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Florida Law Review

Founded 1948

Formerly

University of Florida Law Review

VOLUME 53 JANUARY 2001 NUMBER 1

MANAGED CARE LIABILITY FOR BREACH OF FIDUCIARY DUTY AFTER *PEGRAM v. HERDRICH*: THE END OF ERISA PREEMPTION FOR STATE LAW LIABILITY FOR MEDICAL CARE DECISION MAKING

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I. INTRODUCTION

When the Supreme Court announced its unanimous verdict in *Pegram v. Herdrich*,[1] a case concerning the rights of a plaintiff to sue an Health Maintenance Organization (HMO)[2] in federal court under the Employee Retirement Income Security Act of 1974 (ERISA),[3] the media haled it a victory for the managed care industry.[4] The plaintiff, Cynthia Herdrich, alleged that the HMO bribed its physicians with a financial incentive plan that induced them to deny her needed care to save the plan money.[5] She sued the HMO for breaching its ERISA fiduciary duty.[6] In finding for the defendant HMO, the Court held that the HMO was not the ERISA plan and that its medical treatment decisions were not governed by ERISA fiduciary

1. 120 S. Ct. 2143 (2000).

2. Health Maintenance Organization, is an insurance business structure for reimbursing the cost of medical services. While the generally accepted term is MCO (managed care organization) this paper will follow the Supreme Court's use of HMO.

3. Employee Retirement Income Security Act of 1974 , 29 U.S.C. §§ 1001 *et seq.* (2000).

4. Jane Crawford Greenburg, *Court Spares HMO from US Suits*, CHI. TRIB., June 13, 2000, at A1 ("In a resounding victory for the managed care industry, the U.S. Supreme Court unanimously ruled Monday that a former legal secretary could not use a federal law to sue her Illinois HMO for offering its physicians financial incentives to keep down costs.").

5. *Pegram*, 120 S. Ct. at 2147.

6. *Id.*

duty provisions.[7] HMO stocks immediately soared[8] because the Court's opinion took notice that while there are risks associated with rationing medical care,[9] "no HMO organization could survive without some incentive connecting physician reward with treatment rationing."[10] Further, the court was not prepared to adjudicate the wisdom of medical care rationing.[11] The Court's language clearly removes the threat of ERISA fiduciary liability for managed care decisionmaking.[12]

While *Pegram* is the first decision by the Supreme Court to directly consider a plaintiff's claim that the routine business practices of the HMO industry violated ERISA's standards for fiduciary conduct,[13] we question

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7. *Id.* at 2151.

8. High court rules patients cannot use federal law to sue HMOs over doctor bonuses. www.kcstar.com 6/13/00 (Cigna jumped 21/4 to 903/4. Aetna, which was upgraded by Salomon Smith Barney on Monday, rose 31/4 to 705/8.). *Cf.* Bruce Jaspen, *Illinois HMO Profits Ailing*, CHI. TRIB., Dec. 1, 1999, at B1 (noting that HMO profitability was depressed for several reasons including failure to control costs).

9. *Pegram*, 120 S. Ct. at 2150 ("rationing necessarily raises some risks while reducing others (ruptured appendixes are more likely; unnecessary appendectomies are less so)").

10. *Id.*

11. *Id.* ("[A]ny 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 correlations involving fee-for-service models, and so on.").

12. *Pegram* has far reaching business implications because virtually all of the medical insurance provided by employers is covered by ERISA. An important exception includes medical insurance coverage for workmen's compensation and church plans. 29 U.S.C.S. § 1003 (1997).

> Coverage (a) Except as provided in subsection (b) and in sections 201, 301, and 401 [29 USCS §§ 1051, 1081, and 1101], this title shall apply to any employee benefit plan if it is established or maintained—(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or (3) by both. (b) The provisions of this title shall not apply to any employee benefit plan if—(1) such plan is a governmental plan (as defined in section 3(32) [29 USCS § 1002(32)]); (2) such plan is a church plan (as defined in § 3(33) [29 USCS § 1002(33)]) with respect to which no election has been made under section 410(d) of the Internal Revenue Code of 1986 [26 USCS § 410(d)]; (3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws; (4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or (5) such plan is an excess benefit plan (as defined in § 3(36) [29 USCS § 1002(36)]) and is unfunded.

29 U.S.C.S. § 1003 (1997).

13. No Supreme Court case has thus far addressed the issue of bodily injury or wrongful death arising from the administrative malfeasance of an ERISA plan. Several such cases have been

whether the stock market analysts are correct that the Supreme Court has immunized HMO business practices. It is the premise of this Article that in its holding, the *Pegram* Court also removed the ERISA preemption bar to state law claims for medical malpractice and breach of state fiduciary law. Paradoxically then, although the defendant HMO in *Pegram* won, the managed care industry lost.

In Part II, we review how the HMO industry was initially able to mold ERISA's preemption of state law into a shield that provided the industry with protection from liability when it denied needed medical care and how this has been narrowed by *Pegram*. In Part III, we explore the implications of the *Pegram* rationale for why HMOs are not liable for breach of ERISA statutory fiduciary duties and how this triggers liability for state law claims. HMO medicine has unique features—such as allowing medical decisions to be made remote from a patient's bedside—that do not fit well into state medical malpractice law and are better analyzed under common law, as opposed to ERISA, fiduciary duty theory. Consequently, application of state tort law may become quite complex. We conclude that after *Pegram*, HMOs will be subjected to increased litigation under both of these areas of state law.

The common thread in this analysis is that medical care decisionmaking is ultimately made by individual physicians who are subject to claims under state tort and fiduciary law. To the extent that these physicians are controlled by an HMO or other managed care organization, that entity will be legally responsible for the physician's actions through vicarious liability or through agency theory.[14] All managed care depends on controlling physician behavior, either directly or through physician medical directors, thus regulation of the behavior of these physicians will regulate the managing of patient care. We recognize, however, that this is only relevant to plans that seek to manage medical decisionmaking. Plans may escape this regulation by limiting their role in the decisions about individual patients and the quality of individual patient care, as did insurers before the advent of managed care. To the extent that this disengagement frees physicians to exercise their own conscience about medical care decisionmaking, it can improve patient care. To the extent that it results in shifting the risk of insurance to physicians without regard to their

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denied certiorari, including *Weems v. Jefferson-Pilot Life Ins. Co.*, 663 So. 2d 905 (Ala.), *cert. denied*, 516 U.S. 971 (1995). In *Weems*, the Supreme Court let stand an Alabama Supreme Court decision upholding a breach of fiduciary duty action under ERISA based on injuries to the plaintiff caused by an employer's failure to pay insurance premiums. Further, the Alabama Supreme Court held that breach of the ERISA fiduciary duty can support punitive damages and held that state courts may try such cases. *See id.*

14. While this Article is written in terms of physicians, the same theories apply to other health care professionals to the extent that state law allows them to make impendent medical decisions.

competence and performance, it will hurt the quality of patient care. For these reasons, we conclude that the most important consequence of *Pegram* is the empowerment of state regulators.

II. HMO HEALTH CARE DELIVERY LOSES THE ERISA PREEMPTION SHIELD

On Labor Day 1974, President Ford signed the Employee Retirement Income Security Act [ERISA] to facilitate contracting for national employers by eliminating the need to have to contemplate fifty different state laws. To achieve such a goal, ERISA preempted all state law that "related to" an employee health or welfare plan.[15] But within a decade of ERISA's passage, double-digit medical expense inflation under the prevailing fee-for-service [FFS] reimbursement system pushed health care costs to prohibitive levels for American businesses.[16] In an attempt to resolve such medical inflation, the nation embraced managed care–the delivery of health care modulated by utilization review and financial incentives as the method to reduce medical costs. Stimulated by new demand, the insurance industry produced a number of managed care products of which the quintessential is the HMO. HMOs are the most aggressive in applying utilization review and financial incentives to control medical costs. Additionally, an HMO operating under ERISA had a competitive advantage in the market place because ERISA's preemption of state tort law served to shield the HMO from liability from medical malpractice claims. Soon the majority of medical insurance products offered by employers, as part of a benefit package, were HMOs organized under ERISA.[17]

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15. 29 U.S.C.A. § 1144(a) (West 2000).

16. Before the 1970s, medical decisionmaking was driven by the Hippocratic ideal of providing the patients with the smallest of benefits regardless of cost. Unfortunately, this maxim becomes unrealistic in a world where supplies are limited and medical costs are skyrocketing. Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 435 (1988). In the seventies, the bills of the Great Society and the Vietnam War became past due, thereby producing an inflationary pressure on the American economy. Medical inflation was further aggravated by an Arab oil embargo. All costs rose; and medical costs in particular. To help curb medical costs President Nixon signed the HMO Act in 1973 (42 U.S.C. 300e-10). The following year President Ford signed ERISA which provided that qualified medical plans would be immune from state malpractice laws, and thereby acquire an economic advantage over non-qualified plans. *See* Edward P. Richards & Thomas R. McLean, *Physicians in Managed Care: A Multidimensional Analysis of New Trends in Liability and Business Risk*, 18 J. LEGAL MED. 443 (1996).

