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INTRODUCTION

Managed health care presents one of the greatest challenges facing America as we begin the 21st century. In the United States, approximately 140 million people receive health care benefits through plans from their employers or unions.1 Sixty-nine million of these employees were covered through plans regulated by the Employee Retirement Income Security Act of 1974 ("ERISA").2 This paper will focus on one particular aspect of managed care that presents a dilemma to patients and physicians alike — the ability of a patient who has been harmed by the refusal of an HMO to provide covered benefits to sue the HMO. In Part One of this paper, I will provide a brief history of the difficulty patients encounter when they attempt to sue their HMO's, focusing on the impact of ERISA. Next, I will discuss how the courts have responded to suits for breach of fiduciary duty against HMO's. In addition, the article explores the various state and federal legislative approaches taken to the problem. Finally, I conclude the paper by agreeing with those courts calling for a legislative solution to the problem.

2. Id.
PART I

In 1974, Congress enacted the Employee Retirement Income Security Act ("ERISA"). The express goal of ERISA was the protection of employee pension plans through the regulation mechanisms contained in the statute. In order to ensure that ERISA, rather than state law, would be the definitive regulation regarding employee pension plans, Congress inserted a broad preemption clause in the statute. The preemption clause provides in part, "Except as provided in subsection (b) . . . the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." The United States Supreme Court determined that ERISA broadly preempted state law relating to employee health plans. In other words, in many instances ERISA, not state law, will


4. See 29 U.S.C. § 1001(b) (1994) (stating that the goal of the legislation was to protect the interests of participants in employee benefit plans and their beneficiaries); Donald T. Bogan, Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?, 74 TUL. L. REV. 951 (2000) ("In passing ERISA, Congress intended to reform the pension plan industry and provide comprehensive regulation of pension plans.").


6. § 1144(a). Section 1144 provides in pertinent part: Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities. (B) Neither an employee benefit plan described in section 1003 of this title, which is not exempt under section 1003 (b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(a) (1994). An Employee Benefit Plan is defined in ERISA as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." 29 U.S.C. § 1002(B)(3) (1994). ERISA defines Employee Welfare Benefit Plan and Welfare Plan as: The terms "employee welfare benefit plan" and welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .


govern claims brought against employee health plans. The Supreme Court's interpretation of the preemptive effect of ERISA has lead to an avalanche of litigation in federal and state courts.  

With respect to private health insurance, one of the most vexing questions is whether a plan beneficiary may sue his Health Maintenance Organization ("HMO") when the beneficiary is denied benefits, or for the malpractice of its member physicians. The answer is far from clear. The federal circuit courts of appeals are split as to whether ERISA completely preempts all state law claims against an HMO brought by a plan beneficiary; and if some state actions are permitted by ERISA, under what circumstances may a plan beneficiary bring an action against his HMO.  

A. ERISA Preemption  

Several circuits have held that an ERISA plan beneficiary may not sue his HMO under any state law theory because ERISA completely preempts any state causes of action for medical malpractice against an HMO. In Corcoran v. United Healthcare, the Fifth Circuit Court of Appeals held that a person enrolled in an HMO could not recover from the HMO in a state law wrongful death action because the state law action was completely preempted by ERISA. The facts in Corcoran are relatively common in these types of actions. The plaintiff was a pregnant woman who had complications with past pregnancies. Her doctor recommended hospitalization to monitor the fetus twenty-four hours a day. The defendant HMO, as part of its utilization review procedure, determined that hospitalization was not necessary and denied the request. Instead, the HMO decided that daily visits by a home nurse would supply the proper amount of medical care to the
plaintiff and her unborn fetus. On a day when there was no nurse on duty, the fetus went into distress and died. Consequently, the plaintiff filed a wrongful death action in Louisiana state court against the HMO.

Using a common strategy, the defendant HMO removed the case to federal court claiming that the state law causes of action were completely preempted by ERISA, and subsequently moved for summary judgment. The trial judge granted the motion because he found that the state law claims “related to the employee benefit plan” at issue.

The plaintiff appealed the decision to the Court of Appeals for the Fifth Circuit. The Fifth Circuit upheld the trial court's decision, concluding that the HMO made a medical decision concerning the plaintiff's need for hospitalization; however, it did so in the process of making a determination of the benefits available under the plan. As a result, the court held that ERISA completely preempted the state law claims. Finally, the court held that ERISA itself provides no remedy for the type of malpractice claim advanced by the plaintiff. Interestingly, the Corcoran court

