori Pegram.¹⁹ Six days later on March 7, upon examination of Ms. Herdrich, Dr. Pegram discovered a six by eight centimeter inflamed mass in Herdrich’s abdomen.²⁰ Cynthia Herdrich was suffering from appendicitis.²¹ Dr.

¹⁶Sarah A. Klein, *High Court Hears Doctor Incentive Case*, AM. MED. NEWS, Mar. 13, 2000, at 1. The article explains that at one point Justice Anthony Kennedy asked an attorney for Dr. Pegram and the Plan “if there weren’t times when the physician, as an owner of an HMO, was serving the function of plan fiduciary and a health care professional.” *Id.* Justice Kennedy then directly asked the attorney “[i]s there some gray area where the doctor is wearing two hats?” *Id.* The attorney replied that there may be some gray area but not in the case before them. *Id.*

¹⁷See Sarah A Klein, *Justices Validate HMO Pay Incentives*, AM. MED. NEWS, June 26, 2000, at 1(referring to the ERISA statute). When a state law cause of action is preempted by ERISA, the claim cannot be pursued and must be dismissed and the plaintiff’s only remedy is found in the remedy provisions of the ERISA statute. See discussion *infra* Part III.B.1 (discussing the effect of ERISA on managed care).

¹⁸*Herdrich* at 365.

¹⁹See *Id.* On examination, Dr. Pegram acknowledged that Ms. Herdrich was experiencing pain in the midline area of her groin. See *Id.*

²⁰See *Id.*

Pegram determined that an ultrasound should be performed in order to take a closer look at the mass.²² An ultrasound procedure would be needed in order to determine the nature, size, and exact location of the mass.²³ Ideally, Herdrich should have had the ultrasound administered promptly after the inflamed mass was discovered so her condition could be diagnosed and treated before becoming more serious.²⁴ However, Ms. Herdrich's insurance provider, Carle, required that plan patients receive medical care from Carle facilities in what they classify as non-emergent situations.²⁵

Despite the noticeable inflammation of Ms. Herdrich's abdomen during the examination, Dr. Pegram did not order the ultrasound procedure to be promptly conducted at a local hospital in Bloomington, Illinois.²⁶ Dr. Pegram decided Ms. Herdrich would have the ultrasound procedure performed at a hospital more than fifty miles away in Urbana, Illinois.²⁷ In addition, Ms. Herdrich would need to wait eight days until the procedure could be performed at the second hospital.²⁸ While waiting to have the ultrasound procedure at the Carle facility, Herdrich's appendix ruptured, causing peritonitis, a life-threatening illness.²⁹

Cynthia Herdrich had medical coverage through Carle.³⁰ Carle functions as a Health Maintenance Organization.³¹ Carle operates as a pre-paid health insurance

²¹*Herdrich* at 683. Appendicitis is defined as an inflammation of the appendix usually caused by an infection in the appendix. See MEDICINE.NET.COM MEDICAL DICTIONARY, at <http://www.medicinenet.com> (defining "appendicitis"). Appendicitis often causes fever, loss of appetite, and right lower quadrant abdominal pain. *Id.*

²²*Pegram* at 215.

²³*Herdrich* at 374. Ultrasound imaging (ultrasonography) allows physicians to get an inside view of soft tissues and body cavities without the use of invasive techniques. See, MEDICINE.NET.COM MEDICAL DICTIONARY, *supra* note 21 (defining "ultrasound").

²⁴*Herdrich* at 374. "Doctor Hyman Lans, Herdrich's medical expert, stated at his deposition that Herdrich's condition worsened during the eight-day waiting period '[b]ecause obviously there has been another week of that appendix becoming necrotic and sitting in the pus, and obviously the process has continued during that week and doesn't correct itself.'" *Id.* at 375.

²⁵*Id.* at 374. See also discussion *infra* Part III.A.3.b. (discussing how HMOs control costs through the use of panel selection in which the HMO in many cases requires its members to use only certain physicians or facilities).

²⁶See *Herdrich* at 365.

²⁷*Id.*

²⁸See *Pegram* at 215.

²⁹See *Herdrich* at 374. Peritonitis is defined as an inflammation of the tissue layer of cells lining the inner wall of the abdomen and pelvis that can result from infection, injury and bleeding, or diseases. See MEDICINE.NET.COM MEDICAL DICTIONARY, *supra* note 21 (defining peritonitis). In addition, the Appellate Court points out that despite Carle's attempt to save health care costs "[H]erdrich suffered a life-threatening illness (peritonitis), which necessitated a longer hospital stay and more serious surgery at a greater cost to her and the Plan." *And See Herdrich* at 374.

³⁰See *Pegram* at 215. Petitioners Carle Clinic association, P.C., Health Alliance Medical Plans, Inc., and Carle Health Insurance Management Co., Inc. [collectively referred to as Carle] function as an HMO. See *id.* at 214.

plan which provides both medical and hospital services to its members.³² Prepaid medical services are provided to patients whose employers contract with Carle to provide medical coverage.³³ Ms. Herdrich was covered under Carle through her husband's employer, State Farm Insurance.³⁴ State Farm Insurance provided Carle's health insurance plan as a fringe benefit.³⁵

Carle's owners are physicians.³⁶ Dr. Pegram was a Carle physician.³⁷ Like other HMO systems, Carle collects its payment in advance of the medical care actually being provided.³⁸ Thus, the less medical care that is provided by Carle, the more profit that Carle's physicians, who are the HMO's owners, have left at the end of the period.³⁹

Like any business, Carle looks to hold down its costs.⁴⁰ Carle accomplishes this through devices called "managed care."⁴¹ Carle members must receive their medical care from Carle's own physicians, if at all possible.⁴² Ms. Herdrich contended that this rule was the cause of the eight-day delay for her ultrasound examination, which resulted in her ruptured appendix.⁴³

³¹See *id.* See also discussion *infra* Part III.A.1 (discussing the historical background and function of HMOs).

³²*Herdrich* at 365.

³³*Pegram* at 215.

³⁴*Id.*

³⁵*Herdrich* at 365. Mr. Herdrich's health insurance was through his employer, State Farm. *Id.* ERISA is applicable to most employer-sponsored health plans and does not apply to self-employed persons or to persons whose health care insurance is not provided by their employer. See discussion *infra* Part III.B (discussing ERISA). "[B]ecause her husband's employer . . . provided Carle's plan as a fringe benefit . . . (making it a "welfare benefit plan" under ERISA)." And See *Herdrich* at 683.

³⁶*Pegram* at 215 (explaining that Carle's "[o]wners are physicians providing prepaid medical services to participants whose employers contract with Carle to provide such coverage.").

³⁷See *id.*

³⁸See *Herdrich*, 170 F.3d at 683. See, discussion *infra* Part III.A.1 (defining HMO systems).

³⁹*Id.* See also discussion *infra* Part III.A.3 (describing HMO cost containment techniques).

⁴⁰*Pegram* at 219 (explaining that "[a]t the least, HMOs, like traditional insurers, will in some fashion make coverage determinations, scrutinizing requested services against the contractual provisions to make sure that a request for care falls within the scope of covered circumstances, or that a given treatment falls within the scope of the care promised").

⁴¹*Herdrich* at 683.

⁴²See *id.* See also discussion *infra* Part A.III.3.b (discussing the cost containment technique of panel selection).

⁴³*Herdrich* at 684.

B. United States District Court for the Central District of Illinois

Herdrich filed a complaint in the Circuit Court of McLean County, Illinois, on October 21, 1992, against Dr. Lori Pegram and Carle.⁴⁴ The first two counts of the complaint were based upon a theory of professional medical negligence, alleging that Ms. Herdrich suffered a ruptured appendix and, in turn, contracted peritonitis due to Dr. Pegram's negligence in failing to provide her with timely and adequate medical care.⁴⁵ Herdrich was granted leave to amend her complaint, which she amended to include two counts of state law fraud.⁴⁶ Carle and Pegram responded by stating that ERISA preempted the new counts and removed the case to federal court.⁴⁷ ERISA subjects employee benefit plans to federal regulation.⁴⁸ ERISA preempts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA.⁴⁹

The District Court granted Carle's and Pegram's motions for summary judgment as to the second fraud count.⁵⁰ Summary judgment on this count was granted because Ms. Herdrich relied on an ERISA provision as a basis of monetary relief, as opposed to a basis for equitable relief, and the provision does not provide for extra-contractual damages.⁵¹

However, the District Court did grant Herdrich leave to amend her complaint on the remaining fraud count.⁵² The trial judge concluded ERISA preempted the fraud count because Herdrich's claim was for fraud under state law that involved an employee benefit plan.⁵³ The district court granted Herdrich the opportunity to submit an amended complaint which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision.⁵⁴ Herdrich sought relief under 29 U.S.C. § 1109(a), which provides that:

⁴⁴*Herdrich* at 365.

⁴⁵*Id.* at 365-66.

⁴⁶*Id.* at 366.

⁴⁷*Pegram* at 215. When a state law cause of action is preempted by ERISA, the claim cannot be pursued and must be dismissed and the plaintiff's only remedy is found in the remedy provisions of the ERISA statute. And *see* discussion *infra* Part III.B.1 (discussing the effect of ERISA on managed care).

⁴⁸*Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983) ("[t]he federal Employee Retirement Income Security Act of 1974 . . . subjects to federal regulation plans providing employees with fringe benefits"). In addition, *Shaw* stated that, "ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Id.*

⁴⁹*Id.* at 91.

⁵⁰*Pegram* at 216.

⁵¹*Herdrich* at 366.

⁵²*Pegram* at 216. In Herdrich's amended complaint, "[s]he averred that the defendant's breached their fiduciary duty to plan beneficiaries by depriving them of proper medical care and retaining the savings resulting therefrom for themselves." *Herdrich* at 366.

⁵³*Id.*

⁵⁴*See id.*

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through the use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.⁵⁵

Herdrich amended her complaint by alleging that Carle rewarded its physician owners for limiting medical care and that incentive entailed an “inherent or anticipatory” breach of a fiduciary duty.⁵⁶ Herdrich concentrated on a “year end distribution” to the owners by arguing these “rewards” created an incentive to make decisions in the physician’s self-interest, rather than in the exclusive interest of the patient.⁵⁷ The defendants, Carle and Pegram, then moved to dismiss Herdrich’s amended complaint pursuant to Rule 12 of the Federal Rules of Civil Procedure for failure to state a claim upon which relief could be granted.⁵⁸

By agreement, the case was assigned to a magistrate judge.⁵⁹ The magistrate judge recommended the amended state fraud count be dismissed because in his opinion, “the plaintiff Herdrich failed to identify how any of the defendants is involved as a fiduciary to the Plan.”⁶⁰ However, the magistrate did recommend the court give Herdrich one last opportunity to re-plead her claim under ERISA.⁶¹ Herdrich chose not to replead her claim and stood on the count as amended.⁶² The District Court granted Carle’s motion to dismiss the claim, stating that Carle was not involved in these events as a fiduciary.⁶³

The remaining malpractice claims were tried to a jury.⁶⁴ Herdrich prevailed on both malpractice claims and received \$35,000 in compensation for her injury.⁶⁵

⁵⁵*Pegram* at 217.

⁵⁶*Id.*

⁵⁷*Id.* at 220.

⁵⁸*Herdrich* at 367.

⁵⁹*Id.*

⁶⁰*Id.*

⁶¹*Id.*

⁶²*Id.* In response to the magistrate’s decision to allow her to replead her claim, Herdrich filled a Rule 72 objection to the recommendation. *See Herdrich*, at 367. Less than two weeks later, the District Court denied that objection and adopted the magistrate’s recommendation. *Id.* The court gave Herdrich twenty-one days from the entry of the order to re-plead her claim, which Herdrich chose not to do. *See id.*

⁶³*Pegram* at 217. The District Court accepted the Magistrate Judge’s determination that Carle was not involved in these events as an ERISA fiduciary. *Id.*

⁶⁴*Herdrich* at 367.

⁶⁵*Id.* (stating that, “[t]he remaining counts, I and II, went to trial in early December 1996, and the jury returned a verdict in Herdrich’s favor on both counts, awarding her \$35,000 in compensatory damages.”).

C. Seventh Circuit Court of Appeals

Ms. Herdrich appealed the dismissal of the ERISA claim alleging a breach of fiduciary duty.⁶⁶ Herdrich alleged that she did state a cause of action for breach of a fiduciary duty under ERISA.⁶⁷ The Seventh Circuit found Carle was acting as a fiduciary when its physicians made decisions regarding Herdrich's care and that these allegations were sufficient to state a claim.⁶⁸ In order to properly state a claim for breach of fiduciary duty under ERISA, the plaintiffs complaint must allege facts which set forth three factors: (1) that the defendants are plan fiduciaries; (2) that the defendants breached their fiduciary duties; and (3) that a cognizable loss resulted.⁶⁹ The appellate court was of the opinion that Herdrich's pleadings had sufficiently alleged each of the elements.⁷⁰

1. The Majority Opinion

The majority relied heavily on the fact that Congress, when it enacted ERISA, intended the statutory definition of "fiduciary" to be broadly interpreted.⁷¹ In addition, a fiduciary breaches its duty of care under ERISA whenever it acts to

⁶⁶*Id.*

⁶⁷*Id.*

⁶⁸*Id.* at 373 (holding that "[i]ncentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses)"). However, the Appellate Court also stated that "[o]ur decision does not stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty." *See Herdrich* at 367.

⁶⁹*Id.* at 369. ERISA defines the term "fiduciary" as:

[e]xcept as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such a 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.

29 U.S.C. § 1002(21)(A) (1999).

⁷⁰*Herdrich* at 369.

⁷¹*Id.* at 370.

A fiduciary need not be a person with direct access to the assets of the plan . . . [c]onduct alone may in an appropriate circumstance impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed on him by this statute be deemed to be a fiduciary

Id. (quoting Chairman of the House Committee on Education and Labor, 120 CONG. REC. 3977, 3983 (Feb. 25, 1974) *reprinted in*, 2 LEGISLATIVE HISTORY OF THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974, at 3293.) The Appellate Court also stated "[c]onsistent with the expressed intent of Congress, this court has routinely construed the ERISA term, 'fiduciary,' broadly." *Id.*

benefit its own interests.⁷² It was found that incentives can rise to the level of a breach where the fiduciary trust between plan participants and plan fiduciaries no longer exists.⁷³ Fiduciary trust is broken where physicians delay in providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses.⁷⁴ It was concluded that Herdrich had successfully argued there was a flaw in the structure of the incentive program established by Carle.⁷⁵ This flaw comes from the authority of the physician owners of Carle to simultaneously control the care of their patients and reap the profits generated by the HMO through the use of limited tests and referrals.⁷⁶ “Under the terms of ERISA, Herdrich most certainly has raised the specter that the self-dealing physician/owners in this appeal were not acting ‘solely in the interest of the participants’ of the Plan.”⁷⁷

In summary, the majority held the complaint was sufficient in alleging that Carle’s incentive system depleted plan resources as to benefit physicians, possibly to the detriment of their patients.⁷⁸ The court held the ultimate determination of whether fiduciary obligations were breached must be decided by the trial court and thus remanded the case for further review.⁷⁹

2. The Dissenting Opinion

The dissent relied on what has been termed the “market forces” argument.⁸⁰ The “market forces” argument assumes that companies sponsoring ERISA plans are

⁷²*Id.* at 371 (quoting 29 U.S.C. § 1106(b): “ERISA expressly prohibits fiduciaries from ‘deal[ing] with the assets of the plan in his own interest or for his own account,’ or ‘receiv[ing] any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving assets of the plan’”).