17. Edward B. Hirshfield *et al.*, *Structuring Provider-Sponsored Organizations*, 20 J. LEGAL MED. 297, 300 (1999) (citing Levit *et al.*, *National Health Spending Trends in 1996*, 17 HEALTH AFF. 35, 36 (1998)) (Presently, ERISA organized HMOs account for 60% of the non-Medicare

ERISA's preemption of state law meant that any state tort law, including medical malpractice, that "related to" an ERISA plan was preempted.[18] Accordingly, in the early years of managed care, the courts had to determine whether a denial of care decision was a utilization of benefits decision (hence "related to" the ERISA plan) or medical malpractice (that was not "related to" the plan). The first courts to tackle this problem viewed a denial-of-care decision to be a utilization review decision by the ERISA plan, and not a source for medical malpractice.[19] This freedom from medical malpractice liability gained by an HMO under ERISA provided a qualified employer benefit plan with a competitive advantage in the market place because the HMO would not have to purchase insurance coverage.[20] Because individual state tort law interference with the operation of a national employer's plan was precisely the evil that ERISA sought to prevent through the use of preemption, as applied to health care, ERISA preemption was soon used as a shield to protect the HMO from exposure to medical malpractice liability.

Thus, the perceived "positive" of cost efficient managed care was that it would control medical inflation and therefore help to make national employers more cost competitive in the new global market. However, the downside of more "cost efficient" health care[21] is that managed care is

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insurance market.).

18. *See, e.g.*, Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985) (finding no implied right to private action); Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983) (deciding that ERISA preempts New York human rights law).

19. The leading cases holding denial of utilization review are *Wickline v. State*, 239 Cal. Rptr. 810 (Ct. App. 1986) and *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

20. Richards & McLean, *supra* note 16, at 451.

21. Whether managed care provides for more cost efficient health care delivery is debatable. Alice A. Noble & Troyen A. Brennan, *The Stages of Managed Care Regulation: Developing Better Rules*, 24 J. HEALTH POL. POL'Y & L. 1275 (1999) (discussing consumer backlash when managed care products fail to control cost and provide what is conceived to be less than ideal care); William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1704 (1999) ("Not surprisingly, corporate intrusion into health care decisions turned out to be as unpalatable as government intervention, prompting the current backlash against managed care and renewing interest in preserving professional ideals through regulation. Rather than asserting an alternative paradigm, this most recent upheaval is searching for a way to manage managed care–to control cost and maintain access without leaving life-and-death decisions to executives and accountants."); Charles Van Way, *Death of Managed Care?*, METROPOLITAN MEDICAL SOCIETY OF GREATER KANSAS CITY BULLETIN, Mar. 2000, at http://www.metromed.org/ ("It is a central assumption of the Great Health Care Revolution that medical care can be managed. So we have tried. We've tried very hard. A lot of businessmen and managers have become wealthy, but has it worked? Well, no. It's failed. In fact, it's failed in a spectacular enough fashion to seriously annoy the voting public."); Thomas M. Burton, *Examining the Table: Operation that Rated Hospital Was a Success, but the Patient Died*, WALL ST. J., Aug. 23, 1999, at A1. (If there was a true crisis in the delivery of heath care in America, i.e. a true demand for "quality" health care, it would be provided, perhaps at a higher cost, but in many cases

perceived to distort the loyalty of the physician providers.[22] Under fee-for-service reimbursement, the traditional theory was that the interests of the doctor and patient were aligned; thus, more medical care was seen by both the patient and the physician to be good medical care.[23] Patients appreciated the extra attention, while the physicians received lavish remuneration. In contrast, under managed care, the interests of the doctor and patient are clearly disassociated. In fact, the doctors' and patients' interests have become "triangulated" such that the third corner of the triangle is occupied by an HMO.[24] The addition of the HMO to the doctor-patient relationship inexorably produces a paradigm shift in the relation of the doctor to the patient, which undermines the relationship of trust between the doctor and the patient.[25] Ultimately, whether a particular patient is over or under treated rests upon the professional integrity of the treating physician.[26]

Congress in 1974, which had only the year before passed measures to aid the infant manage care industry,[27] could not have imagined that the enactment of ERISA could distort the fundamental unit of health care delivery, that is, the doctor-patient relationship. But by the mid-1990's, the implications of the Supreme Court's expansive view of "related to" as a trigger for ERISA preemption[28] was recognized in multiple industries.[29]

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it could be done at the same or lower costs–if the plans had a long enough time horizon so that the full costs of improvident short term cost saving strategies were incorporated in the plan costs.).

22. Neade v. Portes, 710 N.E.2d 418 (Ill. App. Ct. 1999); Herdrich v. Pegram, 154 F.3d 362 (7th Cir. 1998); Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997); Lancaster by Lancaster v. Kaiser Found. Health Plan, 958 F. Supp. 1137 (E.D. Va. 1997).

23. In practice, more care is not necessarily good care, since it might place the patient at needless risk because the physicians might have a financial incentive to perform care that was beyond their expertise. Also, even if arguably medically necessary, the care might be unwanted but accepted anyway because many patients have trouble resisting the moral authority of their physician. *See* Elliot S. Fisher & H. Gilbert Welch, *Avoiding the Unintended Consequences of Growth in Medical Care*, 281 JAMA 446-53 (1999).

24. Richards & McLean, *supra* note 16, at 447-50 (providing a more detailed discussion of the structure and functioning of managed care organizations).

25. Evidence that patient's need to have trust in their physicians may be observed in the public's favorable response to US Healthcare's granting physicians more autonomy. Laura Landro, *Living With Change The Decision Is Yours: Doctors Are Starting to Embrace Information Technology and Its Changing Their Relationship With Patients*, WALL ST. J., Oct. 18, 1999, at R13.

26. Pegram v. Herdrich, 120 S. Ct. 2143, 2149 (2000) ("[I]n an HMO system, a physician's financial interest lies in providing less care, not more. The check on this influence (like that on the converse, fee-for-service incentive) is the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest.").

27. 42 U.S.C. § 300e-10 (2000).

28. *See, e.g.*, Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985); Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983).

29. De Buono v. NYSA-ILA Medic. & Clinical Servs. Fund, 520 U.S. 806 (1997); *see also* California Div. Labor Standards Enforcement v. Dillingham Const., Inc., 519 U.S. 316 (1997); New

Once some aspect of state law was found to be "related to" an employee benefits plan, that aspect of state law was nullified by ERISA's preemption clause. With respect to health care, preemption of state tort law meant that a patient-beneficiary who sustained bodily injury due to a denial-of-care administrative decision of an ERISA plan could be left "without a remedy"[30] because ERISA limited relief to equitable remedies–that is, non pecuniary relief.[31] As construed by *Massachusetts Mutual Life Insurance*

York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

30. *E.g.*, Dockter v. Aetna Life Ins. Co., 1993 US App. LEXIS 4385, at *5-6 (9th Cir. 1993) ("[U]nder the law, however, ERISA preempts state law claims even if the plaintiff is left without a remedy.") (*citation omitted*). *See also* Olson v. General Dynamics Corp., 960 F.2d 1418, 1422-23 (9th Cir. 1991) (holding state law claims are preempted under ERISA and "[d]eclining to devise a federal common law remedy even where plaintiff is left without a remedy").

31. Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985). Prior to *Pegram*, the "Russell Doctrine" shaped the court's view of compensating an ERISA beneficiary for harm due to denial of care. *Id.* Russell alleged that she had been wrongfully denied medical coverage by her insurer and consequently suffered financial embarrassment when such coverage had to be acquired on the spot market. *Id.* at 136-37. The issue distinguishing *Russell* from *Pegram* is that the plaintiff in *Russell* never sustained any physical injury; her injury was purely financial. A monetary award for Russell's damages was held to be inconsistent with the "legislative intent and consistency with the legislative scheme." *Id.* at 145. The *Russell* court followed the reasoning of *Cort v. Ash*, 422 U.S. 66, 78 (1975) in "determining whether a private remedy is implicit in a statute not expressly providing one." *Russell*, 473 U.S. at 136-37.

> First, is the plaintiff one of the class for whose especial benefit the statute was enacted,—that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

Cort, 422 U.S. at 78 (citations omitted). Specifically, "[t]he assumption of inadvertent omission [of legal remedies] is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute.'" *Russell*, 473 U.S. at 146 (citing Nachman Corp. v. Pension Benefit Guar. Corp., 446 U.S. 359, 361 (1980)). *Russell* considered the ERISA plan and the fiduciary to be a single entity, adding "Congress did not provide, and did not intend the judiciary to imply, a cause of action for extra contractual damages caused by improper or untimely processing of benefit claims." *Id.* at 148. Moreover, ERISA "already provided specific relief for the sort of injury the plaintiff had suffered (wrongful denial of benefits)." Varity Corp. v. Howe, 516 U.S. 489, 510 (1996). For *Russell*, the proper remedy for wrongful denial of benefits was for the plaintiff to file a suit for recovery of the benefit. *Russell*, 473 U.S. at 144. Such a suit is based on 29 U.S.C. § 1133 (2000) ("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

Co. v. Russell,[32] the combination of ERISA preemption of state tort law and the limited options for granting relief under ERISA was translated to mean that victims of wrongful denial-of-care decisions were left without remedy for harm suffered by the administrative malfeasance of an ERISA plan.[33] This anomalous situation was made worse because patients of non-ERISA qualified plans who were denied medical care were free to seek compensation from their insurance plans.[34] More fundamentally, the states were denied the power to address these problems through administrative regulation of qualified plans because state regulation of benefits was also preempted.