17. Id. at 1324.
18. Id. at 1321. The Corcorans alleged that their unborn child died as a result of various acts of negligence committed by Blue Cross and United. Id. The couple sought damages for lost love, society and affection of their unborn child. Id. Mrs. Corcoran sought damages for the aggravation of a pre-existing depressive condition and the loss of consortium; Mr. Corcoran sought damages for loss of consortium. Id.
19. Id. In moving for summary judgment, the defendants argued that in essence the plaintiff's complaint sought damages for improper claim administration. Id.
20. Id. at 1326. In granting the defendant's summary judgment motion, the district court determined that the state law claim brought by the plaintiffs was related to the employee benefit plan. The district court also noted that Mrs. Corcoran could have brought a declaratory judgment action against the defendants under ERISA seeking hospitalization benefits, or in the alternative, she could have paid for her own hospitalization and subsequently brought suit under ERISA to recover these expenses. Id.
21. Corcoran, 965 F.2d 1321, 1326
22. Id. at 1331.
23. Id.
24. Id. at 1339. The plaintiff attempted to argue that if ERISA did preempt their state law causes of action, the plaintiff could recover under the civil enforcement provision of ERISA. Id. The civil enforcement provision states in pertinent part:
A civil action may be brought . . . (3) by a participant, beneficiary, or fiduciary (a) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan . . . .
29 U.S.C. § 1132(a)(3) (1994). The plaintiff argued that section (B) would apply in this case. Corcoran, 965 F.2d at 1338. The court held that emotional distress and mental anguish
noted that "the result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake." The end result in this case, and others like it, compel the conclusion that people injured through cost containment procedures like utilization review, administered by an HMO governed by ERISA, will have no remedy at law in jurisdictions that support a broad interpretation of ERISA's preemption clause.

B. Cracking ERISA Preemption

In response to the Corcoran decision, several federal circuit courts of appeals have taken the opposite approach with respect to interpreting ERISA to preempt traditional state law malpractice claims. Recently, in Bauman v. U.S. Healthcare, the Third Circuit Court of Appeals interpreted the preemption clause of ERISA to permit state law claims that were "directed at the quality of benefits provided." The facts in Bauman are again typical in cases involving malpractice claims against an HMO charged with administering an ERISA benefit plan. In accordance with the HMO's policy, Mrs. Bauman was discharged, along with her daughter, from the hospital twenty-four hours after giving birth. The next day the Baumans noticed that the child was ill. In order to make a diagnosis and treatment, the Baumans made several telephone calls to their doctor who did not advise them to bring their daughter back to the hospital. The Baumans also contacted the defendant, requesting an in-home visit by a pediatric nurse; however, a nurse was not provided. Later that day, the infant died from an undiagnosed Group B strep infection that had developed into meningitis.

Subsequently, within a month the Baumans filed an action against U.S. Healthcare in New Jersey state court alleging several state causes of action. In response, the defendant removed the damages were not recoverable under section (a)(3)(B). Id.

25. Corcoran, 965 F.2d at 1338.
27. Bauman, 193 F.3d at 155.
28. Id.
29. Id.
30. Id.
31. Id.
32. Bauman, 193 F.3d at 156. In their first count, the plaintiffs alleged that the HMO
case to the Federal District Court for the District of New Jersey on the ground that ERISA preempted the state action filed by the Bauman's. The Bauman's motioned the district court to remand the case to state court. While the district judge was considering the motions, the defendant moved to dismiss all claims against it because it believed that ERISA completely preempted them. The district judge dismissed one count, and remanded three counts to the state court; the defendant appealed.

In affirming the lower court, the Third Circuit Court of Appeals, relying on an earlier case, drew a distinction between state law claims directed to the quality of benefits provided and claims directed to the quantity of benefits provided. The court noted that often an HMO acts in a dual capacity: one, as administrator of the plan; and two, as a health care provider. When acting as an administrator, the HMO determines eligibility for benefits, calculates benefits, disburses benefits to participants, keeps records, and monitors available funds. State law claims directed to these types of subjects are completely preempted by ERISA; conversely, the HMO acts as a health care provider when it provides or arranges for medical treatment. As a result, the court held that the plaintiff's state law claims were directed at the HMO as a medical provider because the twenty-four hour discharge policy (hospital precertification) "encouraged, pressured, and/or directly" required the 24 hour pre-certified discharge used by the doctor and hospital. The next count alleged that U.S Healthcare acted in reckless disregard for the well being of its members when it implemented its 24 hour discharge policy because it knew that newborns were at risk for developing diseases and the policy would delay treatment.