⁷³*Herdrich* at 373.

⁷⁴*Id.*

⁷⁵*Id.*

⁷⁶*Id.* Herdrich’s complaint set forth the intricacies of the defendant’s incentive structure which included:

The Plan dictated the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators’ year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. *Id.*

⁷⁷*Herdrich* at 373.

⁷⁸*Id.* at 380 (concluding that “[o]n the surface, 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”).

⁷⁹*Id.* (“based on the record we have before us, we hold that the plaintiff has alleged sufficiently a breach of the defendants’ fiduciary duty”).

⁸⁰*Id.* at 381 (Cir. J. Flaum, dissenting). *See also id.* at 380.

customers who have chosen which group insurance policies they will use.⁸¹ These employers would like to see their employees claims granted because they want their employees to ultimately be satisfied with the fringe benefits offered by the employer.⁸² These employers have the bargaining power to take their business elsewhere if employee satisfaction with the plan is poor.⁸³ In the long run, the insurer plan would be harmed if employers left and damaged the plan's chances of acquiring new customers based on their reputation of denying claims.⁸⁴ Thus, market forces help to reduce the risk that the fiduciary's potential conflict of interest "will work to the detriment of the plan and the plan beneficiaries."⁸⁵

In addition, the dissent argued that since many plan sponsors and beneficiaries view financial incentives as a desirable way of conserving the plan's assets by encouraging physicians to use resources more efficiently, merely alleging the existence of incentives to limit care is not enough to create a claim of breach of fiduciary duty.⁸⁶ Because the complaint only asserted that the incentives used by Carle were too high, Ms. Herdrich was, inviting the court to make a "determination about the appropriate incentive levels in managed care."⁸⁷ No such standards for this type of review exist and review of this nature would preempt legislative and regulatory efforts in this area.⁸⁸

The dissent did voice support of the full disclosure of financial incentives and noted that it would find a breach of fiduciary duty under ERISA if incentives were not disclosed.⁸⁹ However, there was no allegation of nondisclosure in the *Herdrich* complaint.⁹⁰ "The complaint . . . fails to make any allegations suggesting that the

⁸¹*Herdrich* at 381.

⁸²*Id.* at 382.

⁸³*Id.* at 381-82.

⁸⁴*Id.* See also *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (explaining that "[i]t is . . . a poor business decision to make it a practice of resisting claims for benefits. In the long run, such a practice would dampen loyalties of current employees while hindering attempts to attract new talent") (citation omitted). See also *Mers v. Marriot Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) (stating that "[i]t is a poor business decisions to resist paying meritorious claims for benefits").

⁸⁵*Herdrich* at 381.

⁸⁶*Id.* at 383 ("[T]he goal of a managed care plan is to deliver health care more cost-effectively by eliminating unnecessary or ineffective treatments more efficiently. Some plans, like the one addressed in this case, attempt to achieve these goals by introducing incentives that encourage physicians to internalize part of the costs of treatment"). In addition, the dissent argued that "the desirability of these cost-containment measures from a policy standpoint is not our concern." *Id.* at 382 n.1.

⁸⁷*Id.* at 383.

⁸⁸*Id.* (stating that "[t]he Majority's decision provides little guidance for the district court on remand, and I fear that the decision today could lead, both in this case and in the future, to untethered judicial assessments of permissible incentive levels in health care plans.").

⁸⁹*Herdrich* at 384 ("[i]n order for the market to function in this [market] context . . . sponsors and beneficiaries need information about the financial incentives that are in place").

⁹⁰*Id.*

financial incentives to limit care are anything but the result of the bargain fairly struck between the plan's sponsor, administrator, and beneficiaries."⁹¹ Carle appealed the Seventh Circuit decision and the Supreme Court granted *certiorari*.⁹²

D. United States Supreme Court

The Supreme Court opinion reviews the background, both factually and legally, regarding HMO organizations, medical benefit plans, fiduciary obligations, and the meaning of Ms. Herdrich's allegations.⁹³

In an HMO system, "the physician's financial interests lies in providing less care, not more."⁹⁴ However, the Court argued the check on this influence lies in the professional obligation that the physician must provide covered medical services with a "reasonable degree of skill and judgment" in the patient's best interests.⁹⁵ The inducement to ration care goes to the very heart of any HMO scheme.⁹⁶ The Court conceded that rationing care naturally raises some risks while reducing others, but argued a legal principal attempting to draw a line between good and bad HMOs would in effect be a judgment about socially acceptable medical risk.⁹⁷ The Court concluded this decision would need to be made based on data that the courts do not have access to and therefore should be left to the legislative process.⁹⁸

In the *Herdrich* situation, the Court argued there are two sorts of administrative acts at play: eligibility decisions and treatment decisions.⁹⁹ Both parties conceded these decisions are often impossible to separate from each other.¹⁰⁰ Dr. Pegram's

⁹¹*Id.*

⁹²*Pegram* at 218.

⁹³*Id.* "Whether Carle is a fiduciary when it acts through its physician owners as pleaded in the ERISA count depends on some background of fact and law about HMO organizations, medical benefit plans, fiduciary obligation, and the meaning of Herdrich's allegations."

⁹⁴*Id.* at 218.

⁹⁵*Id.*

⁹⁶*Id.* at 221 (arguing that "no HMO organization could survive without some incentive connecting physician reward with treatment rationing"). The Court also stated that "[t]he essence of an HMO is that salaries and profits are limited by the HMO's fixed membership fees." *Pegram* at 221. See also Orentlicher, *supra* note 8, at 174 (arguing that when a fixed budget is given to a physician, the "physicians will recognize that, every time they order a test or provide a treatment, there will be fewer resources available for other patients who might have a greater need for the resources").

⁹⁷*Pegram* at 221.

⁹⁸*Id.* (indicating that "such complicated fact-finding and such a debatable social judgment are not wisely required of courts unless for some reason resort cannot be had to the legislative process, with its preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health care expenditure").

⁹⁹*Id.* at 228. The court explains that "eligibility decisions turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Id.* On the other hand, "treatment decisions are choices about how to go about diagnosing and treating a patient's condition (*i.e.*, given a patient's constellation of symptoms, what is the appropriate medical response?"). *Id.*

¹⁰⁰*Pegram* at 228.

decision regarding Ms. Herdrich's care was a mixed decision of this sort.¹⁰¹ Dr. Pegram decided Ms. Herdrich's condition did not warrant immediate action and the consequence of that determination was that Carle would not cover the immediate care, whereas it would have done so if Dr. Pegram had made the proper diagnosis and the decision to treat Herdrich immediately.¹⁰² The Supreme Court reasoned that Congress did not intend Carle to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians.¹⁰³ The Court held mixed eligibility decisions by an HMO only have a limited resemblance to the usual business of traditional trustees in the classic fiduciary relationship.¹⁰⁴

The Court also reviewed how the fiduciary standard, if applied, would affect HMOs.¹⁰⁵ Recovery on this type of claim would be warranted "simply upon a showing that the profit incentive to ration care would generally affect mixed [eligibility] decisions" and convert the HMO into a guarantor of recovery, opening the floodgates to claims of this kind.¹⁰⁶ The Court stated:

If Congress wishes to restrict its approval of HMO practice to certain preferred forms, it may choose to do so . . . [b]ut the Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm.¹⁰⁷

The Court believed every claim of fiduciary breach by an HMO physician making mixed decisions would boil down to another malpractice claim.¹⁰⁸ The only advantage the Court found in allowing malpractice actions, as ERISA federal fiduciary breach claims against HMOs, was that patients would be eligible for reimbursement of attorney's fees if they prevailed.¹⁰⁹ Also, the Court feared the physician could possibly be held liable for both a state and federal malpractice claim.¹¹⁰

¹⁰¹*Id.*

¹⁰²*Id.*

¹⁰³*Id.* at 231 (holding that "[b]ased on our understanding of the matters just discussed, we think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians.").

¹⁰⁴*Id.* at 232 (arguing that "[p]rivate trustees do not make treatment judgments, whereas treatment judgments are what physicians reaching mixed decisions do make, by definition.").

¹⁰⁵*Pegram* at 232.

¹⁰⁶*Id.*

¹⁰⁷*Id.* at 233-34.

¹⁰⁸*Id.* at 235.

¹⁰⁹*Id.* at 236 ("we can be fairly sure that Congress did not create fiduciary obligations out of concern that state plaintiffs were not suing often enough, or were paying too much in legal fees.").

¹¹⁰*Pegram* at 236 (arguing that "not only would an HMO be liable as a fiduciary in the first instance for its own breach of fiduciary duty committed through the acts of its physician

The Court, in a unanimous decision, reversed the Seventh Circuit decision holding “mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA” and thus Herdrich’s ERISA count failed to state a claim.¹¹¹

III. BACKGROUND

A. *The Health Management Organization*

1. Historical Background and Function of HMOs

Traditional medical care in the United States has been provided on a “fee-for-service” basis in which the physician charges a certain amount for each procedure performed (*i.e.* general physical exam, vaccination, tonsillectomy).¹¹² Physicians were faced with very few constraints and practiced more or less how they wanted.¹¹³ Insurance companies simply paid the bills submitted to them from the physicians with little review.¹¹⁴ Most insurers even let the physicians determine both the rates and terms of reimbursement.¹¹⁵ In this type of system, a physician’s financial incentive is to provide more care, not less.¹¹⁶

In addition to the use of the “fee-for-service” system, non-economic factors have caused the cost of health care to continually rise. Physicians have a desire to please patients and to convince them that they are receiving high-quality health care, thus they order more tests and procedures.¹¹⁷ Also, our medical care system functions in

employee, but the physician employee would also be subject to liability on the same basic analysis that would charge the HMO.”).

¹¹¹*Id.* at 237.

¹¹²*Id.* at 218 (explaining that “the physician bills the patient for services provided or, if there is insurance and the doctor is willing, submits the bill for the patient’s care to the insurer, for payment subject to the terms of the insurance.”).

¹¹³ROSENBLATT, *supra* note 4, at 543 (citing Jonathan Weiner & Gregory de Lissoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL., POL’Y, & L. 75, 76-78 (1993) (explaining that “[i]nsurance companies usually served as passive go-betweens: the intermediary between the employer and provider.”).

¹¹⁴*Id.* (explaining that “[w]ith little scrutiny they paid bills submitted to them on a fee-for-service (FFS), retrospective basis.”).

¹¹⁵*Id.* (further explaining “[l]ike other indemnity-orientated policies, underwriting losses experiences by the carrier were ultimately passed to the purchaser in the form of increased premiums.”).

¹¹⁶HEALTH INS. ASS’N OF AM., *MANAGED CARE: INTEGRATING THE DELIVERY AND FINANCING OF HEALTH CARE, PART A 3* (1996). “Physicians play a key role in determining what medical resources are used.” *Supra*. “Once an individual decides to seek care, physicians either strongly influence, or directly make, most of the decisions that determine the cost of care.” *Id.* “Unfortunately, most physicians have had neither the knowledge or the incentive to be concerned about cost.” *Id.*

¹¹⁷*Id.* at 4.

an environment of constantly changing technology, which may push a physician to do more than just provide only necessary and effective care.¹¹⁸

The threat of malpractice suits against physicians also adds to the increased cost of health care. The physician community's fear of adverse malpractice judgements caused physicians to practice "defensive medicine."¹¹⁹ "Defensive medicine" involves the utilization of unnecessary medical tests in order to limit the physician's potential liability for malpractice, but in the long run it caused skyrocketing health care costs.¹²⁰ These rising costs made managed care a necessity.¹²¹

Managed care has been around since the 1930s when the first prepaid medical group practices were established.¹²² The group practices would become the forerunners to modern HMOs.¹²³ These group practices were established as a way to improve access to quality health care and as a vehicle to provide basic medical services.¹²⁴ Since the 1930s, there has been an explosion of HMOs, largely due in response to the ever-rising cost of healthcare.¹²⁵ By 1995, more than 140 million privately insured Americans, or seventy-eight percent, were members of some kind of managed care plan.¹²⁶

¹¹⁸See HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 3-4. In addition, new technologies can use more resources than they replace. *Id.* at 5. Some new technologies are beneficial in improving patient welfare, however, others contribute little to improved health status. *Id.* "The proliferation of new technologies reflect Americans' general tendency to place excessive reliance on technology and medical intervention to manage health care problems." *Id.*

¹¹⁹Corrine P. Parver & Kimberly Alyson Martinez, *Holding Decision Makers Liable: Assessing Liability Under A Managed Health Care System*, 51 ADMIN. L. REV. 199, 202 (1999).

¹²⁰*Id.* at 202. "In addition, the cost of litigating and settling those disputes that go to court adds to malpractice premium costs, which are ultimately translated into higher provider fees." HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 6. Also, states that have not placed limits on malpractice award for punitive damages contribute to the rising costs of health care. *Id.*

¹²¹See Parver, *supra* note 119, at 202.

¹²²See HEALTH INS. ASS'N OF AM., PART B, *supra* note 5, at 2. Kaiser Foundation offered its first health care plans in the 1930s. See, Parver, *supra* note 119, at 203.

¹²³See HEALTH INS. ASS'N OF AM., PART B, *supra* note 5, at 2.

¹²⁴*Id.*

¹²⁵*Id.* at 2. In addition, a rapid expansion of HMOs occurred when Congress passed the Health Maintenance Organization Act [hereinafter HMO Act] in 1973. See Parver, *supra* note 119, at 204. This legislation created industry growth by providing federal grants and loans to HMOs qualifying under the act. *Id.* The HMO Act originally defined an HMO as "a public or private entity that provides basis and supplemental health services to its enrollees, without limiting the time or cost of those services." HEALTH INS. ASS'N OF AM., PART B, *supra* note 5, at 166. The statute was amended in 1988 to permit HMOs to provide at least ten percent of their health services through out-of-network physicians and charge reasonable deductibles for those out-of-network services. *Id.* at 167.

¹²⁶See ROSENBLATT, *supra* note 4, at 544. Managed care not only affects privately insured persons. *Id.* "By 1996 one-third of the nation's nearly 36 million Medicaid beneficiaries were enrolled in some form of managed care." *Id.* In addition, nine percent of the Medicare

There can be significant variations among the different types of modern HMOs.¹²⁷ However, four main characteristics are found in all HMO systems.¹²⁸ First, HMOs establish arrangements with selected providers to furnish a comprehensive set of health care services to enrollees.¹²⁹ Second, HMOs create and utilize explicit standards for the selection of their health care providers.¹³⁰ Third, all HMOs implement formal programs for ongoing quality assurance and utilization review programs.¹³¹ Finally, most HMOs utilize financial incentives to enrollees to encourage the use of providers and procedures covered by the HMO.¹³²

“Experts in managed care note that there is no universally accepted managed care terminology.”¹³³ Despite its many forms, HMOs can be defined as:

Any health coverage arrangement in which, for a pre-set fee . . . a company sells a defined package of benefits to a purchaser, with services furnished to enrolled members through a network of participating providers who operate under written contractual or employment agreements, and whose selection and authority to furnish covered benefits is controlled by the managed care company.¹³⁴

Regardless of the type of HMO, all managed care plans combine traditional notions of insurance with medical care itself, selling care from physicians who are members of the HMO network to purchasers for a pre-negotiated fee.¹³⁵ The HMO assumes the financial risk of providing the benefits promised in the contract and keeps the money paid regardless of the usage of health benefits by the participant.¹³⁶ For example, if the participant becomes expensively ill, the HMO is responsible for

population, which is over three million beneficiaries, were members of Medicare managed care plans. *Id.*

¹²⁷See HEALTH INS. ASS’N OF AM., PART B, *supra* note 5, at 2.