A. *The "Related to" Problem Found in ERISA Preemption*

As any curbstone philosopher can tell you, the problem with using "related to" as a trigger for ERISA preemption is that everything is related to everything else to one degree or another.[35] Hence, any state law which was remotely "related to" an employer's benefit plan, including laws concerned with patient safety were preempted by ERISA. By the mid-1990s, the expansive nature of "related to" was causing unanticipated consequences in a number of industries. The tide changed with the Supreme Court's 1995 opinion in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*[36] After *Blue Cross*, state laws that were of general applicability, laws which only indirectly

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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."). Accordingly, the *Russell* court declined to "tamper" with the statutory remedies. *Russell*, 473 U.S. at 147. Because Russell's actual damages were limited to pecuniary losses, the damages are analogous to those that Congress had anticipated as occurring secondary to the administrative malfeasance of a pension fund. Given the facts at hand in *Russell*, the Court appropriately limited the plaintiff's remedies under ERISA. However, the injury sustained by plaintiffs like Cynthia Herdrich represent an unprecedented form of injury caused by breach of an ERISA fiduciary duty. *Pegram*, 120 S. Ct. at 2143. Unfortunately, the failure to distinguish financial damage from bodily injury damage after a patient is denied medical care pervades legal analysis of ERISA medical administrative malfeasance cases prior to *Pegram*.

32. 473 U.S. 134 (1985).

33. 29 U.S.C.A. § 1132 note (citing Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997) ("ERISA's civil enforcement provision . . . does not authorize recovery for wrongful death, personal injury, or other consequential damages caused by improper refusal of insurer or utilization review provider to authorize treatment.")).

34. Fox v. Health Net. of Cal., Cause No. 219692 (Cal. Super. Ct., Riverside City, 12/23/93).

35. California Div. of Labor Standards Enforcement v. Dillingham Const. Inc., 519 U.S. 316, 336 (1997). "I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the 'relate to' clause of the pre-emption provision is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption applies*." *Id.*

36. 514 U.S. 645 (1995).

impact on the ERISA plans, would no longer be preempted under ERISA.[37] The key question left unanswered by the *Blue Cross, California Division of Labor Standards Enforcement v. Dillingham Construction, Inc.*,[38] and *DeBuono*[39] line of cases was precisely which laws are too tenuously related to employee benefit plans so as not to trigger ERISA preemption. After *Blue Cross* the appellate courts struggled with where to draw the line between "related to" and too tenuously related with respect to HMO administrative malfeasance in health care delivery.

One of the first cases after *Blue Cross* to address this issue was the *Lancaster by Lancaster v. Kaiser Foundation Health Plan*[40] case, which involved the medical care given to an eleven-year-old child with headaches.[41] Beginning in 1991, the child was taken to her primary care physician [PCP], an employee of Kaiser Foundation Health Plan, which operated under ERISA.[42] While treated under the Kaiser HMO for five years, no diagnostic tests were performed and the patient was never referred to a neurologist for evaluation.[43] The child was treated symptomatically with adult strength narcotics until 1996, when the child's school performance began deteriorating.[44] The child's school psychologist urged a neurologic evaluation, which revealed that forty percent of the child's brain had been replaced by a tumor.[45]

Kaiser is an interesting example of the use of branding in HMOs. While most commentators know of the Kaiser model in California, with its large physician panels and access to a broad variety of hospitals, in other states Kaiser is often organized very differently, with very small panels of physicians, limited specialty coverage, and inadequate access to hospitals and clinical facilities. Thus, a Kaiser plan in Virginia, where this case took place, may be very different from the California model, which accurately reflects the public's perception of Kaiser. This leads to a potentially troubling consumer expectations. This is critical to *Lancaster* because the issue became one of denying her proper testing and referral to a specialist. Moreover, these plans have two corporate entities. The insurance plan is set up as a non-profit corporation and Kaiser emphasizes this in its public relations campaigns. The physicians work for a separate for-profit corporation, become stockholders, and thus share in the profits. The two

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37. *See, e.g.*, De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806 (1997); Dillingham Const., 519 U.S. at 316.

38. 519 U.S. 316 (1997).

39. 520 U.S. 806 (1997).

40. 958 F. Supp. 1137 (E.D. Va. 1997).

41. *Id.*

42. *Id.* at 1139.

43. *Id.* at 1139-40.

44. *Id.* at 1140.

45. *Id.*

corporations are tightly intertwined, with the plan buying care from the physician corporation. The physician corporation, in turn, pays the physicians incentives "whereby physicians receive bonuses for avoiding excessive treatment and tests."[46] The key factors driving these incentive schemes, which are used in most HMOs and are the focus of a lot of litigation, are the costs of sending patients outside the plan, running tests, and admitting and treating patients in the hospital, especially in hospitals that are not controlled by the plan. Care rendered by in-plan physicians does not increase costs, therefore in-plan referrals are generally not penalized, while out-of-plan referrals are. Thus, the defendant physician in *Lancaster* would see his bonus reduced if he sent the patient to a specialist outside the plan or if he ordered diagnostic tests. In the California style Kaiser plan, this is not a critical issue because the plan has adequate access to specialists and testing facilities. However, in a location with few physicians and facilities, the same incentive scheme has become very dangerous.

Negligent care was clearly rendered to the Lancaster child, and formed the basis for a classical medical malpractice claim. Additionally, the plaintiff argued that the same facts established a breach of fiduciary duty by the physician and the plan. This allegation was based on the negligent establishment of an "[I]ncentive Program and for intentionally and knowingly concealing its existence from the plaintiffs."[47] Kaiser "characterized this claim as attacking an administrative decision of the plan, not a medical decision,"[48] which the *Lancaster* court accepted. The *Lancaster* court then looked for precedent in a line of cases involving utilization review, which concluded that administrative decisions involving benefits are preempted under ERISA.[49] Since such fraud claims are based on state law, "[p]ermitting these claims to proceed would undermine the congressional policies that underlie ERISA. Absent preemption, for instance, benefit plans would be subject to conflicting directives from one state to the next . . . ."[50] The *Lancaster* court then limited the plaintiff's recovery to classic medical malpractice against the physician and vicarious liability against the plan, a decision based upon Kaiser's characterization of physicians as plan employees through its corporate branding of the physician group. The *Lancaster* court rejected the breach of fiduciary duty based on the incentive scheme and suggested that "there is no remedy

46. *Id.*

47. *Id.* at 1146.

48. Richards & McLean, *supra* note 16, at 457.

49. *Lancaster*, 958 F. Supp. at 1144 (citing Jass v. Prudential Health Care Plan, 88 F.3d 1482 (7th Cir. 1996)).

50. *Id.* at 1150.

against an ERISA plan using an improper incentive plan or even hiding the incentive plan from its patients."[51]

Lancaster is illustrative of a body of case law that had developed in the previous ten to fifteen years. The courts took the view that ERISA's preemption of state law allows for the ERISA qualified health plan to engage in administrative malfeasance either by arbitrary denial of care, or by the creation of disingenuous physician incentives, without triggering state law liability for any bodily injury caused to a patient-beneficiary. Hence, while the physician in *Lancaster* could be sued in state court for the failure to make a proper referral, the fact that the physician's conduct was directly caused by HMO enticement was neither a defense to the physician nor the basis for a cause of action against the HMO. Moreover, the *Lancaster* court allowed the plaintiff a cause of action against Kaiser which was predicated on vicarious liability for holding out the physicians as "Kaiser" physicians. Thus the Lancaster court distinguished direct plan liability and vicarious liability for medical malpractice. In contrast to direct liability, which the Lancaster court considered to be barred under ERISA preemption, ERISA was not a barrier to an action for vicarious liability.

B. *Using Fiduciary Law to Solve the "Related to" Problem*

In addition to state tort law, fiduciary law is used to modulate the professional behavior of physicians, thereby indirectly influencing HMO behavior. Thus, independent of the medical malpractice approach of *Lancaster*, the issue of whether breach of fiduciary duty was "related to" ERISA plans arose as the plaintiff's lawyer tried to collaterally attack HMO administrative malfeasance. *Shea v. Esensten*[52] and *Neade v. Portes*[53] analyzed the degree to which fiduciary law was related to an employee benefit plan. While separated by nearly two years, *Shea* and *Neade* have very similar facts and the legal theory in *Neade* was clearly based on the holding in *Shea*. Patrick Shea was a forty-year-old executive in the computer industry who had a history of heart disease in his family, but was in good health personally.[54] While on a business trip he suffered chest pains, and, upon his return, he sought out his family physician for a diagnostic workup.[55] As described in the plaintiff's complaint, Mr. Shea's primary care physician (PCP) reassured him that he had nothing to worry about, as he was too young to have a heart attack.[56] His pains persisted, as

51. Richards & McLean, *supra* note 16, at 458.

52. 107 F.3d 625 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997), *appeal after remand*, Shea v. Esensten, 208 F.3d 712 (8th Cir. 2000).

53. 710 N.E.2d 418 (Ill. App. Ct. 1999).

54. *Shea*, 107 F.3d at 626.

55. *Id.*

56. *Id.*

did the reassurances.[57] After several months of trusting, and after being dissuaded by his physician that it was necessary for Mr. Shea to spend his own money to see a cardiologist, Mr. Shea died of "heart failure."[58] Upon investigation, what was on its face a simple case of grossly negligent medical care became a complex ERISA case of breached fiduciary obligations.[59] The appeals court held that under ERISA, Mr. Shea's widow did have a cause of action for breach of fiduciary duty since the physician's incentive program, in essence, bribed the physician-fiduciary not to provide medical care.[60] Interestingly, the *Shea* court never explicitly stated just who was the fiduciary;[61] whether it was a particular physician or a non-medical administrator of the ERISA plan. The *Shea* court remanded the case without specific instructions on the nature of the remedy.[62]

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57. *Id.*

58. *Id.* Since this case arose from a dismissal, the court only explored the plaintiff's facts. It is possible that they did not paint an accurate picture of the care provided by defendant and that a different picture will emerge as facts are developed with further discovery.