Perhaps the most significant contribution made by the Dukes opinion was the distinction drawn between (1) state-law claims directed to the quality of benefits provided, which are not completely preempted, and (2) claims that the plans erroneously withheld benefits due or that seek to enforce plaintiffs' rights under their respective plans or to clarify their rights to future benefits, which are subject to complete preemption.

footnotes:
33. Id. at 157.
34. Id.
35. Id.
36. Id.
37. Bauman, 193 F.3d at 161-62. The court relied on Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d. Cir. 1995), where plaintiffs in a consolidated action alleged negligence on the part of the defendant HMO for selection of medical personnel providing care to the plaintiffs. The court held that the plaintiffs were attacking the quality of the care received, not that benefits under the plan were "erroneously withheld." Id. Indeed, the Court of Appeals concluded that:

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footnotes:
38. Id.
39. Id.
policy was a medical determination about the proper standard of care that resulted in the death of the infant, not a claim that a benefit was requested and denied.\textsuperscript{40} Bauman seems to stand for the proposition that an HMO will not be able to completely shield itself from liability, via ERISA, for traditional medical malpractice claims.\textsuperscript{41} Further, it appears that if plaintiffs do not allege in their pleadings that the HMO failed to provide or authorize benefits, the court will likely conclude that ERISA preempts the state law claims.\textsuperscript{42}

When one compares the approach to the ERISA preemption problem taken by the Fifth Circuit Court of Appeals and that taken by the Third Circuit Court of Appeals, the approach of the Third Circuit Court of Appeals appears better reasoned. This is so because ERISA is simply devoid of any substantive regulation of health care. The Act is replete with complicated provisions laying out in painstaking detail various requirements pertaining to employee pension plans. This would indicate that Congress never intended ERISA to have the effect of barring, in effect, state law medical malpractice claims against health insurers.

In sum, recovery under a state law theory of medical malpractice against an HMO will depend largely on what jurisdiction the

\textsuperscript{40} Bauman, 193 F.3d at 163. The court found that as to count one, the plaintiffs pled facts which place it within the quality of care context rather than the quantity of care because the plaintiffs alleged that the hospital's early discharge policy had the effect of not giving the plaintiffs the option of making an informed decision as to whether to pay for the hospitalization out of pocket. \textit{Id.} As to count two of the complaint, the court found that the allegation that the defendant knew that its policy would endanger the lives of children after they left the hospital was sufficient to fall within the quality of benefit context. \textit{Id.} Finally, the plaintiffs contended that "the HMO adopted policies that encouraged pressured, and/or directly or indirectly required their participating physicians to discharge newborn infants and that also discouraged physicians to readmit newborn infants when the appropriate standard of care required otherwise under state law." \textit{Id.} The court concluded that based on these allegations the plaintiffs' theory was within the realm of quality of care provided because it was aimed at a discretionary medical decision rather than an administrative one. \textit{Id.}

\textsuperscript{41} For a recent case, decided December 26, 2000, interpreting ERISA preemption in the Third Circuit, see \textit{Lazorko v. Pennsylvania Hosp.}, 2000 WL 1886619 (3d Cir. 2000). In \textit{Lazorko}, the plaintiff alleged that an HMO's disincentive structure discouraged his wife's doctor from providing her with additional treatment for various mental illnesses. \textit{Id.} As a result, the plaintiff's wife committed suicide. The plaintiff asserted that the HMO was directly and vicariously liable for his wife's death. \textit{Id.} The district court held that ERISA did not preempt the plaintiff's vicarious liability claims, but ERISA did preempt any direct claims against the HMO since those claims were in the nature of a denial of benefits guaranteed by the plan. \textit{Id.} The Third Circuit Court of Appeals reversed, holding that the direct claims "challenge the soundness of a medical decision by a health care provider rather than the administration of benefits under an ERISA plan." \textit{Id.}

\textsuperscript{42} \textit{See id.} at 162. (stating that "It is significant that none of these three counts as pled alleges a failure to provide or authorize benefits under the plan . . . .").
plaintiff is in. Further, since the federal courts are fairly uniform in concluding that extra-contractual damages are not available under the civil enforcement provisions of ERISA, injured parties in those circuits that have adopted a broad view of the preemption clause will be left without a remedy for serious injuries. Consequently, HMO’s in jurisdictions that favor broad preemption will be able to use ERISA as a shield of immunity against claims for medical malpractice, thus providing an incentive to place a higher premium on cost containment than patient care. As a result, the two primary goals of Congress in enacting ERISA, protection of plan beneficiaries and uniformity of law, will not be met. Part II of this paper will explore how several federal circuit courts of appeals have responded to this apparent dichotomy by upholding actions against HMO’s for breach of fiduciary duty under ERISA.

PART II. ACTIONS UNDER ERISA

Perhaps in response to the inequity involved in cases like Corcoran, in 1997 in Shea v. Esensten, the Eighth Circuit Court of Appeals held that an HMO could be liable for breach of a fiduciary duty under ERISA for failing to disclose financial incentives. In Shea, the plaintiff was the widow of a deceased plan participant of an HMO that administered an ERISA health plan. The plaintiff’s husband went to his primary care physician complaining of chest pains, difficulty breathing and dizziness. The physician refused to refer Mr. Shea to a cardiologist, even after Mr. Shea offered to pay for the specialist himself. Apparently discounting Mr. Shea’s extensive family history of heart disease, his physician told him that, first, he was too young for a referral, and, second, he “did not have enough symptoms to justify a visit to a cardiologist.”