¹²⁸*Id.*

¹²⁹*Id.* See also discussion *infra* Part III.A.3.b (discussing the cost-containment technique of panel selection in which the HMO manages care by encouraging, and sometime requiring, its members to use only certain facilities or physicians).

¹³⁰See HEALTH INS. ASS’N OF AM., B, *supra* note 5, at 2.

¹³¹*Id.* See also discussion *infra* Part III.A.3.a (discussing utilization review programs in the HMO setting).

¹³²See HEALTH INS. ASS’N OF AM., B, *supra* note 5, at 2. See also discussion *infra* Part III.A.3.c (discussing HMO financial incentive programs).

¹³³ROSENBLATT, *supra* note 4, at 551 (quoting Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance since 1980: A Literature Analysis*, 271 JAMA 1512 (1994) (quotations omitted)).

¹³⁴*Id.* at 551-52. “What usually distinguishes the managed care plans from those that are more traditional is that there is a party that takes responsibility for integrating and coordinating the financing and delivery of services across what previously were fragmented provider and payer entities.” *Id.* at 545 (quoting Weiner, *supra* note 113, at 77).

¹³⁵*Id.* at 552.

¹³⁶*Pegram* at 216.

the treatment agreed upon even if its cost exceeds the participant's premiums.¹³⁷ Physicians are required to administer any "medically necessary care" that is required under the contract.¹³⁸ Unlike the "fee-for-service" program, physicians are given an incentive not to provide unnecessary medical care.¹³⁹ HMOs enable employers who offer health care benefits and their employees an opportunity to save money.¹⁴⁰ In 1999, approximately sixty million people in the United States were enrolled in HMO programs.¹⁴¹

2. Types of HMOs

There are several models of HMOs.¹⁴² HMO models are defined by the organizational structure of the participating physicians and the relationship between the HMO and the contracting physicians or physician organizations.¹⁴³ The three main types of HMOs are: the staff model, the independent practice association model (IPA), and the group model.¹⁴⁴

a. The Staff Model

The staff model is comprised of physicians who are employed by and are paid a salary by the HMO.¹⁴⁵ "Frequently, the employed physicians provide services exclusively to the enrollees of a specific plan."¹⁴⁶ Staff model arrangements provide a high degree of control over both the cost and delivery of medical services.¹⁴⁷

¹³⁷*Id.*

¹³⁸See Christine E. Brasel, Comment, *Managed Care Liability: State Legislation May Arm Angry Members Legal Ammo To Fire At Their MCOs For Cost Containment Tactics . . . But Could It Backfire?*, 27 CAP. U. L. REV. 449, 451 (1999). The definition of the term "medical necessity" has been a topic of debate in the courts. See ROSENBLATT, *supra* note 4, at 213 (citing *Dallis v. Aetna Life Ins. Co.*, 574 F. Supp 547, 550 (N.D. Ga. 1983)) (stating, "[n]o insurance is afforded . . . as to charges . . . for care, treatment, services or supplies which are not necessary for the treatment of the injury or illness concerned"). See also *Siegal v. Health Care Serv. Corp.*, 401 N.E.2d 1037 (Ill. App. Ct. 1980) (stating "where there is no ambiguity that contract limits coverage to medically necessary services, 'medically necessary' is an issue of fact to be decided by the jury.").

¹³⁹See Brasel, *supra* note 138, at 451.

¹⁴⁰*Id.*

¹⁴¹*Id.*

¹⁴²See HEALTH INS. ASS'N OF AM., PART B, *supra* note 5, at 44.

¹⁴³*Id.*

¹⁴⁴Brasel, *supra* note 138, at 451. Not all HMOs fit neatly into one of the above listed categories. *Id.* at 452. In addition there is a PPO in which physicians, hospitals, and other health care providers join together to provide services to members who generally pay a premium to the PPO which reimburses the health care providers for services rendered. *Id.*

¹⁴⁵*Id.* at 451.

¹⁴⁶See HEALTH INS. ASS'N OF AM., PART B, *supra* note 5, at 44.

¹⁴⁷*Id.* (arguing that the Staff Model "may be desirable and/or necessary where the local provider community is unwilling or has limited capacity to enter into HMO contracts or serve the plan's enrollment.").

Developing and operating health care facilities and employing health care professions requires a significant amount of capital and capabilities beyond those of most insurers.¹⁴⁸ Thus, developing a staff model HMO is only appropriate in situations in which there is an insufficient supply of independent physicians in the community willing to participate in the HMO and the HMO has sufficient capital.¹⁴⁹

b. The IPA Model

In contrast, the IPA model is composed of a group of physicians that contract with an HMO to provide services to the HMO's contract members.¹⁵⁰ However, IPA physicians also treat individuals who are not members of HMOs.¹⁵¹ The physicians in an IPA model are paid a fee based on the services that are rendered or through capitation.¹⁵² Capitation is a method by which physicians are paid a fixed amount per patient and receive the same amount irrespective of the quantity of services that are provided to the HMO contract member.¹⁵³

The IPA model has at least one principal disadvantage. When the IPA model is compared to the staff model, it is more difficult to control costs and affect the practice patterns of independent physicians.¹⁵⁴ Control is especially difficult when only a small portion of the physician's practice is under the HMO.¹⁵⁵

However, IPAs are the fastest growing type of HMO.¹⁵⁶ This growth can be attributed to the limited liability assumed in the IPA setting.¹⁵⁷ The HMO's liability is most limited in this model due to the several layers of separation between the HMO and the physician.¹⁵⁸ "Control in terms of an agency relationship is more difficult to establish here."¹⁵⁹ When a patient goes to the doctor's office instead of the HMO office, proving reliance on the doctor as an HMO employee rather than an independent contractor is more troublesome.¹⁶⁰

¹⁴⁸*Id.* at 45.

¹⁴⁹*Id.* Other important factors include: (a) the HMO has a high market penetration; (b) there is access to sufficient capital; and, (c) there exists extensive familiarity with operating health care facilities and managing health professionals. *See id.* at 45.

¹⁵⁰*See*, Brasel, *supra* note 138, at 451. IPA is the term used to describe the Independent Practice Association Model. *See* Parver, *supra* note 119, at 204.

¹⁵¹*Id.* at 452. IPA doctors work in their own offices, employ their own staffs and keep their own records. *See* Parver, *supra* note 119, at 204.

¹⁵²*See* Brasel, *supra* note 138, at 452.

¹⁵³*Id.*

¹⁵⁴*See* HEALTH INS. ASS'N OF AM., PART B, *supra* note 5, at 47.

¹⁵⁵*Id.*

¹⁵⁶*See* Parver, *supra* note 119, at 205.

¹⁵⁷*Id.*

¹⁵⁸*Id.*

¹⁵⁹*Id.*

¹⁶⁰*Id.* at 205.

c. The Group Model

Finally, the group model is generally described as a contract between an employer and a medical group affiliated with the HMO to render medical services to its employees.¹⁶¹ In the group model, fees are paid to the medical group on a "capitation basis."¹⁶² The HMO pays a physician group a negotiated, per capita rate, which the medical group distributes among the individual physicians in a variety of ways.¹⁶³

The above described types of HMOs have different levels of legal liability. Overall, the legal liability of an HMO for the health care that it manages for its members depends on the amount and level of control exerted by the managed care organization over physicians.¹⁶⁴ The liability is the greatest in the staff model and lower in the IPA and Group models.¹⁶⁵ In IPA and Group models there are more layers of separation between the physicians and the HMO thus the control exerted by the HMO over the physician is lower.¹⁶⁶ In the staff-model the HMO directly employs the doctors which sets up an employer-employee relationship. Thus, the legal liability of the HMO is lighter in this model.¹⁶⁷

3. Controlling Costs and Cost Containment

Health care reform in the 1980s and 1990s has focused on cost containment.¹⁶⁸ As with other risk-bearing organizations, HMOs take steps to control costs.¹⁶⁹ There are three main types of cost containment methods utilized by HMOs: Utilization Review; Panel Selection; and Direct Physician Financial Incentives. All three methods are discussed in more detail below.

a. Utilization Review

Utilization review has been defined as "a comprehensive evaluation of the efficiency, appropriateness, and medical necessity of healthcare."¹⁷⁰ These programs

¹⁶¹See Brasel, *supra* note 138, at 452.

¹⁶²*Id.* See also discussion *infra* Part III.A.3.C.2 (discussing physician capitation reimbursement which is normally a fixed member per month payment or a percentage of the premium payment for the contracted services).

¹⁶³HEALTH INS. ASS'N OF AM., PART B, *supra* note 5, at 3. See also discussion *infra* Part III.A.3.C.2 (discussing physician capitation reimbursement programs).

¹⁶⁴Parver, *supra* note 119, at 204.

¹⁶⁵*Id.*

¹⁶⁶*Id.*

¹⁶⁷*Id.*

¹⁶⁸Parver, *supra* note 119, at 202 (arguing that "Corporate America has recognized that rapidly increasing health care costs decrease competitiveness in the new global market."). In addition, health care costs consume an increasingly large share of state and federal and federal budgets, thus limiting other policy objectives. *Id.*

¹⁶⁹Pegram at 216.

¹⁷⁰J. Scott Andresen, *Is Utilization Review The Practice of Medicine?*, 19 J. LEGAL MED. 431, 433 (1998).

are designed to reduce unnecessary medical services.¹⁷¹ Utilization review is not a new concept; health insurers have always reviewed medical claims on the basis of medical necessity.¹⁷²

There are two main types of utilization review; retrospective and prospective.¹⁷³ In general, a retrospective utilization review occurs after the medical treatment has already been given and a prospective review occurs before the treatment has been conducted.¹⁷⁴ Traditionally, utilization review has been conducted on a retrospective basis and the patient was assured treatment regardless of whether the claim was eventually paid or denied by the HMO.¹⁷⁵

In contrast, prospective review does not carry the same assurances of medical treatment as retrospective review.¹⁷⁶ With prospective review, treatment is often denied until the questions of payment are settled.¹⁷⁷ Prospective review commonly is required for facility admissions, expensive diagnostic testing, surgical procedures, and referrals to physicians or facilities outside the particular HMO.¹⁷⁸ Thus, through prospective utilization review the HMO is playing an active role in determining both the course and scope of the patient's medical treatment.¹⁷⁹

b. Panel Selection

In a panel selection and de-selection system, the HMO manages the care indirectly by encouraging, and in many cases requiring, its members to use only certain physicians or facilities.¹⁸⁰ Physicians and facilities are often jointly termed

¹⁷¹See HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 239. "The purpose of utilization review is to assure that only procedures deemed medically necessary and appropriate to the patient's needs are reimbursed." Andresen, *supra* note 170, at 432.

¹⁷²*Id.* at 434. Medical Necessity is a term used by "insurers to describe medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice." See HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 232. *But see supra* note 138 (discussing the lack of agreement in the courts regarding the definition of medical necessity).

¹⁷³See Parver, *supra* note 119, at 205. In addition, prospective review can be further divided into pre-admission and concurrent review. *Id.* See also Andresen, *supra* note 170, at 434 (describing concurrent utilization review in greater detail).

¹⁷⁴Parver, *supra* note 119, at 205.

¹⁷⁵See Andresen, *supra* note 170, at 434.

¹⁷⁶Parver, *supra* note 119, at 205.

¹⁷⁷*Id.*

¹⁷⁸See Andresen, *supra* note 170, at 435.

¹⁷⁹*Id.* (explaining that "review agents . . . apply the patient's characteristics to the preestablished UR [Utilization Review] criteria for the particular diagnosis or treatment at issue . . . [and] if the criteria are not met . . . the case is forwarded to the UR administrator for a final determination"). As a result of this process, "utilization review places an MCO, or its UR director, in a position where they may be substituting their judgement for that of the attending physician directly providing the care." *Id.*

¹⁸⁰Henry T. Greeley, *Direct Financial Incentives In Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53, 56 (1996).

providers.¹⁸¹ The HMO selects the providers that are to be a part of their plan based on several criteria.¹⁸² Most important among the criteria is the cost to the HMO.¹⁸³ The providers selected by the HMO are encouraged to be economical in their practice style.¹⁸⁴ The providers are aware that if they choose not to meet the HMO's standards for both cost and practice style they will no longer be a part of that particular HMO panel and thus de-selected.¹⁸⁵ This situation creates an "indirect" financial incentive for the providers because de-selection causes the provider to lose HMO patients and in the end reduces their overall income.¹⁸⁶

c. Direct Physician Financial Incentives

Direct financial incentives were also found in the old "fee for service" system where the more the physician did, the more the physician was paid.¹⁸⁷ However, the financial incentives in a managed care plan are different.¹⁸⁸ In the HMO system the incentives are aimed at discouraging the physician from performing unnecessary treatment.¹⁸⁹ The HMO system focuses on providing the "right" amount of care rather than performing unnecessary preemptive medicine.¹⁹⁰ The Omnibus Budget Reconciliation Act of 1990 loosely defined a physician incentive plan as "any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of limiting services provided with respect to individuals enrolled with the organization."¹⁹¹ Four general approaches are usually utilized: salary, capitation, bonus and profit sharing.¹⁹²

¹⁸¹*Id.*

¹⁸²*Id.*

¹⁸³*Id.* (explaining that "these costs encompass both the amount of the fees charged by the provider, often heavily discounted, and the cost of that provider's style of practice.").

¹⁸⁴*See* Greely, *supra* note 180, at 56. In addition, panel selection programs may reduce costs by limiting the number of providers in the plan's network. *See* ROSENBLATT, *supra* note 4, at 559.

¹⁸⁵*Id.* (arguing that "the providers are encouraged to be economical not by direct micro-management, but by knowing that they will no longer be on the panel should they fail to meet the plan's standards for the cost of practice style.").

¹⁸⁶*Id.* *See also* ROSENBLATT, *supra* note 4, at 559 ("[t]he threat of network exclusion represents a potentially powerful tool for ensuring compliance with coverage and utilization review standards and guidelines.").

¹⁸⁷*See* Greely, *supra* note 180, at 56.

¹⁸⁸*Id.*

¹⁸⁹*Id.* *See also* discussion *infra* III.A.3.a (discussing the utilization review process and how that process discourages the performance of unnecessary treatment).

¹⁹⁰Greely, *supra* note 180, at 56.

¹⁹¹*Id.* (quoting The Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, S 4204(a)(1)(B), Stat. 1388-108 (1990) *amending*, 42 U.S.C. § 1395 mm(I)).

¹⁹²*Id.* at 57.

i. Salary

In a salaried situation, the physician's income is set annually by the HMO through the issuance of a salary.¹⁹³ The physician does not have the "fee-for-service" incentive to do more for the patients in order to make more money.¹⁹⁴ The physician in a salary situation understands that his salary can be raised, lowered, or that he may even be terminated if the HMO does not agree with his practice patterns.¹⁹⁵

ii. Capitation

In a capitation situation, the physician is generally paid a set amount monthly for each of the individual HMO patients for whom he is responsible.¹⁹⁶ To determine the appropriate amount of payment, the services provided by the physician must be carefully defined in order to estimate the total cost for the care.¹⁹⁷ This determination may include adjustments for the age and gender of the physician's patients.¹⁹⁸ For example, the physician may be paid twenty-five dollars per-member, per-month, which is also referred to as PMPM.¹⁹⁹ In addition, many HMOs make a portion of the capitation payment dependent on the number and length of hospital admissions.²⁰⁰ For example, if the PMPM is twenty-five dollars, five dollars per month is set aside and paid to the physician only if certain utilization targets are met.²⁰¹

The main point is that the physician is paid the same amount of money each month for each HMO patient regardless of the number of visits or the cost of the services that are provided.²⁰² "In its purest form, if the doctor spends less than the capitated amount, she makes a profit on that patient; if she spends more, she takes a loss."²⁰³

¹⁹³*Id.* Staff Model HMOs usually pay physicians on a salaried basis. See HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 56. See also discussion *infra* Part III.A.2.a (discussing Staff Model HMOs).