59. *Id.*

> Unknown to Mr. Shea, Medica's contracts with its preferred doctors created financial incentives that were designed to minimize referrals. Specifically, the primary care doctors were rewarded for not making covered referrals to specialists, and were docked a portion of their fees if they made too many. According to Mr. Shea's widow Dianne, if her husband had known his doctor earned a bonus for treating less, he would have disregarded his doctor's advice, sought a cardiologist's opinion at his own expense, and would still be alive today.

Id.

60. *Id.* at 629.

> [W]e believe Mrs. Shea has stated a claim against Medica for breaching the fiduciary obligation to disclose all the material facts affecting her husband's health care interests. 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.

Id.; *see also* Lazorko v. Pennsylvania Hosp., WL 405055 at *5 (E.D.Pa., Jun 30, 1998) (discussing *Shea*).

61. *Shea*, 107 F.3d at 625. The fact that the *Shea* court did not define the fiduciary is key to understanding *Pegram*. The citations used to support the *Shea* opinion suggest that fiduciary common law was contemplated. This would have been appropriate under ERISA because ERISA incorporates fiduciary common law. In contrast, the *Pegram* court considered only statutory fiduciary duty as established by ERISA.

62. Although *Shea* was unprecedented as a breach fiduciary duty cause of action arising under ERISA, *Shea* implicitly contemplates damages for bodily injury arising from medical administrative malfeasance, and recognized that an incentive program that corrupts the judgment of a fiduciary is far from unheard of under ERISA. *See also* Dasler v. E.F. Hutton & Co., 694 F. Supp. 624, 634 (D. Minn. 1988) (holding defendant liable for breach of fiduciary duty where incentive program

Similar to the facts in *Shea*, Anthony Neade was approximately thirty-seven-years-old in 1990 when he began to show the classic symptoms of coronary artery disease, including chest pain radiating into his arm and shortness of breath.[63] Neade had a family history of heart disease, was overweight, suffered from hypertension, smoked, and had a high cholesterol count.[64] While in the hospital, Neade underwent various tests, including a thallium stress test, which was interpreted as normal.[65] Following his discharge from the hospital, Neade continued to experience chest pain, and like Mr. Shea, was assured that his chest pain was not cardiac in origin. On one such occasion a doctor taking call for Mr. Neade's PCP evaluated Mr. Neade, and recommended the "gold standard" for the evaluation of coronary artery disease: coronary angiography. However, Mr. Neade's PCP, without any re-evaluation, terminated further diagnostic testing.[66] Ultimately, Mr. Neade suffered a massive myocardial infarction caused by coronary artery blockage, and died nine days later.[67] The care rendered to Mr. Neade was sub-optimal, since he should have received further medical evaluation.[68] In its review of the case, the *Neade* court recognized that an action for breach of fiduciary duty could arise from the same set of facts that support a cause of action for medical malpractice.[69]

Two factors emerge as common threads in *Lancaster, Shea* and *Neade*. First, the alleged medical malpractice was not a single mistake, based on information from a single patient encounter, but a systematic failure to re-evaluate the initial diagnostic decision in the face of symptoms and complaints by the patient that were incompatible with the diagnosis. Second, re-evaluation of the patient would have required spending plan resources for hospitalization, additional testing, and/or out-of-panel

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resulted in excessive trading in security); Anweiler v. American Elec. Power Serv. Corp., 3 F.3d 986, 991-92 (7th Cir. 1993) (holding that defendant breached fiduciary duty by failing to provide complete material information concerning the methods of reimbursement); Ries v. Humana Health Plan, Inc., No. 94 C 6180, 1995 Lexis 16592 at *10 (N.D. Ill., Nov. 8, 1995) (citing 29 U.S.C.A. § 1104(a)(1)(A)) ("fiduciary's covert profiteering at the expense of insureds is inconsistent with its duties of acting 'solely in the interest of the participants and beneficiaries'").

63. Neade v. Portes, 710 N.E.2d 418, 421 (Ill. App. Ct. 1999).

64. *Id.*

65. *Id.* Thallium studies have a false positive rate of approximately 20% for detecting coronary artery disease when compared with coronary angiography. *Id.*

66. *Id.* Even after the PCP requested a consultative examination by a part-time physician, the PCP elected not to proceed with coronary angiography choosing instead to rely on the reported results of the thallium scan. *Id.*

67. *Id.*

68. *See, e.g.*, Macdonald v. United States, 853 F. Supp. 1430 (M.D. Ga. 1994) (finding that a similar patient history should have alerted the physician to the patient's high risk of a heart attack).

69. *Neade*, 710 N.E.2d at 426.

expertise which would have thereby increased the cost to the plan and decreased the physician's reimbursement. Under FFS, which tends to err on the side of too much/unnecessary care, it is very likely that the patient would have received the hospitalization, testing, and specialist referral. While the PCP might be equally incompetent in both scenarios, the involvement of other professionals and the additional test information would make the patient's condition much harder to ignore.

In contrast, several factors distinguish *Lancaster* from *Shea and Neade*. The most important distinction is the consideration given to the degree of fiduciary duty owed by the physician to the patient under ERISA. The word "fiduciary" does not even appear in the court's analysis of *Lancaster*. In contrast, the court's analysis in *Shea* is heavily focused upon the fiduciary duty owed by physicians, especially the obligation for physicians to conduct themselves with good faith and undivided loyalty to their patients.

Second, *Lancaster* viewed denial of care decisions as being a utilization and review decision and thus not a medical decision. From the *Lancaster* court's vantagepoint, managed care health plans provide two independent functions; "namely that of health care insurer and that of medical services provider."[70] The *Lancaster* court concluded that health plans only make administrative decisions and not medical decisions because such decisions "cannot be stretched to imply that [a defendant] went beyond the administration of benefits and undertook to provide [the decedent] with medical advice."[71] For the *Lancaster* court it was only natural that denial of medical care decisions should fall under the heading of utilization and review because:

> The absurd consequences of concluding otherwise confirm the correctness of this conclusion. ERISA plans are required to provide a participant or beneficiary written notice of a denial of benefits and an opportunity for a full and fair review of that denial by an appropriate plan fiduciary. . . . The ERISA participant or beneficiary denied benefits under his or her plan can then seek judicial review of that specific administrative denial. . . . Thus, if every instance of negligent treatment by a physician were construed as an administrative denial of a claim for plan benefits, then in every such case the patient would have the right to notice and review with respect to that medical treatment decision, followed by a hearing and judicial review with respect to each "denial" of a plan benefit.

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70. *Lancaster*, 958 F. Supp. at 1144.

71. *Id.* at 1148 n.33 (quoting Kuhl v. Lincoln Nat'l Health Plan, Inc., 999 F.2d 298, 302 (8th Cir. 1993)).

> ERISA neither contemplates nor requires such an absurd result.[72]

In short, under *Lancaster*, utilization and review decisions, including denial of care decisions, are to be analyzed separately and independently from medical decisions.

To the *Shea* court, a "denial of care" decision is a medical decision, rather than an allocation of resources issue.[73] Interestingly, the *Shea* court cited the same case cited by the *Lancaster* court when it recognized the case at hand as a medical decision rather than a utilization and review decision.[74] Because physicians in a managed care environment made medical decisions, the physician had a "fiduciary obligation to disclose all the material facts" to the patient.[75] In implying that physicians are fiduciaries under ERISA, the *Shea* court took notice that some injuries have irrevocable consequences.[76] A utilization and review decision, when made in the context of the administration of a pension plan, can be litigated for years without fear that a party will suffer physical injury. But, as the tragedies of the *Shea, Neade,* and *Herdrich* well illustrate, time is critical in medical decision cases and delay in treatment can have irreversible consequences.

The final factor which distinguishes *Lancaster* from *Shea* and *Neade* was the degree to which the court believed the plaintiff had an adequate remedy. The *Lancaster* court concluded that the plaintiff's medical malpractice posed "no ERISA questions because ERISA does not apply to medical care decisions made by treating physicians."[77] Moreover, the *Lancaster* court explained that the plaintiff's vicarious liability claim

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72. *Id.*

73. Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997); *see, e.g.*, Murphy v. Bd. of Med. Exam'rs, 949 P.2d 530 (Ariz. Ct. App. 1997). Dr. Murphy, an Arizona licensed physician, was the medical director for a national HMO and in that role authorized pre-certifications for medical treatment. *See Murphy*, 949 P.2d at 532. When pre-certification was denied, a patient would have to pay out-of-pocket for the denied treatment. *See id.* However, when the Arizona Board of Medical Examiners issued Dr. Murphy an advisory letter of concern regarding "an inappropriate medical decision which could have caused harm to a patient," he objected. *Id.* at 534. He claimed that he could not be censured by the licensing authority since he was not engaged in the practice of medicine. *Id.* at 535. The Arizona Supreme Court disagreed, finding that when the administrative work of a medical director included decisions that affected the care of individual patients, the medical director is making medical decisions, and therefore can be subject to the jurisdiction of an administrative oversight committee. *Id.* at 535-36.

74. *See Shea*, 107 F.3d at 627 (citing Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 301-04 (8th Cir. 1993)) ("we have held that claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision").

75. *Id.* at 629.

76. *Id.*

77. Richards & McLean, *supra* note 16, at 456, (citing *Lancaster*, 958 F. Supp. at 1143).

against the plan based on ostensible agency was not preempted by ERISA, therefore, the plaintiff was left with a clear remedy against the plan.[78] *Lancaster* envisioned that the plaintiff would receive some compensation on a tort theory from the state court upon remand.[79] In contrast, the *Shea* court observed that "the district court correctly decided that ERISA preempts Mrs. Shea's state-law claims."[80] Thus, the *Shea* court must have contemplated that its award for breach of fiduciary duty was to be the sole form of relief available to Mr. Shea's widow.