Mr. Shea did not know that his HMO, by the terms of its contract with his primary care physician, gave financial incentives to primary care physicians for not making referrals to specialists. Furthermore, the contract also provided that the primary care physician would be penalized financially if he made too many referrals to specialists. Several months later Mr. Shea died of

44. Id. at 626
45. Id.
46. Id.
47. Id.
48. Shea, 107 F.3d at 627.
49. Id.
massive heart failure. Mr. Shea's widow filed a wrongful death claim against the HMO in state court. The HMO removed the case to federal court; Mrs. Shea filed an amended complaint alleging that the HMO violated its fiduciary duty under ERISA by implementing the secret financial incentive structure. The trial court dismissed the complaint for failure to state a claim.

The Eighth Circuit Court of Appeals reversed the trial court, holding that "when an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties." In reaching its holding, the court noted that ERISA requires plan fiduciaries to act solely in the interests of plan beneficiaries. In addition, Judge Fagg, writing for the majority, opined that ERISA fiduciaries owe beneficiaries the common law duty of loyalty which requires a fiduciary "to communicate any material facts which could adversely affect a plan member's interest." The court continued and noted that the salient

50. Id. at 626.
51. Id. at 627.
52. Id.
53. Shea, 107 F.3d at 627. The plaintiff filed a motion to remand the action to state court, which was denied by the district court. She then filed an amended complaint where she alleged that the HMO's "behind the scenes efforts" to reduce covered referrals violated the HMO's fiduciary duties under ERISA. Id. The district court held that the financial incentive scheme involved was not a "material fact affecting a beneficiary's interests"; therefore, the court dismissed the action on a FED. R. CIV. P. 12(b)(6) motion by the defendant. Id.
54. Id. at 629. It should be noted here that the court of appeals agreed with the district court that ERISA completely preempted the plaintiff's state law cause of action. The court of appeals held that the plaintiff's tort claims against the HMO were completely preempted because ERISA supercedes state law insofar as it "relates to any employee benefit plan." Id. at 627 (quoting 29 U.S.C. § 1144(a)). The court observed, "to this end, the language of ERISA's preemption clause sweeps broadly, embracing common law causes of action if they have a connection with or a reference to an ERISA plan." Id. The fiduciary duties are prescribed by section 1104 of ERISA that provides in pertinent part:

Subject to sections . . . a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) with the care, skill, prudence, and diligence . . . that a prudent man . . . would use in the conduct of an enterprise of like character and with like aims . . . .
55. Id. at 628 (quoting 29 U.S.C. § 1104(a)(1) (1994)).
56. Id. In characterizing ERISA's fiduciary standard, the court relied on an earlier case, Varity Corp. v. Howe, 116 S. Ct. 1065 (1996), for the proposition that ERISA fiduciaries must comply with the common law duty of loyalty, which includes fair dealing and honesty with respect to plan members. Id. The court also relied on precedent from the D.C. Circuit Court
incentives involved were material because the patient relied on his doctor's advice, and in order for the patient to make an informed decision he would have to know if his doctor's advice was affected by other forces. The court did not discuss the type of damages recoverable by Mrs. Shea. This case indicates a willingness on the part of some federal courts, seemingly frustrated with ERISA preemption relating to medical malpractice claims, to entertain suits against HMO's under ERISA itself.

However, the Shea decision has not been met with widespread acceptance. Indeed, the Fifth Circuit Court of Appeals recently rejected the Shea court's holding in Ehlman v. Kaiser Foundation Health Plan of Texas. In Ehlmann, the court held that ERISA did not impose a duty on HMO's to disclose their physician incentive plans because the text of the statute does not specifically impose the disclosure of physician compensation schemes. The court reasoned that since the statute contained numerous other disclosure provisions, the failure to place physician incentives among these illustrates that Congress could not have intended ERISA to require an HMO to disclose its physician compensation plans. Furthermore, the court criticized the Shea court's reasoning because it failed to engage in a statutory analysis to ascertain the intent of Congress with respect to fiduciary reporting requirements.

In contrast, the Seventh Circuit Court of Appeals attempted to expand the possible range of liability against an HMO for breach of

of Appeals. In Eddy v. Colonial Life Ins. Co. of America., 919 F.2d 747, 750 (D.C. Cir. 1990), the court held that "the duty to disclose material information is the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA." 57. Shea, 107 F.3d at 628-29. The language of the court was particularly strong as Judge Fagg concluded that "this kind of patient necessarily relies on the doctor's advice about treatment options, and the patient must know whether the advice is influenced by self serving financial considerations created by the health insurance provider." Id.

58. Id. at 629.

59. 198 F.3d 552, 555 (5th Cir. 2000).