¹⁹⁴See Greely, *supra* note 180, at 57. See also *infra* notes 112-15 (discussing the fee-for-service payment system).

¹⁹⁵See Greely, *supra* note 180, at 57. Due to the fact that the performance of the physician in a Staff Model HMO "has a direct bearing on the financial health of the 'HMO,' their performance is the target of incentives and risk agreements." See HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 56.

¹⁹⁶See Greely, *supra* note 180, at 57.

¹⁹⁷See HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 56.

¹⁹⁸*Id.*

¹⁹⁹*Id.*

²⁰⁰*Id.*

²⁰¹*Id.* at 57.

²⁰²HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 56.

²⁰³Greely, *supra* note 180, at 57.

Overall, there is one important difference between salary and capitation as far as the physician's personal incentives.²⁰⁴ In the capitation situation, physicians have an incentive to increase the number of patients for whom they have responsibility and in the salary situation; physicians have an incentive to reduce the number of patients for whom they have responsibility.²⁰⁵ In principal, capitation and salary are interchangeable since they both result in physicians being paid a fixed amount of compensation no matter how many or how few services they provide.²⁰⁶

iii. Bonus

In the bonus situation, the physicians may be paid during a fixed period under any system but at the end of the period they receive a bonus.²⁰⁷ The bonus is based on the HMO's financial results in that year and the individual physician's contribution to them.²⁰⁸ The method under which the bonus is determined can differ.²⁰⁹ Many times bonus arrangements are used to control the use of ancillary services.²¹⁰ Ancillary services are defined as health care services that are conducted by providers other than a primary care physician.²¹¹ Examples of ancillary services are laboratory tests and radiology screenings.²¹² HMOs may set aside a separate pool of funds to pay for ancillary services.²¹³ If at the end of the year there are funds still left in the pool, the funds are distributed to the physicians as a bonus.²¹⁴ Thus, the

²⁰⁴See Orentlicher, *supra* note 8, at 159. However, "even with their [capitation's] built-in incentive to limit care, pure salary and capitation may not provide sufficient incentive for physicians to limit the costs of care provided to their patients." *Id.* at 159-60 (arguing that physicians rely on different medical services to provide care to their patients and that capitation may just cause the physician to "alter the mix of services" provided to their patients, causing costs overall to actually rise.).

²⁰⁵*Id.* at 159.

²⁰⁶*Id.*

²⁰⁷See Greely, *supra* note 180, at 59.

²⁰⁸*Id.*

²⁰⁹*Id.*

²¹⁰*Id.* Fee-withholds and expanded capitation are also used to restrain physicians from overusing ancillary services. See Orentlicher, *supra* note 8, at 160.

²¹¹See HEALTH INS. ASS'N OF AM., PART B, *supra* note 5, at 201 (defining "ancillary services."). A primary care physician [hereinafter "PCP"] can be defined as the primary deliverer and manager of an HMO member's care and is central to controlling costs and utilization. *Id.* at 210. The PCP provides basic care to the member including the basic care of the member and any follow up care that may be needed. *Id.* Usually PCPs are physicians practicing in such areas as internal medicine, family practice, and pediatrics. *Id.* at 211.

²¹²*Id.* at 89.

²¹³See Orentlicher, *supra* note 8, at 160.

²¹⁴*Id.*

physicians recognize that they can increase the amount of their compensation if they reduce the use of ancillary services.²¹⁵

iv. Profit Sharing

Under the profit sharing method physicians receive a negotiated share of the HMO's profits.²¹⁶ The physicians may receive this share as owners of the plan or through a contractual agreement.²¹⁷ This method is sometimes used to determine the bonus payment as described above.²¹⁸ Individual profit-sharing plans may differ greatly.²¹⁹

All of these methods can be used and many of them can be combined.²²⁰ For example, a salary system will usually have some kind of bonus that may include some profit sharing.²²¹ A bonus may be determined as a result of a comparison to expected capitation results and a capitation system itself may include a bonus.²²² "The number of possible systems of direct financial incentives is virtually unlimited."²²³

d. The Use of Direct Financial Incentives By HMOs

Due to the various combinations of financial incentives that may be used by HMOs, it is difficult to ascertain the number of HMOs using a certain incentive system and, furthermore, the number of patients receiving care under each financial arrangement.²²⁴ However, we do know that financial incentives are greatly used.²²⁵ In 1995, a report based on California HMOs found that financial incentives were commonly used by HMOs.²²⁶ The report stated that a 1987 survey indicated that eighty-five percent of California HMOs used financial incentives and a 1988 study

²¹⁵*Id.* (indicating that bonus-type "[f]inancial incentives to limit care discourage physicians from providing high levels of care by transferring from the health plan to the physician some of the financial risk of costly medical care.").

²¹⁶*See* Greely, *supra* note 180, at 59.

²¹⁷*Id.*

²¹⁸*Id.*

²¹⁹*Id.*

²²⁰*Id.*

²²¹*Greely, supra* note 180, at 59.

²²²*Id.*

²²³*Id.*

²²⁴*Id.* (stating that "our next problem is to determine how often each [reimbursement] method is actually being used.").

²²⁵*Id.* at 60.

²²⁶*See* Greely, *supra* note 180, at 60 (discussing a report found in HEALTH EDUC. & HUMAN SERV. DIV., U.S. GEN. ACCT. OFFICE, MEDICAID MANAGED CARE: MORE COMPETITION AND OVERSIGHT WOULD IMPROVE CALIFORNIA'S EXPANSION PLAN (1995) (GAO Report)). The report noted, "there are no reliable current data regarding the extent to which HMOs use financial incentive arrangements or the prevalence of the different types of arrangements." *Id.*

showed that ninety-five percent of HMOs used them.²²⁷ The California report concluded “it has become increasingly common for HMOs to capitate physicians . . . for all medical services including inpatient care.”²²⁸

Information on a national level has not proved to be any more helpful.²²⁹ We do know that some forms of compensation are more popular than others in certain HMO settings. For example, staff models prefer salary systems, IPA models do not.²³⁰ Profit sharing models are not popular while capitation systems are popular.²³¹

e. Cases Discussing the Use of Financial Incentives

Legal involvement regarding the question of whether an HMO can be held liable for medical malpractice because of financial incentives or financial risk imposed on physicians, is in its infancy.²³² Currently, there are few published court opinions discussing the subject; however, legal involvement in this area is likely to grow significantly.²³³

An unpublished Michigan trial court opinion allowed a jury to evaluate how the physician financial incentives operated in a particular case.²³⁴ In *Bush v. Dake*²³⁵ the

²²⁷*Id.*

²²⁸*Id.*

²²⁹*Id.*

²³⁰*See* Greeley, *supra* note 180, at 61. In addition, it is difficult to calculate how many patients are covered by what kinds of direct financial incentive systems. *See Id.* “Even when a plan uses the same general approach in compensating physicians, its arrangements with different groups may include different provisions, leading to different incentives.” *Id.* Thus, we cannot just find out what methods different HMOs use and then add up the number of their members. *See Id.* at 61-62. “To determine how many patients are covered by each type of direct financial incentive system, we would have to ask HMOs what systems they use to pay which physicians, and then ask how many of their members use each set of differently compensated physicians.” *Id.* at 62.

²³¹Greely, *supra* note 180, at 61.

²³²*See* ROSENBLATT, *supra* note 4, at 1069.

²³³*Id.* *See* Pulvers v. Kaiser Found. Health Plan, 99 Cal. App. 3d 560 (1979) (regarding one of the few published court opinions discussing physician financial incentive programs). This case involved a suit against HMO alleging negligent delay of a biopsy as the cause of patient’s death. *Id.* at 564. The plaintiff’s third cause of action rested on the theory that the health plan utilized a system whereby the individual doctors were encouraged, by an incentive plan, to be conservative in ordering unnecessary tests and treatments. *Id.* at 565. The plaintiff argued that he was fraudulently led to believe that he would receive the “best quality” of care and treatment. *Id.* The court dismissed claim of HMO fraudulent concealment of physician financial incentives on the grounds that such incentives were recommended by professional organizations and “required” by the HMO Act of 1973, 42 U.S.C. § 300e. *Id.* (holding that “we can see in the plan no suggestion that individual doctors act negligently or that they refrain from recommending whatever diagnostic procedures or treatments the accepted standards of their profession require.”).

²³⁴ROSENBLATT, *supra* note 4, at 1069-71. The Rosenblatt case book has printed the unpublished 1989 Saginaw County, Michigan trial court opinion. *Id.* The case is *Bush v. Dake*, No. 86-25767NM-2 (Mich. Cir. Ct. 1989) (unreported). All facts stated are taken from the version printed in the case book.

plaintiffs alleged that their HMO's system of financial incentives was contrary to public policy and the use of this system constituted negligence, gross negligence, fraud, a breach of trust, and a tortious breach of the relationship between the plaintiff patient and her doctors.²³⁶ The case arose out of the alleged failure by the HMO physician to timely diagnose and treat the plaintiff's cervical cancer.²³⁷ The HMO in this case set aside a certain amount of money each year for a "referral pool" and a "hospital/ancillary pool" for the HMO physicians.²³⁸ A referral is the transfer of a patient from their primary doctor to a specialty physician for special care or diagnostic testing.²³⁹ As patients are referred to specialists, money in these funds is depleted.²⁴⁰ Any money that is left in these pools at the end of the year is divided amongst the HMO and its physicians.²⁴¹

The plaintiffs contended it was this incentive agreement that led in part to the late diagnosis of her cervical cancer.²⁴² The plaintiff had requested a referral from her primary physician in order to see a specialist in obstetrics and gynecology regarding vaginal bleeding.²⁴³ The plaintiff was given a referral to see the specialist; however, when she requested an additional referral due to her persistent condition, she was not allowed one.²⁴⁴ It turned out that a simple diagnostic test, a pap smear, would have revealed the cancer at an earlier stage.²⁴⁵ Pap smears can be done by the primary physician but the primary physician is not paid anything in addition to the existing capitation payment for performing the test.²⁴⁶

The court dismissed the plaintiff's allegation that the incentive programs were contrary to public policy; however, the court found that there was a genuine issue of material fact as to whether the HMO's incentive system in and of itself proximately contributed to the malpractice in the case.²⁴⁷ The court stated "[d]ocumentary

²³⁵ROSENBLATT, *supra* note 4, at 1069-71.

²³⁶See ROSENBLATT, *supra* note 4, at 1069.

²³⁷*Id.* at 1070.

²³⁸*Id.*

²³⁹See HEALTH INS. ASS'N OF AM., PART A, *supra* note 116, at 237 (defining "referral").

²⁴⁰See ROSENBLATT, *supra* note 4, at 1070.

²⁴¹*Id.*

²⁴²*Id.* Plaintiffs contended that "the system in question is wrongful, in that it provides the physicians involved with financial disincentives to properly treat, refer, and hospitalize patients." *Id.* at 1070-71. The plaintiffs further contended that the court should find "a) that the system violates public policy and b) that there is a jury question presented as to whether the system itself contributed to the malpractice in this case." *Id.* at 1071.

²⁴³See ROSENBLATT, *supra* note 4, at 1070.

²⁴⁴*Id.*

²⁴⁵*Id.* A Pap test is an examination under a microscope of cells collected from the cervix that are placed on a slide and specially stained to reveal cancerous and non-cancerous changes in the cells. MEDICINET.COM MEDICAL DICTIONARY, *supra* note 21. Cervical and uterine cancer can be detected in their early stages with this test. *See id.*

²⁴⁶See ROSENBLATT, *supra* note 4, at 1070.

²⁴⁷*Id.* at 1071.

evidence has been presented which supports the plaintiffs' theory that the manner in which the system operated in this case contributed to the improper treatment and delay in diagnosis of Mrs. Bush's cancerous condition."²⁴⁸

In addition, cases have alleged that HMO financial arrangements create personal financial interests for the physician, which are against the patient's best interests. A noteworthy case, *Fox v. Health Net*,²⁴⁹ concerned the denial by an HMO of an experimental treatment for metastatic breast cancer, which resulted in a jury verdict of eighty-nine million dollars against a California HMO.²⁵⁰ The case included charges that the personal, financial interests of the physician medical director making the decision on the procedure, affected the result.²⁵¹

A third case involved a cancer patient who died in her early thirties of colon cancer.²⁵² The complaint alleged that the cancer should have been diagnosed at an earlier and more treatable stage, but that the capitation agreement created by the patient's physicians made them reluctant to spend the money needed for the relevant tests.²⁵³ The suit did not include the health plan but instead added a cause of action for breach of fiduciary duty, arguing that the managed care contract created an impermissible conflict between the interests of the patient and the physician.²⁵⁴ Before the case went to the jury, the judge granted a directed verdict on this cause of action, removing it from the jury.²⁵⁵ However, the testimony was not forgotten by the jury as they returned a verdict of \$3 million on the remaining malpractice charges.²⁵⁶

Although the previous cases are unpublished decisions, they are proof of the existence of claims based on breaches of fiduciary duty premised on financial

²⁴⁸*Id.* (holding that the question should be submitted to the jury for determination at trial).

²⁴⁹*See* Greely, *supra* note 180.

²⁵⁰*See* Greely, *supra* note 180, at 75. The *Fox* case was settled before the appeal was heard, so it did not result in a reported opinion. The case is well described in Christine Woolsey, *Jury Hits HMO for Coverage Denial*, BUS. INS., Jan. 3, 1994, at 1, 23 (describing the complaint and the decision of the California Superior Court). *See also* Greely, *supra* note 180, at n.42.

²⁵¹*See* Greely, *supra* note 180, at 75 (explaining that the HMO's medical director was the person who decide whether the procedure sought was experimental).

²⁵²*Id.* The facts from the *Ching* case are taken from the Greely article. Greely bases his description of the case from a copy of the complaint and David R. Olmos, *Cutting Medical Costs or Cutting Corners?*, L.A. TIMES, May 5, 1995, at A1. *See* Greely, *supra* note 180, at 76, n.43.

²⁵³*Id.* at 75. The patient was a member of an HMO and received her care through a physician group that received \$27.94 a month for her care. *See Id.* The complaint alleged that the physician group had to pay for diagnostic tests or procedures by specialists. *See Id.*

²⁵⁴*Id.* at 76. "Mrs. Ching's husband and young son did not sue the health plan, probably because of the barriers ERISA imposes." *See* Greely, *supra* note 180, at 76. *See also* discussion *infra* Part III.B.1 (explaining ERISA preemption).

²⁵⁵*See* Greely, *supra* note 180, at 76.

²⁵⁶*Id.* Note that this amount was reduced to \$700,000 as a result of California's cap on non-economic damages in medical malpractice case. *See Id.*

incentives. These cases present evidence that financial arrangements may present great influence in the decisions that physicians make for their patients.