C. *Applying ERISA Statutory Fiduciary Law to Solve the "Related to" Problem*

Cynthia Herdrich filed suit against her physician and Carle Clinic for breach of fiduciary duty, arising from medical care provided by an ERISA qualified plan.[81] Defendant Carle Clinic "operate[d] a pre-paid health insurance plan which provide[d] medical and hospital services"[82] and employed Ms. Herdrich's physician, Dr. Pegram. Examination of Ms. Herdrich by Dr. Pegram identified a six by eight centimeter abdominal mass, which was inflamed.[83] Dr. Pegram allegedly "delayed instituting an immediate treatment of Herdrich," per the policies of the plan.[84] To make matters worse,

> [d]uring this unnecessary waiting period, Herdrich's health problems were exacerbated and the situation rapidly turned into an "emergency"—her appendix ruptured, resulting in the onset of peritonitis. In 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.[85]

As such, the delay "subjected [Ms. Herdrich] to a life threatening illness, a longer period of hospitalization and treatment, more extensive, invasive and dangerous surgery, increased hospitalization costs, and a greater ingestion of prescription drugs."[86] Similar to the plaintiffs in *Lancaster*,

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78. *Lancaster*, 958 F. Supp. at 1149; *see also id.* at 1148 n.32.
79. *Id.* at 1150.
80. *Shea*, 107 F.3d at 627.
81. Herdrich v. Pegram, 154 F.3d 362, 364-65 (7th Cir. 1998), *rev'd* 120 S. Ct. 2143 (2000).
82. *Id.* at 365.
83. *Id.* at 374.
84. *Id.*
85. *Id.*
86. *Id.* at 378.

Shea and *Neade*, Herdrich's complaint alleged "the intricacies of the defendants' incentive structure . . . [provided for] an incentive . . . for [physicians] to limit treatment."[87] Moreover, such incentives meant 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.[88]

In analyzing *Herdrich*, the appellate court noticed that "the defendants had the exclusive right to decide all disputed and non-routine claims and thus were in fact, ERISA fiduciaries."[89] In fact, Dr. Pegram owed fiduciary duties not only to Ms. Herdrich due to the nature of the doctor-patient relationship, but also to her employer, Carle Clinic, and to the ERISA plan itself. Dr. Pegram's multiple fiduciary duties were not mutually exclusive and frequently led to conflicts of interest, as the doctor attempted to serve multiple masters. The *Herdrich* court concluded that the incentive plan could reasonably have corrupted the fiduciary duty owed by the physicians and the plan to the patient beneficiary.[90] The appellate court then remanded the case for a determination of damages along guidelines outlined by the court.[91] The *Herdrich* court directed that a determination of damages for breach of ERISA fiduciary duty was to be indexed according to the unnecessary medical expenses incurred by the plan.[92] Requiring that damages be structured in such a manner was clearly within a literal reading of the determinations of damages to an ERISA pension plan.[93]

Shea, Neade, and the appellate decision in *Herdrich* all attempt to resolve a major anomaly in the law: when a health plan's administrative malfeasance results in bodily injury to a beneficiary, the traditional

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87. *Id.* at 372 (emphasis omitted).
88. *Id.* at 370.
89. *Id.* at 380.
90. *Id.*
91. *Id.* at 331.
92. *Id.*
93. 29 U.S.C.A. § 1132; *see also* Harsch v. Eisenberg, 956 F.2d 651, 660 (7th Cir. 1992) (Extracontractual compensatory damages are not available under ERISA). ERISA allows a "participant or beneficiary. . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of his plan, or to clarify his rights to future benefits under the terms of the plan." *Id.* at 654. Pursuant to national policy, Congress wished to protect the pension plans from unexpected and excessive financial liability. Accordingly, Congress prescribed that damages were to be clearly definable and hence predictable.

remedies available to such a beneficiary are markedly different if the plan is an ERISA qualified plan.

In all of the above cases, the HMO administering an ERISA health plan used financial incentives to modify their physicians' judgment. Such financial arrangements are frequently kept secret from patient-beneficiaries by the use of a "gag rule" clause in the physician provider's contract.[94] Whether such business practices are used alone or in tandem as part of a system with other behavior modifiers, their purpose is the same—to establish dual loyalties in physicians. The problem with dual loyalties in physicians is, of course, that the need to serve multiple masters perniciously corrupts the physician's decisionmaking process.

D. Pegram's *Narrowing of ERISA Preemption*

Against this confusing and contradictory back drop of appellate cases,[95] the Supreme Court accepted *Pegram* for review. There are two keys to understanding Justice Souter's opinion. The most important is the Court's narrow view of what constitutes an employee health plan under ERISA.[96] This excludes the HMO from ERISA preemption because the provision of medical care is not the ERISA plan. Second, after *Pegram*, an action against a physician or HMO for breach of statutory fiduciary duty, as in *Herdrich*, is no longer available to plaintiffs, but the court did not limit the application of fiduciary common law actions against either of these two categories of defendants. Consequently, the Court has left the door open for fiduciary common law actions and remedies to be used as a method to remedy wrongful HMO denial of care decisions.

The *Pegram* court noticed that "'ERISA's definition of an employee welfare benefit plan is ultimately circular: any plan, fund, or program . . . to the extent that such plan, fund, or program was established . . . for the

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94. A typical gag clause prohibits a contracting physician from making disclosures that could undermine the trust the patient has in the physician and/or insurer. As the physician generally has as much to gain as the HMO by keeping incentive plans secret, it is mere speculation that the simple prohibition of such clauses in a physician contract will induce the physician to have a more open discussion with patients about financial incentives. However, because employers provide the majority of commercial insurance, ERISA preemption has in the past nullified the anti-gag rule statutes. In light of the recent holding in *Pegram*, gag rules may now be enforceable across the board.

95. Confusion exists in these cases as to which law was applicable. *Shea* and *Neade* contemplated that the physician involved had breached fiduciary common law duties, while *Herdrich* contemplated that the physicians involved had breached ERISA statutory fiduciary obligations to their patient beneficiaries. The contradiction of these opinions is best illustrated by observing the differing remedies which were contemplated by the *Lancaster* and *Shea* courts.

96. Pegram v. Herdrich, 120 S. Ct. 2143, 2151 (2000). ERISA covers employee benefits and pension plans. While ERISA comprehensively regulates pension plans, it provides only minimal details on the management of these benefit/health plans.

purpose of providing . . . through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits."[97] To the *Pegram* court, the word "plan" referred "to a scheme decided upon in advance."[98] In the delivery of health care, this means that the ERISA plan is limited to "a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan."[99] In other words, as it interfaces with the delivery health care, the ERISA plan is limited to the contractual relationship between the employer and employee that outlines the employees' benefits and not the contractual rules by which the HMO operates.[100] The structure of an HMO is not an ERISA plan, nor is the operation of an HMO necessarily part of the HMO plan. To the extent that operation of the HMO is directly dictated by the plan, such operations would be part of the plan. This situation could only arise where a self-insuring employer was operating the HMO themselves.[101] Because the HMO itself is removed from the employer-employee benefit contract, the HMO's contractual relationships that motivate its physician providers are even more removed from the plan. The remoteness of the HMO-provider contractual relationship served as the foundation for the *Pegram* court to conclude that physician incentives are too tenuously connected to the ERISA plan to be "related to" the plan.[102]

However, to the extent that an HMO is acting as a fiduciary agent of the plan, the HMO might still owe the plan and its beneficiaries certain duties under ERISA. A fiduciary under ERISA is defined as anyone who wields "discretionary authority or discretionary responsibility in the administration of [an ERISA] plan."[103] The use of the word "discretionary" was to bring all persons involved in making administrative decisions for ERISA plans into a common regulatory scheme. When Congress enacted ERISA, it "intended that this statutory definition of 'fiduciary' be broadly interpreted."[104] This meant that one could become an ERISA fiduciary

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97. *Id.* (citing 29 U.S.C. § 1002(1)(A)).

98. *Id.* (citing WEBSTER'S NEW INTERNATIONAL DICTIONARY 1879 (2d ed. 1957)); *see also* Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUSTON L. REV. 985, 1050 (1998).

99. *Pegram*, 120 S. Ct. at 2151 (citing Hansen v. Continental Ins. Co., 940 F. 2d 971, 974 (5th Cir. 1991)).

100. *Id.* "[T]he provisions of documents that set up the HMO are not, as such, an ERISA plan, but the agreement between an HMO and an employer who pays the premiums may. . . ." *Id.*

101. This would be in accordance with ERISA's "deemer" clause, 29 U.S.C.A. § 1144[c], which is beyond the scope of this Article.

102. *Pegram*, 120 S. Ct. at 2155-56.

103. *Id.* at 2151 (citing 29 U.S.C. § 1002(21)(A)(iii)).

104. Herdrich v. Pegram, 154 F.3d 362, 370 (7th Cir. 1998), *rev'd* 120 S. Ct. 2143 (2000) (citing Chairman of the House Committee on Education and Labor, 120 CONG. REC. 3977, 3983

without having a formal contractual relationship with the beneficiary.[105] The statutory definition of a fiduciary under ERISA reflects the realization by Congress that it would need the business expertise of the employers to design ERISA-qualified plans. With respect to pension funds for employees, the employer had an obvious conflict of interest. By defining the ERISA fiduciary on the basis of discretionary authority, Congress recognized that the contractual relationship between the employer and employee would be inadequate to safeguard funds in a pension plan, hence the plans would have to be policed statutorily. Historically, the common law had policed contracts by finding that a power party owed fiduciary obligations to the other party.[106] Congress' statutory modification of fiduciary common law was simply an attempt to tailor this ancient body of law to a creature of the twentieth century.[107] But in so doing, Congress had accepted that its statutory fiduciaries would, out of necessity, have divided loyalties.