60. Id. at 555. The court reasoned that ERISA makes specific provisions for HMO's to disclose various items; therefore, because physician compensation schemes are not mentioned in them, Congress did not intend to impose that particular duty on HMO's. Id. See 29 U.S.C. §§ 1021-31 (1994).

61. Id. The court concluded that "it is for Congress to determine whether to impose such a duty to disclose under ERISA and this court will not encroach on that authority by imposing a duty which Congress has not chosen to impose." Id.

62. Id. at 556. In construing ERISA, the court reasoned that because ERISA included numerous reporting requirements, the fact that an incentive disclosure structure of the type at issue was not included indicates that Congress never intended ERISA to impose such a duty.
a fiduciary duty in *Herdrich v. Pegram*. The court held that plan administrators breach a fiduciary duty under ERISA when the incentive structure created destroys the fiduciary trust between plan participants and plan fiduciaries by causing doctors to withhold care that would decrease the doctors' profits. The *Herdrich* case involved the same basic fact situation as the cases discussed to this point. In essence, the plaintiff was forced to wait eight days before undergoing a medical examination, so that she could be cared for at the HMO's hospital, even though an ultra-sound examination was certainly necessary after her doctor discovered a large mass in her lower stomach. The mass was the plaintiff's inflamed appendix, which subsequently ruptured during the eight day wait for tests causing a dangerous condition known as peritonitis. The plaintiff survived, and shortly thereafter brought suit against her doctor for negligence and against the HMO under an Illinois consumer fraud statute.

This is where the instant case departs from the prior cases discussed herein because the doctors who owned the practice where the plaintiff's doctor saw her were the same people who oversaw the HMO that the plaintiff belonged to. Therefore, the physicians were in total control of the incentive structure created by the HMO. Indeed, the incentive was a year-end bonus paid to the physicians if the annual expenditures of the plan were less than total plan receipts. Therefore, the plaintiff's doctors could realize a direct financial benefit if they were able to limit referrals and the use of "out of plan" facilities by members of the plan. In other words, the plaintiff's health care providers assumed a dual role: first, as a health care provider, and, second, as an HMO administrator.

Predictably, the defendant HMO removed the case to federal court arguing that the state law fraud claims against it were preempted by ERISA. The trial court gave leave to the plaintiff to

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64. Id. at 373.
65. Id.
66. Id.
67. Id. at 365-66.
68. *Herdrich*, 154 F.3d at 370.
69. Id.
70. Id. at 372.
71. Id. at 373.
72. Id. at 366.
amend her compliant as to the state fraud counts. In response, the trial court granted the HMO's motion to dismiss the claim on the ground that the amended complaint failed to state a claim for which relief could be granted. The plaintiff appealed the dismissal of the ERISA claim to the Seventh Circuit Court of Appeals.

The court of appeals noted that in order for a plaintiff to state a claim for breach of fiduciary duty under ERISA, the plaintiff must show that the defendants are plan fiduciaries who breached their fiduciary duties causing a loss. Judge Coffey, writing for the majority, began by addressing whether the defendants were plan fiduciaries under ERISA. The key in determining fiduciary status is the amount of discretionary control and authority retained by the fiduciary. In the instant case, the defendants had the exclusive right to decide all claims; therefore, it was difficult for the defendants to deny that they were not plan fiduciaries. Further, the majority observed that the defendants, in removing the case to federal court, claimed that they were fiduciaries under ERISA; however, on appeal the defendants claimed that they were not fiduciaries under ERISA. Judge Coffey concluded that the defendants were, in fact, fiduciaries under ERISA.

In the instant case, the court correctly concluded that the defendants clearly breached their fiduciary duty to the plaintiff because the defendants acted in their own pecuniary interests rather than in the interests of plan beneficiaries. Section 1104 of ERISA sets the standard of care a fiduciary must maintain. Federal courts have consistently held that this section imposes on the fiduciary the duty to act solely in the interests of plan beneficiaries.

73. Herdrich, 154 F.3d at 367.
75. Herdrich, 154 F.3d at 367.
76. Id. at 369.
77. Id. ERISA provides in pertinent part:
Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets . . . or (ii) he has any discretionary authority or discretionary responsibility in the administration of such plan . . . .
78. Herdrich, 154 F.3d at 370.
79. Id.
80. Id. at 369 n.5.
81. Id. at 371.
82. See supra note 53 and accompanying text.
beneficiaries.\textsuperscript{83} It would be difficult to imagine that by withholding benefits under the plan in order to increase their bonuses, the physicians were acting solely in the interests of plan participants. As a result, actions of this nature necessarily breach the fiduciary duty that ERISA imposes. To make out an effective claim, however, a plaintiff must also allege that the \textit{plan} incurred a loss.