B. The Effect of ERISA on Managed Care

ERISA has been called “the most important law affecting health care in the United States.”²⁵⁷ “[ERISA] was designed to create a comprehensive, uniform regulatory system for self-funded employee benefit plans. . . .”²⁵⁸ ERISA is applicable to most employer-sponsored health plans, which means that ERISA’s guidelines cover more than one-half of all American workers.²⁵⁹ ERISA does not apply to self-employed persons or to persons whose health care insurance is not provided by their employer.²⁶⁰

1. ERISA Preemption

In order to maintain uniformity by avoiding conflicting state standards, ERISA “supersedes any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”²⁶¹ The preemption applies to common law action, as well as actions instituted under state statutes if the actions “relate to” an employee benefits plan.²⁶² “The preemption clause of ERISA has been given ‘its broadest common sense meaning’ by the Supreme Court.”²⁶³ The necessary relation is established by showing the state law has a “connection with or reference to [an employee benefit plan].”²⁶⁴ In terms of HMO liability, the preemption clause of ERISA must be reviewed in order to determine the validity of state law.²⁶⁵ When a state law cause of

²⁵⁷Brasel, *supra* note 138, at 453.

²⁵⁸HEALTH INS. ASS’N OF AM. PART B, *supra* note 5, at 169 (explaining that “ERISA does not dictate the substance of employee benefit plans, but it does impose fiduciary duties on the administrators of such plans, as well as reporting and disclosure requirements.”).

²⁵⁹*See* Brasel, *supra* note 138, at 453-54 (explaining that “when there is a dispute involving an employee benefit plan, the statute is triggered.”).

²⁶⁰*Id.* at 454. In addition, the statute does not apply to employee benefit plans when the employee works for either a church or the government. *See id.*

²⁶¹Parver, *supra* note 119, at 224 (quoting 29 U.S.C. § 1144(a) (1994)).

²⁶²*Id.*

²⁶³*Id.* *See Shaw*, 463 U.S. at 98 (stating “Congress used the words ‘relate to’ in section 514(a) in their broad sense”). *See also*, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-40 (1985) (stating that ERISA broadly pre-empts state law); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987) (stating “in both cases [*Shaw* and *Metropolitan*] the phrase ‘relate to’ was given its broad common-sense meaning, such that a state law ‘relates’ to a benefit plan ‘in the normal sense of the phrase, if it has a connection with or reference to such a plan.’”).

²⁶⁴Parver, *supra* note 119, at 225 (quoting *Shaw* at 97).

²⁶⁵*See* Brasel, *supra* note 138, at 454. When conducting a pre-emption analysis, one must first ask “whether the case involves an ERISA-regulated plan.” *Id.* at 455. “The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding circumstances from the point of view of a reasonable person.” *Id.* (quoting *McClellan v. Health Maintenance Org. of Pa.*, 604 A.2d 1053, 1063 (Pa. Super. Ct. 1992)).

action is preempted by ERISA, the claim cannot be pursued and must be dismissed.²⁶⁶ Thereafter, the plaintiff's only remedy is found in the remedy provisions of the ERISA statute.

The scope of the ERISA's preemption clause has been drawn into question and still remains unclear.²⁶⁷ Section 514 of ERISA is the substantial preemption section.²⁶⁸ In deciding whether federal law preempts a state provision, the question is one of congressional intent.²⁶⁹ "[T]he purpose of Congress is the ultimate touchstone."²⁷⁰ In order to find Congress' intent, the statutory language and structure must be reviewed.²⁷¹ The Court finds the task of discerning congressional intent considerably simplified due to the broadly worded preemption provision of § 514.²⁷² The key to § 514(a) is found in the words "relate to."²⁷³ Congress has used these words in their broadest sense by rejecting more limited preemption language and by using equally broad language in defining the state laws that would be preempted.²⁷⁴ A state law may "relate to" a benefit plan and thus be preempted even if the law is not specifically designed to affect such plans or the effect is only indirect.²⁷⁵ On the other hand, preemption is not precluded simply because a state law is consistent with ERISA's substantive requirements.²⁷⁶ Overall, § 514 indicates Congress' intent to establish the regulation of employee welfare benefit plans "as exclusively a federal concern."²⁷⁷

²⁶⁶*Id.* at 454.

²⁶⁷*Id.*

²⁶⁸*See* HEALTH INS. ASS'N OF AM. PART B, *supra* note 5, at 170 ("[s]ection 514 of ERISA broadly establishes the federal preemption of any and all state laws that relate to any employee benefit plan.").

²⁶⁹*See* *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137-38 ("[t]he question of whether a certain state action is preempted by federal law is one of congressional intent.").

²⁷⁰*Id.* ("[t]he purpose of Congress is the ultimate touchstone" (quoting *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208 (1985))).

²⁷¹*Id.* ("to discern Congress' intent we examine the explicit statutory language and the structure and purpose of the statute.").

²⁷²*Id.* The Court quotes 29 U.S.C. § 1144(a) (1994) ("§ 514(a) of ERISA is as follows 'Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under 1003(b) of this title.'").

²⁷³*Ingersoll-Rand* at 138.

²⁷⁴*Id.* Such state laws under the preemption include "all laws, decisions, rules, regulations, or other State action having the effect of law." 29 U.S.C. § 1144(c)(1) (1994).

²⁷⁵*Ingersoll-Rand* at 139.

²⁷⁶*Id.*

²⁷⁷*See* *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-657 (1995) ("we have found that in passing § 514(a), Congress intended 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal government . . . ,

2. Fiduciary Duty Under ERISA

A fiduciary within the meaning of ERISA must be someone acting in the capacity of a manager, administrator, or financial advisor to a “plan.”²⁷⁸ A “plan” has been defined as a scheme decided upon in advance.²⁷⁹ Plans include rules governing the collection of premiums, definition of benefits, submission of claims and resolution of disagreements over the entitlements of services.²⁸⁰ ERISA provides that fiduciaries shall discharge their duties with respect to a plan “solely in the interests of the participants and beneficiaries. . . for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan.”²⁸¹

The responsibilities imposed by ERISA sound much like their source in the common law of trusts.²⁸² The common law of trusts charges fiduciaries with a duty of loyalty to guarantee the beneficiaries’ interests and to administer the trust solely in the interests of the beneficiary.²⁸³ The seminal case on the duty of loyalty in the partnership setting, *Meinhard v. Salmon*, reinforces the strength of the duty by stating, “[a] trustee is held to something stricter than the morals of the market place, . . . [n]ot honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.”²⁸⁴

Unlike a trustee under the common law, a fiduciary under ERISA may have a financial interest adverse to the beneficiaries.²⁸⁵ However, ERISA does require that

[and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.’’ (quoting *Ingersoll-Rand* at 142).

²⁷⁸*Pegram* at 223 (quoting 29 U.S.C. §§ 1002(21)(A)(i)-(iii) (1999)).

²⁷⁹*Id.* (“one is left to the common understanding of the word ‘plan’ as referring to a scheme decided upon on advance.”).

²⁸⁰*Id.*

²⁸¹29 U.S.C. § 1104(a)(1)(A) (1999). In addition, fiduciaries must discharge their duties (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; (C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and (D) in accordance with the documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter. 29 U.S.C. § 1104(a)(1).

²⁸²*Pegram* at 224.

²⁸³*Id.*

²⁸⁴*Meinhard v. Salmon*, 164 N.E. 545, 546 (1928) (Cardozo, J). (“many forms of conduct permissible in a workaday world for those acting at arm’s length, are forbidden to those bound by fiduciary ties.”).

²⁸⁵*See Pegram*, 530 U.S. at 224 (explaining that employers can be ERISA fiduciaries and still take actions to the disadvantage of the ERISA beneficiaries when the act like employers (*e.g.*, firing a beneficiary for reasons unrelated to the ERISA plan or modifying the terms of the plan as allowed by ERISA to provide less generous benefits)).

the fiduciary act in adherence to the duty when making fiduciary decisions.²⁸⁶ Plan administrators are fiduciaries only to the extent that they act in such a capacity in relation to a plan.²⁸⁷ Thus, “[i]n every case charging breach of ERISA fiduciary duty . . . the threshold question is not whether the actions of some person employed to provide services under the plan adversely affected a plan beneficiary’s interests, but whether that person was acting as a fiduciary (that is, performing a fiduciary function) when taking the action subject to the complaint.”²⁸⁸

3. The “Savings Clause” and Common-Law Claims

While ERISA broadly preempts state laws that relate to an employee-benefit plan, that preemption is substantially qualified by the “insurance savings clause.”²⁸⁹ This clause states that nothing in ERISA “shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”²⁹⁰ This clause saves state laws, which regulate insurance, banking, or securities, from preemption.²⁹¹ Although the “savings clause” on its face would seem to protect claims regarding employee health benefit plans that provide health insurance from ERISA preemption, and thus allow the claims under state law, it is not that simple.²⁹²

The seminal Supreme Court case discussing the “savings clause” and its impact on the insurance industry is *Metropolitan Life Insurance Company v. Massachusetts*.²⁹³ In this case, the Court set forth a three-factor test to establish whether a state law falls under the “saving clause,” and hence is not preempted by ERISA.²⁹⁴ The factors are: “(1) whether the practice has the effect of transferring or spreading a policyholder’s risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; (3) whether the practice is limited to entities within the insurance industry.”²⁹⁵

The Court applied the three-factor test to a common-law cause of action for breach of contract and tortious bad faith against an insurance company in *Pilot Life Insurance Co. v. Dedeaux*.²⁹⁶ The complaint in *Pilot Life* alleged improper

²⁸⁶*Id.* (“ERISA does require, however, that the fiduciary with two hats wear only one at a time, and where the fiduciary hat when making fiduciary decisions.”).

²⁸⁷29 U.S.C. § 1002(21)(A) (1999).

²⁸⁸*Pegram* at 226.

²⁸⁹*See Metropolitan Life Ins. Co.* at 739.

²⁹⁰29 U.S.C. § 1144(b)(2)(A) (1999).

²⁹¹*Id.*

²⁹²*See Griner, supra* note 12, at 914.

²⁹³*Metropolitan Life Ins. Co.* at 724.

²⁹⁴*Id.* at 743 (stating that “cases interpreting the scope of the McCarren-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within that Act’s reference to the ‘business of insurance.’”).

²⁹⁵*Id.* *See also* *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

²⁹⁶*Pilot Life Ins. Co.* at 41.

processing of a claim for benefits under an employee benefit plan.²⁹⁷ The Court found that the common-law of bad faith does not effect a spreading of policyholder risk, that the connection to the insurer-insured relationship is “attenuated” at best.²⁹⁸ The Court stated that roots of bad faith are “firmly planted” in tort and contract law; the application of these principals was not limited to the insurance industry.²⁹⁹

Herein lies the roadblock for patients bringing tort or contract claims against their HMO. Based on *Pilot Life*, the savings clause will not save any state laws of “general application,” such as common-law principals of contract and tort.³⁰⁰ Therefore, any type of state tort action against a HMO for negligence in a utilization review decision or medical necessity determination under an ERISA qualified plan would not fall under the “savings clause” for insurance regulation and the common law cause of action is preempted by ERISA.³⁰¹ A patient bringing a claim of this kind would thus need to prove the claim using the ERISA statute and not relevant state law.

“Perhaps the most unjust aspect of ERISA preemption is that it destroys a plaintiff’s chance at a level playing field.”³⁰² “When a health plan is an ERISA plan, preemption is fairly certain for at least some claims that otherwise would be viable.”³⁰³ However, when a health plan does not fall under ERISA, there is no ERISA preemption and the patient is allowed full recovery on the same theories of poor care and wrongdoing by an HMO.³⁰⁴ In contrast, patients in health plans that fall under ERISA guidelines can only recover the value of the benefit denied.³⁰⁵ Many feel this is an inadequate remedy for a patient who has been seriously injured or has died due to the negligence of an HMO.³⁰⁶ “[C]ourts . . . are becoming

²⁹⁷*Id.* at 43 (“although Dedeaux sought permanent disability benefits following the 1975 accident, Pilot Life terminated his benefits after two years.”).

²⁹⁸*Id.* at 50-51.

²⁹⁹*Id.* at 50.

³⁰⁰*See* Griner, *supra* note 12, at 916.

³⁰¹*Id.* Griner also points out that not every purchase of group health insurance by an employer constitutes an employee benefit plan within the meaning of ERISA. *See id.* (citing *Fort Halifax Packaging Co., Inc. v. Coyne*, 482 U.S. 1 (1987)). The Fort Halifax ruling has been referred to as a “significant check on the sweep of the *Pilot Life* decision.” *See id.*

³⁰²Parver, *supra* note 119, at 228.

³⁰³*Id.*

³⁰⁴*Id.* (explaining that many times such cases stem from the denial of care pursuant to an HMOs utilization review in which a patient has lost the opportunity to undergo treatment when time was of the essence).

³⁰⁵*Id.* at 207.

³⁰⁶*Id.* Congress has been called on to close the ERISA loophole:

In other contexts throughout our legal system, foreseeable injuries caused by a failure to deliver what has been promised must be compensated. Under ERISA, however, working men and women give their labor in exchange for the promise of benefits, but are not compensated for injures when benefits are wrongly withheld. Under this system, an insurance company or HMO may stubbornly refuse to provide what is promised in the hope that the worker will not finance a court battle, and even if she

increasingly wary of letting third party payors go entirely 'scott-free,' and are devising new techniques to hold payors liable either through traditional agency principals or more direct routes."³⁰⁷

IV. ANALYSIS

The Supreme Court in the case of *Herdrich v. Pegram* should have adhered to the Appellate Court's ruling and remanded the case back to the trial court for further review. Two main arguments support a remand: (1) contrary to the Supreme Court ruling, a fiduciary duty exists between an HMO enrollee and the HMO under ERISA, and (2) physician financial incentive agreements play a direct role in physician decision making. Both reasons are discussed in detail below. In addition, in realizing that financial incentives will continue to be a crucial part of managed care, solutions will be explored as to minimize harm to HMO members.

A. *The Fiduciary Duty*

1. The ERISA Standard

In order for a member of an ERISA HMO to properly state a claim for breach of fiduciary duty, the member's complaint must allege facts that set forth: (1) that the defendants are plan fiduciaries; (2) that the defendants breached their fiduciary duties; and (3) that a cognizable loss resulted.³⁰⁸ The Appellate Court held that Herdrich's pleadings met each of the three requirements.³⁰⁹ The Supreme Court, however, held that mixed eligibility and treatment decisions made by an HMO were not fiduciary acts within the meaning of ERISA.³¹⁰

a. *A Fiduciary Under ERISA*

ERISA defines the term "fiduciary" as a person who (i) exercises discretionary authority or discretionary control respecting management of the plan or exercises any authority of control respecting management or disposition of its assets or . . . (iii) who has any discretionary authority or discretionary responsibility in the

does, years of litigation will produce no more than an order to provide the withheld benefits.

Olena Berg, Ass't Sec'y, Pension & Welfare Benefits Admin., *ERISA Preemption: Remedies for Denied or Delayed Health Claims*, Senate Subcommittee on Labor, Health & Human Servs., Education & Related Agencies, 105th Cong. (1998). See Parver, *supra* note 119, at n.38.

³⁰⁷*Id.* at 207.

³⁰⁸*Herdrich* at 369 (quoting 29 U.S.C. § 1104(a)).

³⁰⁹*Id.* (holding "[w]e are of the opinion that Herdrich's pleadings have more than sufficiently alleged each of these three elements"). See *supra* notes 78-79 and accompanying text (discussing the Appellate Court decision).