In making a medical decision, a health care provider's judgment is guided by personal experience and accumulated medical knowledge. Given that discretionary means "a power or right conferred upon them by law of acting officially in certain circumstances, according to their own judgment and conscience, uncontrolled by the judgment or conscience of others,"[108] it is clear that in making a medical decision the physician uses discretionary judgment. Thus according to ERISA, whenever a health care provider exercises discretionary judgment to provide a medical service, that provider would become an ERISA fiduciary.[109] Importantly, since the

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(Feb. 25, 1974), *reprinted in* 2 Legislative History of the Employee Retirement Income Security Act of 1974, at 3293).

105. *Id.* ("[A] party's fiduciary status hinges not on whether it is named in the plan agreement, but rather on whether it satisfies the statutory definition of a fiduciary in section 1002(21)(A) of ERISA.").

106. Tamar Frankel, *Fiduciary Law.*, 71 CAL. L. REV. 795, 801 (1983) (citing HENRY MAINE, ANCIENT LAW 169-70 (1st ed. 1861)).

107. *Id.* The need to modify the fiduciary common law was driven ultimately by two factors. First, the common law recognized few relationships to be fiduciary. These limited relationships would not have covered all the parties that would have access to the pension funds that Congress sought to protect. *Id.* at 805. Second, divided loyalties were anathema to fiduciary common law. *Id.* at 811. But as noted above, the employers who were to be "conscripted" into managing the plans would have divided loyalties.

108. BLACK'S LAW DICTIONARY 466 (6th ed. 1990).

109. The *Shea* court never explicitly declared the treating physicians to be fiduciaries, but it is implied. Health care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if he or she "knows that silence might be harmful." Shea v. Esenster, 107 F.3d 625, 629 (8th Cir. 1997) (citing Bixler v. Cent. Penn. Teamsters Health & Welfare Fund, 12 F.3d 1292, 1300 (3d Cir. 1993)); *see also* RESTATEMENT (SECOND) OF TRUSTS § 173 (1959). Also,

> [t]his 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-

mere exercise of discretionary judgment over the benefits of an ERISA plan makes an individual a statutory ERISA fiduciary,[110] all medical service providers to ERISA patient-beneficiaries are ERISA fiduciaries regardless of their contractual relationship to the medical plan itself.[111] In short, because of ERISA's broad definition of a fiduciary,[112] every physician involved in the delivery of medical services could be an ERISA fiduciary whose decisions could be subject to breach of fiduciary duty actions. The potential for the federal courts to become clogged by breach of fiduciary duty actions under ERISA that were predicated on a denial of care decision was an unspoken policy motive for the *Pegram* court to conclude that physicians and other health care providers, including HMOs, are not ERISA fiduciaries.[113]

ERISA also incorporates fiduciary common law. Thus, "[r]ather than explicitly enumerating all of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility."[114] At common law "[a] fiduciary relationship exists when the parties are under a duty to act for or give advice for the benefit of another upon matters within the scope of the

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> serving financial considerations created by the health insurance provider. The district court believed Seagate's employees already realized their doctors' pocketbooks would be adversely affected by making referrals to outside specialists. Even if the district court is right, Seagate's employees still would not have known their doctors were penalized for making too many referrals and could earn a bonus by skimping on specialized care.

Shea, 107 F.3d at 628-29.

110. Varity Corp. v. Howe, 516 U.S. 489, 498 (1996) "[A] 'person is a fiduciary with respect to a plan' and therefore subject to ERISA fiduciary duties, 'to the extent' that he or she 'exercises discretionary authority or discretionary responsibility in the administration' of the plan." *Id.* (citing ERISA, 29 U.S.C. § 1102 (1997)); *see also* 29 U.S.C.S. § 1102 (1997); Custer v. Sweeney, 89 F.3d 1156, 1162 (4th Cir. 1996) ("Concept of fiduciary under ERISA is broader than common law concept of trustee; it includes not only those named as fiduciaries in plan instrument, or who, pursuant to procedure specified in plan, are identified as fiduciaries, but any individual who de facto performs specified discretionary functions with respect to management, assets, or administration of plan."); advisory notes accompanying 29 U.S.C.S. § 1106 (1997) (citing Reich v. Hosking, 20 E.B.C. 1090 (E.D. Mich. 1996)) ("Individual can be held liable as ERISA fiduciary if he or she exercises discretionary authority, or possesses discretionary authority.").

111. Herdrich v. Pegram, 154 F.3d 362, 371 (7th Cir. 1998), *rev'd* 120 S. Ct. 2143 (2000).

112. *Id.* at 370 (citing 120 CONG. REC. 3977, 3983 (1974), *reprinted in*, 2 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 3293 (1974)) ("Congress, when it enacted ERISA, intended that this statutory definition of 'fiduciary' be broadly interpreted.").

113. Pegram v. Herdrich, 120 S. Ct. 2143, 2158 (2000) ("But we have seen enough to know that ERISA was not enacted out of concern that physicians were too poor to be sued, or in order to federalize malpractice litigation in the name of fiduciary duty for any other reason.").

114. *Varity*, 516 U.S. at 496 (quoting H.R. REP. NO. 93-533, at 3-5, 11-13 (1973), *reprinted in* 2 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

relationship."[115] Patients have limited contractual rights,[116] while the physicians who arbitrate the patient's medical care exercise power in a non-reciprocal manner.[117] Consequently, it is to be expected that physicians are fiduciaries. In fact, the physician-patient relationship has long been deemed one with a fiduciary character.[118] "The inherent necessity for trust and confidence requires scrupulous good faith on the part of the physician."[119] Moreover, "[a] physician occupies a position of trust and confidence as regards his patient—a fiduciary position."[120] The Missouri Supreme Court opined that "the confidential bond between a doctor and patient is a fiduciary relationship."[121] In our society "a physician occupies a position of trust and confidence as regards his patient—a fiduciary position . . . . This duty of the physician flows from the relationship with his patient and is fixed by law—not by the contract of employment."[122] Currently, most jurisdictions have found physicians to be fiduciaries.[123]

The most significant difference between ERISA's statutory definition of a fiduciary and the way in which the common law views a fiduciary is the degree to which a fiduciary may have divided loyalty. ERISA contemplated that the statutory fiduciary might have divided loyalties.[124]

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115. Associated Indemnity Corp. v. Cat Contracting, Inc., 918 S.W.2d 580, 596 (Tex. Ct. App. 1996) (citing Stephanz v. Laird, 846 S.W.2d 895, 901 (Tex. Ct. App. 1993)).

116. Frequently, as demonstrated in *Shea*, an employer contracts with an insurer to provide for medical coverage. Consequently, the employee is presented a health benefit plan where the specifics of coverage have already been determined. Alternatively, if the patient purchases medical insurance directly from an insurer, the patient receives what in essence is an adhesion contract.

117. While the doctor or insurer may be solicitous of the patient-beneficiary's wishes, hopes and desires, the decision to render medical care at present is entirely within the preview of the physician and insurer.

118. Saulenas v. Penn, 192 N.E. 42, 43 (Mass. 1934); *see also* Warsofsky v. Sherman, 93 N.E.2d 612, 614 (Mass. 1950); Garcia v. Coffman, 946 P.2d 216, 222 (N.M. 1997) (referencing Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 U.PITT. L. REV. 291, 349 (1994)) ("Several treatises on fiduciary law name the physician-patient relationship as a fiduciary one and the courts have tended to concur.").

119. Hunter v. Brown, 484 P.2d 1162, 1166 (1971) (citing Lockett v. Goodill, 430 P.2d 589 (Wash. 1967).

120. Brandt v. Med. Def. Assoc., 856 S.W.2d 667, 670 (Mo. App. 1992); *see also* Moore v. Webb, 345 S.W.2d 239, 243 (Mo. Ct. App. 1961) (stating the exact proposition).

121. *Brandt*, 856 S.W.2d at 670 (citing State ex rel. Woytus v. Ryan, 776 S.W.2d 389, 393 (Mo. 1989)); *see also* State ex rel. McCloud v. Seier, 567 S.W.2d 127, 128 (Mo. 1978) (finding that the physician's undivided loyalty is to his patient).

122. *Moore*, 345 S.W.2d at 243 (Mo. Ct. App. 1961) (citing Parkell v. Fitzporter, 256 S.W. 239 (Mo. 1923)).

123. Garcia v. Coffman, 946 P.2d 216, 222 (N.M. 1997) (referencing Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 U.PITT. L. REV. 291, 349 (1994)) ("Several treatises on fiduciary law name the physician-patient relationship as a fiduciary one and the courts have tended to concur."); *see also* Moore v. Regents of Univ. of Cal., 793 P.2d 479, 479 (Cal. 1990).