ERISA permits a plaintiff to bring a claim for losses to a plan, itself, as a result of the breach of a fiduciary duty.\textsuperscript{84} Section 1109 of ERISA provides that a fiduciary is personally liable for losses to the plan due to the fiduciary's breach.\textsuperscript{85} In the instant case, Judge Coffey held that the plaintiff did allege that the plan suffered a loss (assets paid to the physicians for bonuses) due to the defendant's breach.\textsuperscript{86} As a result, the plan was deprived of supplemental medical expenses that were paid to the physicians which could have been invested by the plan. In sum, the Seventh Circuit Court of Appeals made a valiant effort to attach liability under ERISA to an HMO for breach of fiduciary duty. The defendant appealed the Seventh Circuit's decision to the United States Supreme Court.\textsuperscript{87}

On February 23, 2000, the Supreme Court heard oral arguments in \textit{Herdrich}.\textsuperscript{88} The theory espoused by the defendants aptly illustrates why these malpractice claims belong in state court and, consequently, why ERISA's preemption analysis should be interpreted under the \textit{Bauman} standard. Interestingly, the thrust of the HMO's oral argument was that it was not a plan fiduciary.\textsuperscript{89} Justice Ginsburg pointed out that in removing the case from state court the defendants argued that they were plan fiduciaries, thus providing the grounds for preempting the plaintiff's state law claims under ERISA.\textsuperscript{90} Counsel for the defendant argued that the defendant conceded it was an ERISA fiduciary only for the purpose

\textsuperscript{83} See Anweiler v. American Elec. Power Serv. Corp., 3 F.3d 986, 991-92 (7th Cir. 1993) (holding defendants breached fiduciary duty under ERISA by failing to disclose material information concerning reimbursement under a pension plan).

\textsuperscript{84} See supra note 15 and accompanying text. See also Harsch v. Eisenberg, 956 F.2d 651, 657 (7th Cir. 1992).

\textsuperscript{85} 29 U.S.C. § 1109(a) (1994) (stating in part, "Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries . . . shall be personally liable to make good to such plan any losses to the plan resulting from each such breach . . . .”).

\textsuperscript{86} \textit{Herdrich}, 154 F.3d at 380.

\textsuperscript{87} \textit{Herdrich} v. Pegram, 154 F.3d 362 (7th Cir. 1998), \textit{cert granted}, 120 S. Ct. 10 (1999).


\textsuperscript{89} \textit{Id.}

\textsuperscript{90} \textit{Id.}
of removing the case to federal court, not for the purposes of the merits of the plaintiff's amended complaint.\(^9\) In other words, the HMO should be able to have its cake and eat it.

On June 12, 2000, the Supreme Court issued its decision in *Herdrich*.\(^9\) Justice Souter delivered the unanimous opinion of the Court, holding that the treatment decisions made by an HMO acting through its physician employees were not fiduciary acts within the meaning of ERISA.\(^9\) Specifically, the Court held that mixed questions of eligibility and treatment by HMO doctors are not fiduciary duties under ERISA.\(^9\) Therefore, the defendant could not have breached a fiduciary duty under ERISA.

In reaching its holding, the Court noted that Congress did not intend an HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions.\(^9\) However, the Court did not reach this conclusion by relying on the legislative history of ERISA. Rather, the Court concentrated on the public policy implications of holding that a mixed eligibility/determination falls within the ambit of a fiduciary act under ERISA.\(^9\) Justice Souter pointed out that

\(^9\) Id.
\(^9\) *Pegram* 120 S. Ct. at 2146. Justice Souter began his opinion with a plea to Congress to take action. Specifically, he observed:

But whatever the HMO, there must be rationing and inducement to ration. Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others . . . any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk. A valid conclusion of this sort would, however, necessarily turn on facts to which courts would probably not have ready access: correlations between malpractice rates and various HMO models, similar correlation involving fee-for-service models, and so on. And, of course, assuming such material could be obtained by courts in litigation like this, any standard defining the unacceptably risky HMO structure . . . would depend on a judgment about the appropriate level of expenditure for health care in light of the associated malpractice risk. But 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. The very difficulty of these policy considerations, and Congress' superior institutional competence to pursue this debate, suggest that legislative not judicial solutions are preferable.

*Id.* (citations omitted).