³¹⁰See *Pegram* at 235 (holding "[m]ixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA. Herdrich's ERISA count fails to state an ERISA claim, and the judgment of the Court of Appeals is reversed."). See *supra* notes 99-111 and accompanying text (discussing the Supreme Court's decision).

administration of such plan.”³¹¹ When Congress enacted ERISA, it intended that this statutory definition of fiduciary be broadly interpreted.³¹² “A fiduciary need not be a person with direct access to the assets of the plan. . . . [c]onduct alone may . . . impose a fiduciary obligation.”³¹³

The Court itself describes the defining feature of an HMO as “receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed.”³¹⁴ This element of the HMO system causes Carle to fit neatly into the definition established by ERISA. Carle had, at a minimum, discretionary responsibility in the administration of the plan by operating a pre-paid health insurance plan that provides both medical and hospital services to its members.³¹⁵ Mr. Herdrich’s employer contracted with Carle in order to provide medical benefits to their employees, which would cause Carle to have discretionary responsibility over plan administration.³¹⁶

If Dr. Pegram was a “fee for service” provider, an argument may have been made that the sole administration of the care was managed by the physician due to the large amount of physician control in this type of system.³¹⁷ However, in an HMO system like Carle’s, in which the care is managed by Carle through cost-controlling measures, Carle had at least discretionary responsibility over the administration of the plan.³¹⁸

In addition, it has been found that “conduct alone” may impose a fiduciary obligation.³¹⁹ Any person with a specific duty imposed on them may be deemed to be a fiduciary.³²⁰ Carle provided pre-paid medical services to the employees of State Farm Insurance, Mr. Herdrich’s employer.³²¹ Furthermore, Carle accepted the “duty” as Ms. Herdrich’s health care insurer by establishing a relationship with State

³¹¹29 U.S.C. § 1002(21)(A). *See supra* Part III.B.2 (discussing the fiduciary duty under ERISA).

³¹²*See supra* notes 261, 266.

³¹³*Herdrich* at 370 (“it is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary.”).

³¹⁴*Pegram* at 218. *See supra* note 129 and accompanying text (defining an HMO).

³¹⁵*See supra* notes 24-29 and accompanying text (discussing Carle HMO).

³¹⁶*See Pegram* at 214. *See supra* notes 28-29 and accompanying text (describing Carle’s relationship with State Farm Insurance, Mr. Herdrich’s employer).

³¹⁷*See* discussion *supra* Part III.A.1 (describing the “fee-for-service” physician payment system). *See supra* notes 112-16 and accompanying text (describing how “fee-for-service” allows the physician much control).

³¹⁸*See supra* notes 28-29 and accompanying text (describing Carle’s relationship with State Farm Insurance, Mr. Herdrich’s employer). *See also, Herdrich* (“the defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed.”).

³¹⁹*Id.* at 370.

³²⁰*See supra* discussion Part III.B.2 (describing the fiduciary duty under ERISA).

³²¹*See supra* note 316.

Farm Insurance.³²² Carle had the duty of administering Ms. Herdrich's medical care, and decided where members could receive their care, urging the members to use Carle's own physicians if at all possible.³²³ This conduct on the part of Carle establishes a fiduciary duty under the "broad" ERISA standard.

b. The Role of Utilization Review

i. Control of the Claims Process

An important factor in determining fiduciary status is the retention of control of the claims process.³²⁴ The exclusive right to determine all disputed and non-routine claims is an important factor as well.³²⁵ The very nature of the cost-containment tactics used by HMOs controls the claims process.³²⁶

The use of utilization review as a cost-containment tactic controls the claims process by deciding between those patient claims that are paid and those that are denied. For example, pre-authorization programs will deny patient claims that are not pre-approved by the HMO.³²⁷ In prospective review, coverage can either be approved or denied even before the medical service has been performed.³²⁸ Every type of managed care organization uses utilization review programs.³²⁹ Carle's utilization review system caused them to have retention over the claims process and thus a fiduciary status existed between Carle and the patient.

ii. Liability and Utilization Review

In addition, case law shows that liability has been found solely based on the use of utilization review programs.³³⁰ A material question of liability is found in situations in which the organization's conduct was a "substantial factor" in causing

³²²See *supra* note 276 and accompanying text (stating "[a] fiduciary within the meaning of ERISA must be someone acting in the capacity of a manager, administrator, or financial advisor to a plan.").

³²³See *supra* note 42 and accompanying text (describing Carle's panel provider program), See discussion *supra* Part III.A.3.b (discussing HMO panel selection in general).

³²⁴See *Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 613 (7th Cir. 1995) (holding employer was the plan fiduciary because they had retained the right to direct and control the claims procedures and practices, as well as the right to determine all disputed claims). In addition, the fund was created and fully funded by the employer. See *Id.*

³²⁵*Herdrich* at 370.

³²⁶See *supra* Part III.A.3 (discussing types of cost-containment strategies employed by HMOs).

³²⁷See HEALTH INS. ASS'N OF AM. PART B, *supra* note 5, at 92.

³²⁸See *supra* discussion Part III.A.3.a (describing utilization review). See *supra* notes 166-69 and accompanying text (discussing prospective review).

³²⁹See HEALTH INS. ASS'N OF AM. PART A, *supra* note 116, at 68 ("UR [Utilization Review] programs are used by every type of managed care organization.").

³³⁰See *Wickline v. California*, 239 Cal. Rptr. 810 (1986), and, *Wilson v. Blue Cross of Southern Cal.*, 271 Cal. Rptr. 876 (1990).

the complained circumstances.³³¹ Although the “substantial factor” test has been used in the utilization review setting only, an argument can be made that the inability of Ms. Herdrich to receive a timely ultrasound was a “substantial factor” in the rupturing of her appendix.³³² In fact, case law dealing directly with liability based on physician financial incentive programs has also utilized a causation approach.³³³

The *Bush*³³⁴ case is an example of the judiciary’s willingness to review a causation approach in determining HMO liability.³³⁵ In *Bush*, the court found that there was a genuine issue of material fact as to whether the HMO’s incentive scheme caused the late diagnosis of the plaintiff’s cervical cancer.³³⁶ The causation theory was not rejected based on the idea that the method in which the incentive scheme operated, may have contributed to the improper treatment of the patient.³³⁷

In *Herdrich*, the Supreme Court denied the existence of a fiduciary duty under ERISA between Carle and Ms. Herdrich.³³⁸ However, the administrative ability that Carle retains, as exemplified through the use of utilization management procedures, causes them to retain control over the claims process, which is an important factor in determining fiduciary status under ERISA.³³⁹ The control of the claims process, compounded with the case law finding HMO liability based on the use of utilization review processes, points to the existence of a fiduciary duty even under the ERISA standards.

c. Mixed Eligibility Decisions and Fiduciary Duties

The Supreme Court held that Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians.³⁴⁰ “[P]ure eligibility decisions turn on the plan’s coverage of

³³¹*See Wilson* at 883 (“[t]here is substantial evidence that Western Medical’s decision not to approve further hospitalization was a substantial factor in bringing about the decedent’s demise.”). *Id.*

³³²*See supra* note 24 and accompanying text (arguing that the delay in Ms. Herdrich’s ultrasound caused her appendix to rupture).

³³³*See* discussion *supra* Part III.A.3.e (discussing the unpublished Michigan trial court opinion in *Bush v. Dake*). *Bush* stated that “[d]ocumentary evidence has been presented which supports the plaintiff’s theory that the manner in which the system operated in this contributed to the improper treatment and delay in diagnosis of Mrs. Bush’s cancerous condition.” *Id.*

³³⁴ROSENBLATT, *supra* note 4.

³³⁵*See supra* note 331.

³³⁶*See supra* notes 246-47 and accompanying text (discussing the courts decision in *Bush*).

³³⁷*See supra* notes 237-40 and accompanying text (discussing the incentive scheme in the *Bush* case).

³³⁸*See supra* notes 105-11 and accompanying text (stating the Supreme Court’s review of the fiduciary duty in *Herdrich*).

³³⁹*See supra* note 322 (explaining that the retention of control in the claims process has proven to be an indicator of the existence of a fiduciary duty).

³⁴⁰*Pegram* at 230.

a particular condition or medical procedure.”³⁴¹ In contrast, “treatment decisions are choices about how to go about diagnosing and treating a patient’s condition.”³⁴² The Court held that these two decisions are inextricably mixed like countless medical administrative decisions made every day.³⁴³ Thus, the Court concluded that the decision made on Herdrich’s treatment course, while incorrect, was completely made by Pegram, not Carle.³⁴⁴

When HMOs “direct” where and what procedures will be given through their utilization review programs, they do not consider themselves to be dictating to the physicians how to practice medicine.³⁴⁵ They view their actions as merely setting limits through the use of medical necessity determinations regarding the treatments for which the employers are willing or obligated to pay.³⁴⁶ In essence, the administrators argue that they are only making “business decisions.”³⁴⁷ Physicians, however, claim that these decisions made through utilization review systems do indeed equate to a medical decision made by the HMO.³⁴⁸

Traditionally, physicians had a monopoly on the right to determine the appropriate course of medical treatment for their patients.³⁴⁹ As a result, physicians have bore the sole liability when a medical decision was found to be negligent.³⁵⁰ “The advent of managed care and cost-containment mechanisms has altered decision-making authority.”³⁵¹ Accordingly, a portion of the liability occurring from these decisions must also be shifted onto the managed care plans. The decision of medical treatment is no longer solely left up to the physician.

Case law also reinforces the idea that utilization review decisions are indeed medical decisions. The seminal case in this area is *Corcoran v. United HealthCare*.³⁵² The Fifth Circuit held that the utilization review decisions made by

³⁴¹*Id.* at 228 (defining HMO eligibility decisions).

³⁴²*Id.* (defining physician treatment decisions).

³⁴³*See supra* notes 99-104 and accompanying text (discussing the Court’s analysis of “mixed eligibility” decisions in *Herdrich*).

³⁴⁴*Pegram* at 228.

³⁴⁵*See Andresen, supra* note 170, at 441.

³⁴⁶*Id.*

³⁴⁷*Id.* at 442 (stating that “these decisions involve coverage or reimbursement determinations that are in place to effectuate the cost-containment objectives at the core of managed care.”).

³⁴⁸*Id.* Some physicians argue that HMO administrators are exercising medical judgment without sufficient knowledge or ability to determine medical necessity and others argue that it interferes with the physician-patient relationship. *Id.* Courts and administrative bodies are equally divided on the issue. *See Anderson, supra* note 170, at 442.

³⁴⁹*Id.* at 446. *See discussion supra* Part III.A.1 (describing the “fee-for-service” physician payment system); *See supra* notes 112-16 and accompanying text (describing how “fee-for-service” allows the physician much control).

³⁵⁰*See Andresen, supra* note 170, at 446.

³⁵¹*Id.*

³⁵²*Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

the HMO were, in fact, medical decisions.³⁵³ The court stated that “[b]y its very nature, a system of prospective decision making influences the beneficiary’s choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system.”³⁵⁴

A decision was made that Ms. Herdrich would wait eight days in order to have her ultrasound procedure at a Carle facility.³⁵⁵ This treatment decision, although defined by the Court as mixed, was made by the HMO through their use of a “preferred provider” for ultrasound treatment located fifty miles away.³⁵⁶ Carle required that plan patients receive their medical care from Carle facilities.³⁵⁷ Whatever the term that is placed on the decision, it was made by the HMO and liability should be shared with Dr. Pegram by the HMO.³⁵⁸

In addition, the Supreme Court argues treatment decisions made by the HMO have only a “limited” resemblance to the usual business of traditional trustees in the classic fiduciary relationship.³⁵⁹ The Court readily admits that “physicians (like regular trustees) draw on resources held for others and make decisions to distribute them in accordance with entitlements expressed in a written instrument.”³⁶⁰ However, the Court states that trustees do not make treatment decisions because these decisions are left to the discretion of the physicians.³⁶¹ Herein lies the flaw in the Court’s argument. In modern times, physicians do not make treatment decisions; they are made by the HMO.³⁶² This switch in the decision-making power of physicians is evidenced by the use of utilization review and panel selection.³⁶³ Utilization review controls the procedures ordered by the physician and panel selection controls the providers in which the physician may refer the patient.³⁶⁴ These controls were not utilized in the former fee-for-service system but are mainstays in today’s health care environment. This shift in the control of physician

³⁵³*Id.* at 1331.

³⁵⁴*Id.* at 1332 (interestingly, while giving an indication that utilization review involves something more than an administrative question, the court did not allow the Corcorans to proceed at trial based on the fact that ERISA preempted any recovery).

³⁵⁵*See supra* note 28 and accompanying text (describing the eight-day delay in receiving the ultrasound treatment).

³⁵⁶*See supra* notes 27-29 (discussing Carle’s use of the hospital fifty miles away).

³⁵⁷*See supra* notes 40-42 (discussing Carle’s use of “preferred providers” for their member’s care).

³⁵⁸*But see Wickline*, at 1645 (“[t]he physician who complies without protest with the limitations imposed by a third-party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care.”).

³⁵⁹*Pegram* at 231.

³⁶⁰*Id.*

³⁶¹*Id.* at 232.

³⁶²*See discussion supra* Part III.A.3 (discussing the different types of cost-containment programs used by HMOs).

³⁶³*Id.*

³⁶⁴*See discussion supra* Part III.A.3.a-b (discussing utilization review and panel selection).

decision-making has caused the physician to resemble the trustee in the classic trust relationship.³⁶⁵ Thus, in modern times trust relationship analogies may be utilized in describing the relationship between the HMO and the patient.

The Court also argued it was “questionable” whether Congress had mixed eligibility decisions in mind when it provided that decisions in administering a plan were fiduciary in nature.³⁶⁶ The problem with the Court’s argument is that when ERISA was first passed in 1974, HMO and other third-party payment systems did not exist in the same manner as they do today.³⁶⁷ It would have been impossible for the drafters of ERISA to imagine that HMOs would eventually manage health care and decisions. Despite changes in the health care system since ERISA’s birth, the congressional intent on which ERISA was based should still cover mixed eligibility decisions made in modern HMOs.³⁶⁸

Congressional intent in drafting a statute is first reviewed when attempting to decipher when an action falls under the statute.³⁶⁹ By drawing an analogy to the pension situation in which ERISA was created, it can be concluded that it was the intent of Congress to protect patients and not to fully shelter HMO systems from liability. ERISA was first established to protect retirees from the difficulties that they experienced in receiving their pension payments and the financial mismanagement that had often deprived the retirees of their benefits.³⁷⁰ Retirees were the persons the ERISA statute was created to protect. In the modern health care system, it is the HMO members that the statute should protect.

Based on the plain definition utilized by ERISA in determining who is a fiduciary, Carle clearly is in a fiduciary relationship with Ms. Herdrich. An important factor in determining fiduciary status is the retention of control over the claims process. Through Carle’s use of modern HMO cost-containment techniques, like utilization review, Carle had control of the processing of its member’s medical claims. Recent case law has shown that HMOs have been held liable on the decisions made through the use of utilization review procedures. In addition, utilization review decisions are medical decisions made by an HMO that should be considered fiduciary in nature. Thus, all of these factors demonstrate that a fiduciary relationship between Carle and Ms. Herdrich existed.

³⁶⁵See *supra* notes 280-86 and accompanying text (describing the classic trust fiduciary relationship).

³⁶⁶*Pegram* at 232 (“when Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on a fiduciaries’ financial decisions, focusing on pension plans.”).

³⁶⁷See Griner, *supra* note 12, at 920 (“[e]specially since any finding of third-party payor liability for negligence would not place any fiscal or administrative burden upon an employee benefit plan itself, there is no reason to extend ERISA preemption to this type of action.”).

³⁶⁸See *supra* note 275 and accompanying text (explaining the congressional intent of ERISA).