124. ERISA's allowance for divided loyalties was predicated upon the realization that to have

The extent of scrutiny an ERISA fiduciary is to receive during a review of the fiduciary's conduct was to be determined by the degree to which the fiduciary's decision was made in the absence of divided loyalty. When a fiduciary decision was made in the presence of undivided loyalty to the plan, Congress determined the fiduciary should be reviewed under the prudent person standard.[125] In essence, ERISA's prudent person standard for breach of fiduciary duty is simply a restatement of the standard of review for a common law breach of fiduciary duty.[126] However, when an ERISA "fiduciary has dual loyalties, his independent investigation into the basis for an investment decision which presents a potential conflict of interests must be both intensive and scrupulous and must be discharged with the greatest degree of care that could be expected under all the circumstances by reasonable beneficiaries and participants of the plan."[127] The greatest degree of care possible means that "even a good faith belief, held by the trustees does not insulate them from charges that they have acted imprudently."[128] Conversely, a fortuitous discretionary decision by an ERISA fiduciary that yields a solution in the best interest of the plan is not a substitute for a detailed investigation of the highest possible care by the ERISA fiduciary.[129] "Employers, for example, can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries, when they act as employers (e.g., firing a beneficiary for reasons unrelated to the ERISA plan), or even as plan sponsors (e.g., modifying the terms of a plan as allowed by ERISA to provide less generous benefits)."[130]

In contrast to ERISA's pragmatic view, at common law, dual loyalties are an anathema to the exercise of fiduciary duty. "Professor Scott's treatise admonishes that the trustee 'is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries.'"[131] "Prohibition of dual loyalties in its purest form eliminates conflict of interest, and hence [is] one protective mechanism

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sufficient business expertise to administrate the complicated employee pension plans, the services of the beneficiaries' employers would have to be enlisted. 29 U.S.C. § 1108(c)(3) (2000).

125. 29 U.S.C. § 1104(a)(1)(A) (1999) ("[f]iduciary 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").

126. This is consistent with ERISA's incorporation of the Common Law of Trusts. *See* 29 U.S.C. § 1104 note (2000).

127. Donovan v. Bierwirth, 538 F. Supp. 463, 470 (E.D.N.Y. 1981).

128. *Id.*

129. *Id.* at 471.

130. Pegram v. Herdrich, 120 S. Ct. 2143, 2152 (2000).

131. *Id.* (citing AUSTIN W. SCOTT & WILLIAM F. FRATCHER, LAW OF TRUSTS 311, § 170 (1987)).

against abuse of fiduciary power."[132] As such, ERISA's allowance for dual loyalties in its fiduciaries therefore threatens "one of the Act's declared purposes to protect employees' interests in benefit plans."[133]

Pegram recognized that financial incentives, which by their nature have the potential to divide the loyalty of physicians, would lead to problematic legal analysis because of this dichotomy in the way in which ERISA statutorily allowed for dual loyalty and the common laws abhorrence of the same.[134] The Court pointed out that in

> every case charging breach of ERISA fiduciary duty, then, the threshold question is not whether the actions of some person providing services under the plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary when taking the action subject to complaint.[135]

Realizing that the instant case under review had multiple fiduciaries (the HMO and its physician agents are ERISA statutory fiduciaries to the extent that they make discretionary decisions over medical services, and physicians are independently ERISA fiduciaries due to ERISA incorporation of the common law of trusts) to answer this question, the Court had to first parse out to which fiduciary the complaint was addressed.

The Court concluded that the complaint did not address the medical decisionmaking by the treating physicians. "Herdrich does not point to a particular act by any Carle physician owner as a breach."[136] Moreover, "at oral argument her counsel confirmed that the ERISA count could have been brought, and would have been no different, if Herdrich had never had a sick day in her life."[137] Rather, the complaint was directed solely at the HMO for breach of "its duty to act solely in the interest of beneficiaries by making decisions affecting medical treatment"[138] while simultaneously maximizing their own profits by inducing the physicians providers to make medical "choices to minimize the medical services provided."[139] Thereafter, Justice Souter's discussion only contemplates the HMO's liability under ERISA for breach of statutory fiduciary duty. The court's silence on physician's common law obligations to their patients leaves

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132. Frankel, *supra* note 106, at 811.

133. Schoenholtz v. Doniger, 657F. Supp. 899, 914 (S.D.N.Y. 1987) (citing 29U.S.C. § 1001(b) (1982)).

134. *Pegram*, 120 S. Ct. at 2150.

135. *Id.* at 2146.

136. *Id.* at 2153.

137. *Id.*

138. *Id.*

139. *Id.*

open the possibility that fiduciary common law could be used as mechanism to regulate both physicians and HMOs.[140]

In regards to the HMO's liability for breach of fiduciary duty under ERISA, a two-prong analysis is required: first, was the HMO's incentive plan part of the ERISA plan (thereby triggering ERISA preemption) and second, was sufficient discretionary authority wielded by the HMO to make it a fiduciary under ERISA? The Court answered the first prong unequivocally, "No." "The HMO is not the ERISA plan."[141] Under *Pegram*, HMOs are merely contractors who implement the employer's benefits plan Then, because the HMO was not an ERISA plan, the administration of the plan was not related to the plan itself and cannot trigger ERISA preemption of state tort or fiduciary law.

To determine whether fiduciary obligations to the patient-beneficiary were breached requires a more detailed analysis, because there are potentially multiple fiduciaries (due to exercise of discretionary authority over plan assets): the employer, the HMO, and the physicians who actually provide the plan benefits.[142] First, the Court contemplated whether the employer, as a fiduciary, breached its duty to the plan by contracting with the particular HMO. *Pegram* again concluded that the answer was "no." An "employer's decisions about the content of a plan are not themselves fiduciary acts."[143] Similarly, the incorporators of the HMO did not violate the employer's ERISA plan by setting up a financial incentive to control their physician's behavior.[144] In other words, what the Court is saying is that neither the structure of the employer's benefit plan nor the structure or internal operations of the HMO, acting alone or in concert with each other, can result in breach of statutory fiduciary under ERISA.

Next, *Pegram* addressed the potential for breach of fiduciary duty by the HMO. The court divided the HMO's responsibilities in regards to patient care into "eligibility decisions," "treatment decisions" and "mixed

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140. *See infra* Parts III & IV (discussing this potential).

141. *Pegram*, 120 S. Ct. at 2153.

142. In analyzing ERISA fiduciary duty, the Court clearly contemplated the actions of the HMO. The actions of the physicians are mentioned only collaterally, because the physicians in this particular case were owners of the HMO. However, the statutory fiduciary rules applied by the court to the HMO should be applicable to all non-owner physicians practicing in the HMO environment, because under ERISA, both the HMO and the physicians are conceptually fiduciaries due to their delegated discretionary authority to make decisions regarding plan assets. *See id.* A "physician employee would also be subject to liability as a fiduciary on the same basic analysis that would charge the HMO." *Id.* at 2158. The physician would be a statutory fiduciary to the extent that the HMO is a statutory fiduciary.

143. *Id.* at 2153 (citing Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996) ("Nothing in ERISA requires employers to establish employee benefit plans. Nor does ERISA mandate what kind of benefit employers must provide if they choose to have such a plan.")).

144. *Id.* at 2148.

eligibility treatment decisions."[145] Pure eligibility decisions are those decisions which concern the particular condition or medical procedure for a treatment covered by the plan.[146] Pure eligibility decisions are clearly covered by ERISA because they are related to the plan. In contrast, "treatment decisions" are "choices about how to go about diagnosing and treating a patent's condition: given a patient's constellation of symptoms, what is the appropriate medical response."[147] What the court termed treatment decisions are in reality medical decisions, which clearly would not trigger ERISA protection because they are too tenuously related to the plan.

In contrast, mixed eligibility treatment decisions are those decisions predicated on

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than Carle's; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition.[148]

In essence, mixed eligibility treatment decisions are a hybrid of the eligibility and treatment decisions. In the business of health care delivery such decisions are termed "denial of care" decisions. Virtually all decisionmaking in delivering health care in a HMO environment–whether it be a medical director's decision that a condition is not covered, or a decision of a treating physician not to treat or refer a medical condition, would be classified as mixed eligibility treatment decisions by the *Pegram* Court. To determine if mixed decisions are related to the ERISA plan, the Court needed to locate mixed decisions on the spectrum of eligibility-treatment decisions. Notice was taken that "the common law trustee's most defining concern historically has been the payment of money in the interest of the beneficiary."[149] Further, "when Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits."[150] Accordingly, the *Pegram* Court opined, "Congress did not

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145. Although the *Pegram* Court used different language than the appellate courts, the concept is the same: in ERISA health care cases one must distinguish the utilization review decisions, which are related to the plan, from the medical decisions, which are not related to the ERISA plan.

146. *Id.* at 2154.

147. *Id.*

148. *Id.* at 2155.

149. *Id.*

150. *Id.* at 2156 (citing S. REP. NO. 93-127, at 5 (1973); S. REP. NO. 93-383, at 17 (1973)).

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."[151]

However, the far-reaching implications of the *Pegram* decision can best be elucidated by looking at the converse situation. If mixed eligibility-treatment HMO administrative decisions are not covered under ERISA, then which HMO administrative decisions are covered? Based on the Court's discussion, only pure eligibility decisions are related to the plan and hence covered under ERISA. Importantly, because pure eligibility decisions are the only HMO administrative decision covered by ERISA, such decisions are the only ones that are entitled to ERISA preemption protection. After *Pegram*, if an HMO engages in administrative malfeasance, the ERISA preemption shield will only be available for those pure eligibility decisions. When a patient is harmed by a denial of care decision, because such decisions are no longer covered by ERISA, the HMO will not be able to remove the case to federal court based on a question of federal law. In essence, while it is true that ERISA preemption protection is available to the HMO for pure eligibility decisions, *Pegram* has so narrowed the ERISA's preemption in the delivery of health care as to make it an inconsequential form of protection.[152]

Pegram thus ratifies the current majority view of the appellate courts that ERISA's preemption shield is not available for administrative malfeasance in the delivery of health care.[153] *DeLucia v. St. Lukes's Hospital*[154] found that ERISA did not prevent a state court from deciding the liability of a insurer for allegedly providing suboptimal health care. *Crum v. Health Alliance-Midwest*[155] held that because the issue under review was the quality of health care, rather than erroneous denial of benefits, ERISA preemption was not triggered. The different roles of an

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151. *Id.* at 2155.