\(^9\) Id. at 2156. Mixed eligibility decisions refer to decisions made regarding treatment and eligibility for benefits. *Id.*

\(^9\) See *id.* at 2156 (stating that "our doubt that Congress intended the category of fiduciary administrative functions to encompass the mixed determinations at issue here hardens into conviction when we consider the consequences that would follow from Herdrich's contrary view.").
taken to its logical end, liability for breach of fiduciary duty would attach whenever an HMO had a profit incentive to ration care that affected mixed decisions.\textsuperscript{97} As a result, according to the Court, if the lower court's decision was allowed to stand, it would prompt an upheaval in the HMO system in the United States by effectively putting HMO's out of business.\textsuperscript{98} This result would be contrary to the congressional policy of promoting HMO's.\textsuperscript{99}

It seems inconceivable that the defendant could argue that it is an ERISA fiduciary for purposes of defeating the plaintiff's state law claim, but, once in federal court, argue that it cannot be liable for breach of a fiduciary duty under ERISA because it is not a fiduciary. This argument illustrates how ERISA, as applied to HMO's in malpractice cases, has evolved into nothing short of a broad shield of tort immunity that is used for purposes of defeating otherwise viable state law claims. When this is coupled with ERISA's almost complete lack of health care regulation, only one conclusion can be drawn. A scheme has evolved that is teeming with inequity and cries out for action by Congress.\textsuperscript{100}

Judicial expansion of liability under ERISA for breach of fiduciary duty would be tenuous at best due to the nature of the recovery permitted. As discussed above, the fiduciary would not be liable to any one specific beneficiary for damages resulting from the breach. This failure of ERISA to provide damages to an aggrieved party is an inherent weakness in breach of fiduciary duty claims under ERISA and stands in stark contrast against traditional state law negligence or fraud claims that provide for extracontractual damages. Because a beneficiary who has been personally injured may not recover personally, he or she will be deprived of compensation for any damages that were sustained.

In contrast, however, the claim for breach of fiduciary duty could be a useful tool in deterring substandard medical decision-making. Because fiduciaries would be personally liable for losses to the plan, they would presumably have an increased incentive to make reasonable medical decisions thereby avoiding the tragedies discussed earlier in this article. Additionally, breach of fiduciary duty claims would provide nationwide uniformity among claims.

\textsuperscript{97} Pegram, 120 S. Ct. at 2156.
\textsuperscript{98} Id. at 2156-58
\textsuperscript{99} Id. at 2156-57.
\textsuperscript{100} See Goodrich v. Aetna, 1999 WL 181418 ( awarding over 120 million dollars against an HMO for failing to provide cancer treatment to plaintiff; allowed because the plan (government sponsored) did not fall within the scope of ERISA).
against HMO's for negligence. However, it is difficult to reconcile these two types of claims because negligence law and the law of fiduciary duty via trusts are two distinct substantive bodies of law. Therefore, it would be difficult to convert what is in essence a negligence claim to a breach of fiduciary duty claim under ERISA.

PART III

A. The Congressional Response or Lack Thereof

None of this has escaped the attention of Congress where several bills have been introduced over the last two sessions that in one guise or another seek to amend ERISA to permit suits against HMO's. Senator Durbin introduced the most cogent bill, S.1136, in the Senate in 1997.101 The finding and purpose section of the bill stated that patients have been left without a remedy for medical malpractice in jurisdictions that have adopted a broad view of ERISA preemption.102 Furthermore, the findings section also states that physicians' behavior is affected by employer-sponsored health insurers' coverage determinations.103 Therefore, the Senator concluded that in order to restore accountability to HMOs, ERISA must be amended.104 Specifically, S.1136 would simply add a paragraph to section 1144(b) of ERISA with language expressly permitting a state cause of action for medical malpractice, personal injury, or wrongful death against any entity that provides health insurance.105 Unfortunately, S.1136 died in the Labor and Human Resources Committee in 1997. However, there is no shortage of proposed legislation in both houses of Congress. Each political party had its own version of bills that would amend ERISA as part of comprehensive "Patients' Bills of Rights."106 However, neither bill

102. Id. § 2.
103. Id.
104. Id. § 3.
105. S.1136, 105th Cong. § 3(a) (1997).
106. See Patients Bill of Rights Act, S.3058.2990, 106th Cong. (2000). S.3058 was introduced in the Senate by Senator Kennedy and proposes to amend section 1144 of ERISA by adding the following subsection:

(f) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS-(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION-(A) IN GENERAL-Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary . . . under State law to recover damages resulting from personal injury or for wrongful death against any person—(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan as defined in section 733, or (ii) that arises out of the
survived the 106th Congress. This result is interesting in light of the fact that a recent poll indicates that 77% of Americans said that "they support changing federal law to allow patients to sue HMOs when they are injured by negligent decisions or cost containment actions."107

B. The State Response

While any meaningful federal legislation addressing the ERISA problem was mired in Congress, several states took action and passed comprehensive patients' bills of rights. The Texas legislature, to its credit, took the lead and passed the nation's first patient bill of rights. President, then Governor, Bush signed the bill into law in 1997. The Texas Health Care Liability Act provides a direct cause of action against an HMO for negligent health care treatment decisions and for the negligence of its member physicians.108 The statute carefully avoids ERISA preemption

arrangement by such person of the provision of such insurance, administrative services, or medical services by other persons.

Id.