³⁶⁹*Ingersoll-Rand Co.* at 137-38. See *supra* note 267 and accompanying text (describing the use of congressional intent).

³⁷⁰*Pegram* at 232.

B. Physician Financial Incentive Agreements Can Rise To A Breach

Based on the fiduciary relationship between the HMO and its membership, a breach of this relationship occurs through the use of direct physician financial incentives. Financial incentives have been found to rise to the level of a breach of fiduciary duty.³⁷¹ The bonus distribution allocated to Carle's physician/owners fits into the category of a physician financial incentive.

1. Carle's Bonus Distribution

The claim in *Herdrich* brings to light Carle's provision for a "year end distribution" to the plan's physicians.³⁷² Herdrich argued this particular incentive device of annually paying physician owners the profits resulting from their own decisions rationing care is a breach of the fiduciary relationship.³⁷³ This type of distribution could be defined as a bonus incentive.³⁷⁴ Bonus incentives are often used to control the use of ancillary services, for example an ultrasound exam.³⁷⁵ Very often, ancillary services are paid out of a separate "pot" of funds and whatever funds are not used at the end of the year from procedures not performed is in turn returned to the physicians.³⁷⁶ Therefore, it could have been possible that Carle's "year-end distribution" included funds not utilized on diagnostic procedures, like ultrasound exams. If true, this bonus agreement could have given Dr. Pegram incentive not to promptly order the ultrasound exam for Ms. Herdrich.³⁷⁷

In addition, ERISA expressly prohibits fiduciaries from dealing with the assets of the plan in its own interests or in its own account based on the idea that a fiduciary must perform his duties solely in the interest of the plan participants.³⁷⁸ A very strong argument can be made that Dr. Pegram had her own financial interests in

³⁷¹*Herdrich* at 373 ("[i]ncentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e. where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses)"). *See also*, *Shea v. Esensten*, 107 F.3d 625, 629 (8th Cir. 1997) (finding a breach of fiduciary duty for not disclosing physician financial incentive agreements). *But see*, *Ehlmann v. Kaiser Found. Health Plan of Texas*, 198 F.3d 552, 555 (5th Cir. 2000) (holding that ERISA does not impose a fiduciary duty on HMOs to disclose physician compensations and reimbursement schemes to plan members).

³⁷²*See supra* notes 56-57 and accompanying text (discussing Carle's "year-end distribution" to the plan's physicians).

³⁷³*Id.*

³⁷⁴*See* discussion *supra* Part III.A.3.c.3 (describing physician bonus agreement and incentives used by HMOs to control costs).

³⁷⁵*See supra* notes 210-12 and accompanying text (explaining that ancillary services are very often a target for bonus withholds and distributions).

³⁷⁶*See supra* notes 213-14 and accompanying text (explaining how ancillary services are often paid out a separate set of funds).

³⁷⁷*See supra* note 215 and accompanying text (stating that physicians recognize that they can increase the amount of their compensation if they reduce the use of ancillary services).

³⁷⁸*Herdrich* at 371 (citing 29 U.S.C. §1104(a)(1)).

mind when she prevented Ms. Herdrich from having the ultrasound procedure at a nearby hospital instead of at the “plan” hospital which was over fifty miles away. Dr. Pegram was likely aware that the fewer procedures enacted on clients, the larger her year end bonus would be.³⁷⁹

Carle’s bonus agreement is not the only incentive at play here. The tactic of panel selection is also involved.³⁸⁰ Panel selection involves the HMO choosing a select number of sites in which services may be conducted for their members. The site where Herdrich had to wait eight days to receive treatment was a panel selection.³⁸¹ The use of panel sites is often encouraged through the use of financial incentives placed on the physicians. Their salary, bonuses, or continuance of an HMO physician may be completely or partially decided based on the use of these pre-selected sites.³⁸²

2. The Effect of Incentive Arrangements on Patient Care: Creating a System of Dual Loyalties

Depending on the exact financial arrangement, the physician may have to choose between her own income and what is needed for the patient’s well-being.³⁸³ This choice creates a system of dual loyalties. Financial incentives create a dual-loyalty that forces physicians to choose between the needs of their patients and physicians’ own financial well-being. HMOs, like Carle, place physicians in this dilemma. A strong argument can be made that current financial incentives placed on physicians like Dr. Pegram, advance this dilemma and encourage a decision based on financial factors.

a. “ERISA Tolerates Some Conflict of Interest”

It is true that ERISA allows fiduciaries to adopt dual loyalties.³⁸⁴ However, tolerance of dual loyalties does not extend to cases like *Herdrich*.³⁸⁵ The point is not

³⁷⁹See *supra* note 215 and accompanying text (stating that physicians recognize that they can increase the amount of their compensation if they reduce the use of ancillary services).

³⁸⁰See discussion *supra* Part III.A.3.b (discussing the panel selection system and how it is a tool for cost-containment).

³⁸¹See *supra* notes 27-29 and accompanying text (explaining that the hospital where Dr. Pegram wanted Ms. Herdrich to have the ultrasound procedure conducted was a Carle facility).

³⁸²See *supra* notes 184-86 and accompanying text (discussing how the panel selection system creates a financial incentive to follow HMO policy in order to remain a part of the physician panel).

³⁸³See Greely, *supra* note 180, at 71-72.

³⁸⁴*Herdrich* at 373 (“[w]e do not disagree with this contention, for it is well established that dual loyalties are tolerated under ERISA.”).

³⁸⁵*Id.*

Our point is not that a fiduciary may not have dual loyalties; it is that the tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of “loyalty” to his own financial interests). . . . Tolerance, in other words, has its limits.
Id.

that there may be dual loyalties; it is that they should not extend to a situation like this in which the fiduciary relinquishes his responsibility in order to improve his own financial standing.³⁸⁶

A doctor that must provide for his own family would be interested in a relatively substantial bonus for himself.³⁸⁷ The complaint in *Herdrich* stated that the Carle doctors stood to benefit financially when they were able to limit the types of treatments and referrals.³⁸⁸ An argument can be made that Carle placed financial pressures on its physicians, like Dr. Pegram, through the use of financial incentives for offering less patient care.³⁸⁹ These dual loyalties arguably caused the Carle doctors to be faced with an incentive to limit care as to guarantee more of a bonus.³⁹⁰ This financial pressure may have caused Dr. Pegram to make a decision based on her own financial well-being, possibly to the detriment of Ms. Herdrich.

In addition, the Carle physicians were “intimately involved” with the financial well-being of the enterprise because the yearly bonus paid to them was controlled by their limited utilization of treatments and referrals to other physicians.³⁹¹ This bonus arrangement has a direct link to the physician’s annual salary. The situation in *Herdrich* is much different than the cases in which the ERISA’s acceptance of dual loyalties is founded. Case law on dual loyalties involves situations in which the dual loyalties did not have a direct link to the fiduciary’s annual salary.³⁹² Thus, a distinction can be made between the fiduciary situation by which ERISA is accepting of dual loyalties and the *Herdrich* case. The *Herdrich* case is a more extreme example of dual loyalties due to the direct link between the action that creates the dual loyalty and the direct effect the dual loyalty has on the fiduciary. In the end, this

³⁸⁶*Herdrich* at 373.

³⁸⁷*Id.* at 379 (explaining that “[a] doctor who is responsible for the real life financial demands of providing for his or her family—sending four children to school (whether it be college, high school or primary school), making house payments, covering office overhead, and paying malpractice insurance, might very well ‘flinch’ at the prospect of obtaining a relatively substantial bonus for himself or herself.”).

³⁸⁸*See supra* notes 56-57 and accompanying text (describing *Herdrich*’s allegations against Carle).

³⁸⁹*See supra* notes 189-90 and accompanying text (discussing how financial incentives are aimed at discouraging the ordering of an “extra” medical procedures).

³⁹⁰*See* discussion *supra* Part III.A.3.c.3 (describing physician bonus agreement and incentives used by HMOs to control costs).

³⁹¹*Herdrich* at 379.

³⁹²*Id.* (“the officers in *Chalmers* who made the decision to distribute severance benefits were not the owners of the corporation”). In addition, the court added that “nothing in the facts of *Chalmers* leads us to infer that Quaker officers were shareholders, or even had an interest in the financial well-being of the company.” *Id.* (comparing the holding in *Chalmers*, 61 F.3d at 1344, that an automatic bias did not exist against the distribution of severance benefits, despite the fact that the members of the committee that distributes the severance benefits were officers of the corporation). The dissent in the *Herdrich* appellate decision argues that this case assists in establishing that ERISA does allow dual-loyalties of a fiduciary. *Herdrich* at 381 (“dual loyalties are not *per se* unlawful under ERISA”). *See also supra* note 84 and accompanying text (quoting *Chalmers* at ____).

dual loyalty makes it very difficult for a physician to choose to administer important, yet borderline necessary treatment, at the expense of their own financial well being.

b. A Lack of Accurate Data

Much literature has been created over the past few decades seeking to find the differences in quality of care between the “fee-for-service” and HMO systems.³⁹³ Overall, the literature seems to show that HMOs do not provide better, or worse care.³⁹⁴ However, it is very important to note that this conclusion is largely drawn from studies completed in the 1970s and 1980s, which were eras that included a different HMO system than today.³⁹⁵ Today’s managed care environment includes the immense use of cost-containment tactics. “We cannot safely extrapolate from the response of physicians in the systems studied in those eras to the responses of physicians in today’s many different systems.”³⁹⁶

Commentators have, however, identified a number of more detailed factors that are related to the degree of influence that direct financial incentives have on physician decision-making.³⁹⁷ The trial court should have reviewed three of these factors in order to better understand Dr. Pegram’s situation in making the treatment decisions that she made. Those factors are: (1) the extent of the physician’s risk, (2) the number of physician’s sharing that risk, and (3) the portion of the physician’s income derived from the HMO.³⁹⁸

The Court argued that if recovery were based on incentive programs implemented by HMOs alone, the HMO would be turned into a guarantor of recovery.³⁹⁹ Utilizing a factor test much like the one described above would not guarantee liability in every situation presented. The test could be used in order to

³⁹³See Greely, *supra* note 180, at 71 (“a voluminous literature has built up over the past few decades seeking to find differences in the quality of care between fee-for-service and HMO systems.”).

³⁹⁴*Id.*

³⁹⁵See *supra* notes 112-21 and accompanying text (describing the change in health care from the traditional “fee-for-service” system to modern managed care systems).

³⁹⁶Greely, *supra* note 180, at 71. See discussion *supra* Part III.A.3 (describing modern managed care cost-containment techniques). See also discussion *supra* Part III.A.3.d (explaining data regarding the use of direct financial incentives by HMOs).

³⁹⁷See Greely, *supra* note 180, at 72.

³⁹⁸*Id.* The complete list of factors is as follows: (1) the extent of the physician’s risk; (2) the existence and term of stop-loss insurance; (3) the distribution of risk to individual doctors or groups; (4) the number of physicians sharing the risk; (5) the number of patients in a physician’s patient panel; (6) the duration of the risk assessment period; (7) the generosity of the physician’s compensation for direct services; (8) the portion of the physician’s income derived from the HMO; and, (9) the generosity of service utilization budgets. *Id.* (citing the GAO report found at, HEALTH, EDUC. & HUMAN SERV. DIV., U.S. GEN. ACCT. OFFICE, MEDICAID MANAGED CARE: MORE COMPETITION AND OVERSIGHT WOULD IMPROVE CALIFORNIA’S EXPANSION PLAN (1995)).

³⁹⁹*Pegram* at 234-35 (“[I]t would be so easy to allege, and to find, an economic influence when sparing care did not lead to a well patient, that any such standard in practice would allow a factfinder to convert an HMO into a guarantor of recovery.”).

conduct a fair analysis of the physician's relation to the HMO's financial incentives. Perhaps a review of the factors introduced would determine that Dr. Pegram did make her decision to prolong the ultrasound analysis based on strict medical-judgment. The problem is that the *Herdrich* record is void of any analysis of this sort. The Court erred in not allowing the case to be remanded to the trial court in order to investigate the payment scheme utilized by Carle on Dr. Pegram. Only broad generalizations were made by the Court in citing a "flood gate" theory in not allowing the case to be reviewed again by the trial court.⁴⁰⁰

c. The Physician Response and Patient Trust

Additional evidence can be found by looking at how physicians feel about HMO cost-control arrangements. Many physicians, with financial incentives placed on them by health plans, believe undivided loyalty to their patients has diminished in the profession during the past ten years.⁴⁰¹ Commentators argue that the economic exigencies of the time require adjustment of the moral standard of undivided loyalty.⁴⁰² It has been demonstrated that physicians with financial incentives based on productivity are less satisfied with their practices and are more "ethically troubled" than their colleagues who are not in the same environment.⁴⁰³ "Physicians imbued with a sense of professional identity that has stressed altruism and loyalty to patients may experience the appeal to financial self-interests as a means of controlling costs, as a direct threat to their self-understanding as professionals."⁴⁰⁴ It is not difficult to discern from the above data that Dr. Pegram may have been experiencing many of the expressed feelings in deciding a treatment course for Ms. Herdrich. What role the financial incentives played with Dr. Pegram is still unknown.

Trust is at the center of the physician-patient relationship.⁴⁰⁵ Patient reports regarding their trust in their physician are tightly correlated with the perceptions of physicians.⁴⁰⁶ The "dual agency" inherent in these financial arrangements may feed

⁴⁰⁰*Id.* at 237 ("[W]hat would be gained by opening the federal courthouse doors for a fiduciary malpractice claim, save for possibly random fortuities such as more favorable scheduling, or the ancillary opportunity to seek attorney's fees.").

⁴⁰¹*See* Sulmasy, *supra* note 6, at 7 (explaining that "in a multivariate regression analysis, physicians who reported financial incentives to limit tests, treatments, and referrals were significantly and independently more likely to find such financial incentives morally troubling, to believe that commitment to the ethic of undivided loyalty to patients has eroded, and to report diminished patient trust in them."). *See also supra* note 11 (discussing the parameters in which the survey and analysis was conducted).

⁴⁰²*See* Sulmasy, *supra* note 6, at 2.

⁴⁰³*Id.* at 7.

⁴⁰⁴*Id.*

⁴⁰⁵*Id.* at 9. *See also* E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1727 (1987) ("The patient must be able to repose confidence in his physician, believing that the latter will be not only professionally competent but also devoted to his interests.").

⁴⁰⁶*See* Sulmasy, *supra* note 6, at 9.

patient skeptics about their physician's loyalty to them.⁴⁰⁷ A trusting relationship is essential to good health care.⁴⁰⁸ "To permit physicians routinely to balance their patients' interests against others economic welfare could devastate this fiduciary relationship."⁴⁰⁹ The patient must believe that the physician will not only be professionally competent but also devoted to his interests.⁴¹⁰

d. The Role of the Market Forces Argument

The dissent in the Seventh Circuit opinion argued that "market forces" help reduce the risk that a fiduciary's conflict of interest will work to the detriment of the plan and the plan beneficiaries.⁴¹¹ The dissent states, without any citation, that "plan sponsors are likely to take their business elsewhere if they perceive that incentives are working to the detriment of beneficiaries or to the plan itself, and thus market forces go a long way towards ensuring that incentives do not rise to a dangerous or undesirable levels."⁴¹²

Herdrich is a clear example of why the market forces argument does not protect HMO members against financial incentives raising to dangerous levels. "The 'market forces' the dissent refers to hardly seem to have produced a positive result in this case. . . ."⁴¹³ Due to the financial incentives placed on Dr. Pegram, which resulted in a delay in diagnosis, Ms. Herdrich suffered a life threatening illness.⁴¹⁴ This illness necessitated a longer hospital stay and a more serious surgery, which came at a greater cost to both Ms. Herdrich and Carle.⁴¹⁵

In addition, the dissent also raises an "efficiency argument" that financial incentives may bring about a more effective use of HMO assets.⁴¹⁶ The flaw in this argument is clearly articulated by the Seventh Circuit: "Indeed, the eight-day delay

⁴⁰⁷*Id.* (explaining that while their data can not establish a clear cause-and-effect relationship between financial incentives and diminished patient trust, the data does add fuel to the argument that there is a connection).