The Patients' Bill of Rights Plus Act of 1999, S.1344, 106th Cong. S.1344 was introduced in the Senate by Senator Lott. Senator Lott's bill does not provide for amending ERISA to permit state law causes of action, but rather proposes a stringent regulatory scheme that provides for grievances and appeals of adverse coverage decisions made by HMO's. Senator Lott's amendment provides in pertinent part:

SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINATION, GRIEVANCES AND APPEALS. (a) CLAIMS PROCEDURE-In accordance with regulations of the Secretary, every employee benefit plan shall—(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Id.

These two provisions illustrate the divergence of opinion within the legislature with respect to the approach to be taken in holding HMO's accountable for decisions that are made in the course of making coverage determinations.


108. TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (West 2000). The statute provides in pertinent part:

(a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care. (b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its: (1) employees;
problems because it does not seek to apply the negligence standard to treatments not covered by the plan. For example, an HMO would not be held to the standard of ordinary care for a decision not to provide a certain type of treatment within the scope of its policy. One cannot escape the fact that the language of the statute is a logical corollary to the approach taken concerning mixed eligibility decisions as formulated by the Third Circuit Court of Appeals because the statute seemingly will hold an HMO liable for its negligence and the negligence of its employees/agents with respect to medical decisions, but does not include eligibility decisions under the plan. Not surprisingly, HMO's in Texas were ready to mount a challenge to the new statute.

That challenge came soon after the statute went into effect in Corporate Health Insurance, Inc. v. Texas Department of Insurance. In Corporate Health, the plaintiff insurance companies brought a declaratory judgment action arguing that the liability provisions, among other provisions in the statute, were preempted by ERISA. The district court granted Texas's motion for summary judgment with respect to the liability provisions of the statute, while denying summary judgment on other challenged provisions. The plaintiffs appealed to the Fifth Circuit Court of Appeals.

In a stunning decision, the Fifth Circuit upheld the liability provisions in the statute. In its analysis, the court concluded that the liability provisions of the statute were not preempted by ERISA because the statute only imposes liability "for a limited universe of events." Those events do not include coverage determinations made by plan administrators. Next, the court seemed to adopt the reasoning of the Third Circuit Court of Appeals when it drew a distinction between HMO's acting as plan administrators and HMO's

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(2) agents; (3) ostensible agents; or (4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised control which result in the failure to exercise ordinary care.


109. The statute provides in part: the standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity. See id. § 88.002 (d).


111. Corporate Health, 12 F. Supp. 2d 597. The plaintiffs included Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc., Aetna Plans of North Texas, Inc. and Aetna Life Insurance Company. The plaintiffs also sought an injunction barring the state insurance commissioner from enforcing the statute. Id.

112. Corporate Health Ins., Inc. v. Texas Dep't of Ins., 215 F.3d 526 (5th Cir. 2000).
acting as medical service providers. Once the court made this distinction, it was relatively simple for the court to conclude that the liability provisions were not preempted by ERISA because the statute carefully excluded "a duty to provide treatment not covered by the plan." Interestingly, the court made only passing reference to Corcoran in this regard. Finally, the court noted that suits for malpractice against a doctor are not preempted by ERISA because the doctor is in a provider network; therefore, an HMO should not be shielded by ERISA from the liability of its agents. Perhaps the Texas Health Care Liability Act was the legislative response, albeit in a different guise, that the Corcoran court was looking for.

CONCLUSION

The Corcoran court concluded that "fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA . . . . [O]ur system, of course, allocates this task to Congress, not the courts." It is doubtful that the framers of ERISA intended the statute, designed to provide comprehensive federal protection to employee pensions, to be used as a shield from tort immunity by health insurers in medical malpractice cases resulting in injured people being wholly deprived of state or federal remedies for their injuries. Therefore, in order to rectify this error, Congress must develop the courage to amend the preemption provision of ERISA to permit state law causes of action against HMO's, or in the alternative, to develop comprehensive legislation that effectively regulates HMO's. Amending the preemption provisions of ERISA would provide the least amount of change to ERISA, and yet produce the equity and uniformity that the current managed care system is lacking.

However, because congressional action is not likely in the near future, the most appropriate response to the preemption problem is for the states to take action similar to that taken by Texas. A state statute subjecting HMO's to essentially a negligence cause of action in instances provided for in the Texas legislation, or alternatively

113. Id. at 534. The court noted, citing Dukes v. U.S. Healthcare, Inc., that "courts have observed that HMOs . . . typically perform two independent functions—health care insurer and medical care providers." Id. The court, relying on Dukes, noted that ERISA's broad preemption clause was not intended by Congress to "supplant" state regulation that is directed to the quality of medical practice.

114. Corporate Health, 215 F.3d at 534.

115. Id. at 535.

by the Third Circuit Court of Appeals, would effectively correct the current abuses taking place in those circuits that have adopted a broad theory of preemption under ERISA.

_Todd A. Portzline_