⁴⁰⁸*See* Morreim, *supra* note 402, at 1727 (explaining that unless patients believe that their physician is acting in their own best interests, it would be difficult for a patient to have a trusting relationship that is essential in the delivery of good health care).

⁴⁰⁹*Id.*

⁴¹⁰*Id.*

⁴¹¹*See Herdrich* at 381. *See* discussion *supra* Part II.C.2 (discussing the dissent in the Seventh Circuit decision). *See supra* notes 80-85 and accompanying text (describing the "market forces" argument in greater detail).

⁴¹²*Herdrich* at 374.

⁴¹³*Id.*

⁴¹⁴*See supra* notes 26-29 and accompanying text (describing the delay of the ultrasound procedure as the cause of Ms. Herdrich's peritonitis).

⁴¹⁵*Herdrich* at 374 (explaining that "[i]n an effort to defray the increased costs associated with the surgery required to drain and cleanse Herdrich's ruptured appendix, Carle insisted that she have the procedure performed at its own Urbana facility, necessitating that Herdrich travel more than fifty miles from her neighborhood hospital in Bloomington, Illinois.").

⁴¹⁶*See supra* note 86, and accompanying text (describing the dissent's "efficiency argument.").

in medical care, and the onset of peritonitis Herdrich incurred as a result of such delay in diagnosis, subjected her to a life-threatening illness, a longer period of hospitalization and treatment, more extensive, invasive, and dangerous surgery, increased hospital costs, and a greater ingestion of prescription drugs.⁴¹⁷ This is not a good example of the efficient use of medical resources. Overall, “[m]arket forces are insufficient to cure the deleterious affects of managed care on the health care industry.”⁴¹⁸

The determination that Carle breached their fiduciary duty to Ms. Herdrich is premised on two facts. First, ERISA expressly prohibits fiduciaries from dealing in the assets of the plan. A strong argument can be made that the bonus agreement that Carle placed on Dr. Pegram caused her to order fewer procedures for her patients knowing that this action would increase her individual bonus at the end of the year. The bonus was directly tied to ordering less care.

Secondly, it can be argued that ERISA would not tolerate a dual loyalties situation in the HMO setting. The cases in which the acceptance of dual loyalties in the fiduciary setting are not analogous to the Herdrich case. The main defining factor being a direct link between the fiduciaries’ annual salary and the medical decisions being made for the fiduciary.

In addition, data suggests that patient trust in their physicians is decreasing. This factor, along with the first two aforementioned clearly establish a breach in the fiduciary relationship between Carle and Ms. Herdrich.

C. Solutions

Whether we like it or not, physician financial incentives are a crucial part of our modern health care economy and are here to stay. In order to prevent situations like Ms. Herdrich’s from occurring, while still continuing to keep health care costs at a manageable level, a delicate balance must be met. Three main things must occur in order for this balance to be met: (1) cases like *Herdrich v. Pegram* must be remanded for continued fact-finding regarding the details of the financial motives involved, (2) ERISA must be amended in order to acknowledge a fiduciary relationship between HMO members and the HMO itself, and (3) physician financial arrangements must be disclosed to HMO patient members.

1. Remand *Herdrich v. Pegram*

Although the amount of hard data available regarding the true impact of physician incentive programs and patient care is sparse, the courts should scrutinize the facts of each incentive case in order to collect information regarding the true impact of these programs.⁴¹⁹ Broad statements can easily be made about the different types of financial incentive agreements utilized by HMOs. However, incentive agreements vary greatly from HMO-to-HMO based on several factors, including the

⁴¹⁷*Herdrich* at 378.

⁴¹⁸*Id.* at 374-75.

⁴¹⁹See discussion *supra* Part IV.B.1.b (discussing the lack of accurate data regarding the effect financial incentives have on physician care). See *supra* notes 224-31 and accompanying text (discussing the extent of the use of financial incentives by HMOs).

type of HMO and physician reimbursement arrangements.⁴²⁰ Factors have been created that set up a framework for reviewing the individual physician's arrangement.⁴²¹ Courts should be encouraged to use this list and to eventually create their own. Case law is sparse in this area and needs to be established.⁴²²

There are many facts that will continue to remain unknown about Dr. Pegram's motives in delaying the ultrasound procedure. We will never know the details on Carle's "year-end" distribution to know if it did play a factor in the delay of the ultrasound. In addition, it will remain unknown the role that the reimbursement system utilized by Carle played in Dr. Pegram's decision-making. Possibly, Dr. Pegram felt pressure to refer patients only to Carle providers for fear that she would be de-selected from Carle's physician panel.⁴²³ The Court should have remanded the *Herdrich* case for these reasons. This case presented the Court with an opportunity to create much needed case law dealing with the impact of these incentive programs and it failed to take advantage of that opportunity.

The Court fears that a decision finding a breach of fiduciary relation based on incentive arrangements would cause a type of "instant liability" for HMOs.⁴²⁴ This is simply not true. By establishing factors to review each physician incentive arrangement involved, a case-by-case analysis could be conducted that will not result in per se liability for the HMO. The longer that the issue of physician incentive agreements is accepted by the court, the more complex and confusing the situation will become. Moreover, HMOs will continue to escape liability.⁴²⁵ It is time that the Court stops hiding behind definitional roadblocks and creates some much needed precedent.

2. Amending ERISA

The *Herdrich* decision, and many others before it, was burdened with the hurdles of ERISA. It was not the intent of the drafters of ERISA to put roadblocks between

⁴²⁰See discussion *supra* Part III.A.2.a-c (discussing the types of HMO's and they methods in which they are organized). See *supra* notes 164-67 and accompanying text (explaining the different levels of liability associated with each HMO type).

⁴²¹See *supra* note 395 and accompanying text (describing the factor test established by the GAO for determining the strength that the individual's financial incentives have on their patient care decision making).

⁴²²See *supra* notes 232-33 and accompanying text (indicating that there are currently very few published opinions regarding the use of physician financial incentive programs by HMOs).

⁴²³See discussion *supra* Part III.A.3. b (discussing panel selection). See *supra* notes 377-79 and accompanying text (discussing how Dr. Pegram may have feared being de-selected from Carle's physician panel).

⁴²⁴See *supra* notes 396-97 and accompanying text (arguing that if a factor type analysis was utilized by the courts, HMOs would not become instant "guarantors of recovery" based solely on its use of financial incentive programs).

⁴²⁵See *supra* notes 298-305 and accompanying text (describing the "roadblocks" that ERISA places in front of a patient attempting to bring a claim against their HMO).

patients and the care that they need.⁴²⁶ A quick look at the early stages of ERISA reveals this fact. ERISA was created to make sure that persons had access to the care they needed.⁴²⁷ Too many courts have used ERISA as a method of avoiding review and eventual decisions of these issues. ERISA has simply turned into a tool used by health care organizations to avoid liability. This could not have been what the drafters intended.⁴²⁸

There are two ways ERISA could be amended: (1) ERISA should be amended to acknowledge a fiduciary relationship between the HMO and HMO patient; and (2) ERISA should be amended to expand the “insurance savings clause” to include common-law tort and contract claims.

a. Acknowledgement of a Fiduciary Relationship

Herdrich is a fine example of a clear fiduciary relationship that is established between an HMO and a member through the utilization programs that are utilized by health care plans.⁴²⁹ Utilization review methods are an accepted method of modern HMO practice and they should be accepted as creating a fiduciary relationship.⁴³⁰ The argument could continue forever on who really makes the decisions: The physician or the HMO.⁴³¹ However, while we are busy arguing this fact, patients are left without a remedy through ERISA against their HMO for mistakes made in the utilization review process.

In the beginning, one of the primary goals of ERISA was to create uniformity in regulation of these types of plans.⁴³² By amending ERISA’s preemption provision to acknowledge a fiduciary relationship between the HMO and the member, uniformity can be achieved in hearing these claims. Claims will finally be argued by looking at the exact incentive schemes of the physician involved.

By declaring that a fiduciary duty exists under ERISA between the HMO and the patient, we are guaranteeing that HMO members will have a cause of action in order to enforce their rights to full and complete medical treatment no matter what the cost- containment tactic utilized by the managed care plan is.

⁴²⁶See *supra* note 367 and accompanying text (explaining what types of people the ERISA statute was designed to protect).

⁴²⁷*Id.* (explaining that ERISA was first established to protect retirees from mismanagement by employers of their retirement benefits which is analogous to protection of the health benefits of the modern day HMO member).

⁴²⁸See *supra* notes 267-70 and accompanying text (explaining the congressional intent behind the ERISA statute).

⁴²⁹See discussion *supra* Part IV.A.1 (arguing that a fiduciary duty does exist between Carle and Ms. Herdrich partly through Carle’s usage of physician incentive programs like utilization review).

⁴³⁰See *supra* note 327 and accompanying text (stating that utilization review is used by almost every HMO in some form or another).

⁴³¹See discussion *supra* Part IV.1.c (discussion the “mixed eligibility decision” debate).

⁴³²See *supra* note 256 and accompanying text (stating the purpose of the ERISA statute to create a comprehensive, uniform regulatory system for self-funded employee benefit plans).

b. Expansion of the "Savings Clause"

According to current case law, common-law tort and contract claims do not fall under the "savings clause" and are preempted by ERISA.⁴³³ Therefore, patients who are part of an ERISA qualified plan are blocked from bringing tort and contract claims.⁴³⁴ The ERISA preemption creates a major roadblock to patient recovery in these types of situations.⁴³⁵ The patient's only option is to attempt to prove a breach by utilizing the ERISA standards, which did not work very well for Ms. Herdrich.

By expanding the "savings clause" to include these common law claims, an additional avenue would be available for patient recovery when harm has been done. By amending the "savings clause," those patients, who are a part of an ERISA qualified plan and those who are not, would be placed on a level playing field. The protection of patient interests is far from adequate under the current ERISA statute and legislative action should be taken to correct this situation.

3. Full Disclosure of Incentive Agreements

HMOs should be required to disclose the financial incentives under which their physicians work. Courts have already endorsed disclosure.⁴³⁶ "From the patients' point of view, a financial incentive scheme put into place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information."⁴³⁷ Patients may make different decisions for their course of treatment if they are aware of the incentive schemes in which their physicians are involved.⁴³⁸

Information that is presented regarding incentive agreements at the time a member enrolls can help the patient plan their coverage more effectively, including choice of health plan and choice of coverage.⁴³⁹ This information should come from the HMO as a part of an integrated communications strategy along with a core obligation of the health plan to provide members with simple descriptions of financial incentives, written in plain language, and distributed in connection with information on physician selection and denial.⁴⁴⁰ If all this information is distributed together, members will be able to make informed health care choices and they will

⁴³³See *supra* notes 296-97 and accompanying text (citing the holding in *Pilot Life* that common law claims for tort and contract do not fall under the "savings clause" of ERISA). See discussion *supra* Part III.B.3 (discussing the "savings clause" of ERISA).

⁴³⁴*Id.*

⁴³⁵See *supra* notes 298-99 and accompanying text (describing the "roadblock" that ERISA pre-emption causes for patients who attempt bring liability claims against their HMO).

⁴³⁶See *supra* note 368 and accompanying text (describing the *Shea* case in which the court found a breach of fiduciary duty for not disclosing physician financial incentive agreements).

⁴³⁷See *Shea* at 628.

⁴³⁸*Id.* at 627 (explaining that according to Mr. Shea's widow, if her husband would have known about his doctor's incentive agreement, he would have disregarded the doctor's advice and sought a second opinion at his own expense).

⁴³⁹See Miller, *supra* note 7, at 5.

⁴⁴⁰*Id.* at 9.

be empowered to exercise their rights as a member of the HMO once they are enrolled.⁴⁴¹

“Disclosure therefore dovetails with a national trend toward creating new legal rights for managed care members, including the right to change primary care physicians, to examine utilization review criteria, and to appeal coverage decisions to an entity independent of the health plan.”⁴⁴² In order to benefit from these entitlements, members must understand the basis of managed care and it is the HMO’s responsibility to make sure that they receive the information.⁴⁴³ Legal mandates for health plan disclosure are already on the rise. Since 1995, nearly twenty states have required insurance companies and HMOs to explain physician compensation methods to enrollees.⁴⁴⁴

V. CONCLUSION

In the past, the incentive for physicians was to provide more care, not less.⁴⁴⁵ In the modern, managed care environment, the incentive has been reversed.⁴⁴⁶ HMOs were created in order to apply much-needed cost-containment programs to the health insurance industry.⁴⁴⁷ HMOs and their utilization review systems have succeeded in controlling health care costs.⁴⁴⁸ However, liability must be accepted by HMOs for use of their cost-containment methods like physician financial incentive programs. These programs establish a fiduciary duty between the HMO and patient that should no longer be ignored.⁴⁴⁹

Future cases similar to *Herdrich v. Pegram* will provide the opportunity for the legal system to take a stand on HMO liability. In this case, the Court missed the opportunity. Financial incentive programs placed on physicians cause them to be

⁴⁴¹*Id.* at 7.

⁴⁴²*Id.*

⁴⁴³*Id.* at 5, 7 (arguing that incentive programs should be discussed with the patient by the HMO and not the physician due to the possible negative impact the information may have on the patient’s view of the physician and the medical profession as a whole). However, trust of physicians involved in an HMO may already be diminished and candor to the patient regarding the existence of incentive programs may reinforce trust for some patients. *And See*, Miller, *supra* note 7, at 57.

⁴⁴⁴*Id.* at 6 (explaining that “the health plan is permitted to include, in a separate section, an explanation or justification for these incentives or penalties.”).

⁴⁴⁵*See supra* note 116 and accompanying text (explaining the physician’s desire to provide more patient care, not less).

⁴⁴⁶*See supra* note 136 and accompanying text (explaining how the modern HMO system encourages a physician to provide less care, not more).

⁴⁴⁷*See supra* notes 117-21 and accompanying text (explaining why health care costs have skyrocketed, thus causing the need for HMOs).

⁴⁴⁸*See* discussion *supra* Part III.A.3.a (discussing utilization review as a cost-containment program).

⁴⁴⁹*See* discussion *supra* Part IV.A.1 (arguing that a fiduciary duty does exist between Carle and Ms. Herdrich partly through Carle’s usage of physician incentive programs like utilization review).

“tempted” to choose between their own financial well-being and the best course of treatment for their patients.⁴⁵⁰ Movement should be made towards striking a balance between all the systems at play causing tension between the patient, physician, and HMO. This balance can be made through disclosure of physician incentive programs and the amendment of ERISA.⁴⁵¹ HMOs serve both an important and effective role in controlling skyrocketing health care costs, but along with this role comes the need to take responsibility for their decisions.

⁴⁵⁰See *supra* note 380 (explaining the dual-loyalties situation).

⁴⁵¹See discussion *supra* Part IV.C.3 (arguing mandatory disclosure to HMO members by the HMO of any financial incentive agreements that they may have with their physicians).