152. The courts may reach a different conclusion for a self-insured plan where the employer controls the HMO. Under such a fact pattern, the ultimate discretionary authority for a denial-of-care decision would lie with the employer and not with the plan. Because a business organization cannot practice medicine, the employer's decision would lack a "treatment" component. Hence, the employer's decision would be more of a pure eligibility decision (or alternatively a decision which wrongfully denied benefits). Herdrich v. Pegram, 154 F.3d 362, 370 (7th Cir. 1988) (citing Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co., 57 F.3d 608, 613 (7th Cir. 1995)). In *Harris Trust*, Campbell Soup Co. bought out a corporation, terminated some of the purchased corporation's employee medical insurance coverage and installed Provident Insurance as the Third Party Insurer to watch over the plan's interests. In a subsequent suit for breach of fiduciary duty, after finding that Campbell was an ERISA fiduciary, the court "emphasized that it was Campbell, not Provident, who retained the right to direct and control the claims procedures and practices, as well as the right to decide all disputed and non-routine claims." *Id.*

153. The minority opinion is exemplified by Pryzbowski v. US Healthcare, Inc., 64 F. Supp. 2d 361, 369 (D.N.J. 1999), a case alleging injury due to the failure of the treating physicians to advocate for out-of-network surgery. The Pryzbowski court characterized this as a challenge to the plan's administration and not the delivery of health care.

154. No. Civ. A. 98-6446, 1999 WL 387211, *4 (E.D. Pa. May 25, 1999).

155. 47 F. Supp. 2d 1013 (CD Ill. 1999).

HMO in health care delivery were distinguished in *Baumen v. US Healthcare, Inc.*[156] While taking notice that the HMO was an ERISA administrator, *Baumen* found that quality (or alleged lack thereof) of health care provided by an HMO was a matter that was not preempted by ERISA. The Pennsylvania Supreme Court held in *Pappas v. Asbel*[157] that state negligence laws had "only a tenuous, remote, or peripheral connection" to ERISA plans and hence were not within the scope of ERISA preemption.[158] In *Prudential Insurance Co. v. Doe*,[159] the Missouri district court found that a variety of tort claims, including intentional infliction of mental distress, were not preempted by ERISA. In fact, in the wake of *Pegram*, there is evidence that the appellate courts are even more skeptical of ERISA preemption:

> Although state efforts to regulate an entity in its capacity as plan administrator are preempted, managed care providers operate in a traditional sphere of state regulation when they wear their hats as medical care providers. ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan, but it does not insulate physicians from accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions. Such accountability is necessary to ensure that plans operate within the broad compass of sound medicine. We are not persuaded that Congress intended for ERISA to supplant this state regulation of the quality of medical practice. While it may impose some indirect costs on ERISA plans, the Court has considered such effects too tenuous to require preemption.[160]

Pegram is unwilling to allow plaintiffs to sue for these mixed decisions under ERISA, and hence extend the ERISA preemption shield to administrative malfeasance in denial of care decisions, because the court believes that this just duplicates remedies already available in state courts:

> What would be the value to the plan participant of having this kind of ERISA fiduciary action? It would simply apply the law already available in state courts and federal diversity actions today, and the formulaic addition of an allegation of

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156. 193 F.3d 151, 162-63 (3rd. Cir. 1999).

157. 724 A.2d 889 (Pa. 1998), *vacated* U.S. Healthcare Sys. v. Penn. Hosp. Ins. Co., 120 S. Ct. 2686, 2686 (2000) ("Judgment vacated, and case remanded to the Supreme Court of Pennsylvania, Eastern District, for further consideration in light [of *Pegram*] . . . .").

158. *Id.* at 892.

159. 46 F. Supp. 2d 925 (E.D. Mo. 1999).

160. Corporate Health Ins., Inc. v. Tex. Dept. of Ins., 215 F.3d 526, 534-35 (5th Cir. Tex. 2000) (citations omitted).

> financial incentive would do nothing but bring the same claim into a federal court under federal-question jurisdiction. It is true that in States that do not allow malpractice actions against HMOs the fiduciary claim would offer a plaintiff a further defendant to be sued for direct liability, and in some cases the HMO might have a deeper pocket than the physician. But we have seen enough to know that ERISA was not enacted out of concern that physicians were too poor to be sued, or in order to federalize malpractice litigation in the name of fiduciary duty for any other reason.[161]

The most interesting comment is the reference to "[s]tates that do not allow malpractice actions against HMOs."[162] If allowing the plaintiff to sue under ERISA for these decisions only duplicates state law in states that do not bar litigation against HMOs, then the Court is saying that there is no ERISA bar to these claims in state court, under state law, including state fiduciary law. Thus, this decision calls into question whether there is any ERISA protection left for HMOs and their physicians, especially their administrative physicians and medical directors, except for the pure eligibility decisions, which are almost never at issue in plaintiff malpractice actions. Furthermore, the Court's discussion of breach of fiduciary duty concerned only breach of fiduciary duty under ERISA, not state common law. Nothing in ERISA would prevent a physician from being sued in state court for breach of fiduciary duty.[163] The problem for the HMO industry is that once the physician is found liable for either medical malpractice or breach of fiduciary duty under state law, the HMO can be found vicariously liable for the physician's conduct if it employed the physicians or represents to the public that the physicians are the HMO's agent.[164]

Pegram thus appears to be a Pyrrhic victory for the HMO industry. In finding that mixed decisions of treatment and eligibility, the essence of a denial of care decisions, are not related to the ERISA plans, the shield of ERISA preemption is no longer available to HMOs that are involved in medical care decisionmaking. This emphasizes the key finding of the case: that the ERISA plan is the employer's designation of preferred benefits, not the medical administrative structure used to deliver the proffered benefits. This decision has no affect on the employer's benefits decisions. HMOs that choose to manage medical decisionmaking, directly or through

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161. Pegram v. Herdrich, 120 S. Ct. 2143, 2158 (2000).

162. *Id.*

163. *See, e.g.*, Maxxam v. Hurwitz, 1992 U.S. Dist. Lexis 5274, 10 (N.D. Cal. 1992) (preempting only claims within scope of 502(a)). *But cf.* Weems v. Jefferson-Pilot Life Ins. Co., 663 So. 2d 905 (Ala. 1995) (denying state law claims based on preemption).

164. Petrovich, v. Share Health Plan, Inc., 719 N.E.2d 756, 775 (Ill. 1999).

branded medical groups, will have to deal with fifty different state laws concerning medical malpractice and breach of fiduciary duty.[165] This will increase administration costs for these HMOs due to the need to absorb the increased liability.[166] As HMO administration costs rise, the ERISA HMOs will loose their competitive advantage over non-ERISA HMOs.[167] In short, we cannot understand why the stock market reacted favorably to the ERISA HMO stock after the announcement of *Pegram.*

Pegram took notice that the judicial system was not the best form for the analysis of HMO decisionmaking. Such decisions concern the rationing of medical care, which is difficult at best.[168] The Court realized that while the rationing might have been done poorly in the case under review,[169] it was fundamental to managed care.[170] Thus, the Court concluded that since the legislature had endorsed such rationing, it was not for the courts to decide which form of rationing better suited the legislature's public policy goals.[171] The Court was well aware of Congress' active involvement in HMO regulation.[172] Moreover, for the Court to impose statutory fiduciary

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165. Brent D. Hitson, *Alabama's Lonely Battle: An Attempt to Exert State Juristiion and Award Punitive Damages for Excusively Federal ERISA Claims in* Weems v. Jefferson-Pilot Life Insurance Co, Inc., 26 CUMB. L. REV. 591, 631 (1996).

166. ERISA authorizes the purchase of insurance.

167. Richards & McLean, *supra* note 16, at 452.

168. *Pegram*, 120 S. Ct. at 2150.

> Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others (ruptured appendixes are more likely; unnecessary appendectomies are less so), any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risks.

Id.

169. *Id.* (citing Kevin Grumbach, et al. *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516 (1998) ("arguing that HMOs that reward quality of care and patient satisfaction would be preferable to HMOs that reward only physician productivity")).

170. *Id.*

171. *Id.* "But such complicated factfinding 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." *Id.* "Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here.'" *Id.* (quoting Walters v. Nat'l Ass'n. of Radiation Survivors, 473 U.S. 305, 331 n.12 (1995)).

172. *Id.* at 2156-57 ("The Health Maintenance Organization Act of 1973, 87 Stat. 914, 42 U.S.C. § 300e *et seq.*, allowed the formation of HMOs that assume financial risks for the provision of health care services, and Congress has amended the Act several times, most recently in 1996. *See* 110 Stat. 1976, *codified at* 42 U.S.C. § 300e (1994 ed. Supp. III). If Congress wishes to restrict its approval of HMO practice to certain preferred forms, it may choose to do so.").

duty on the HMO in the present case would be counter to public policy,[173] because it would increase HMO exposure to liability.[174] Thus the Supreme Court signaled that it no longer wanted to retrospectively review medical decisions based on ERISA statutory fiduciary guidelines. However, courts of law will always be the proper forums to hear actions based on fiduciary common law.

III. REGULATION OF HMOS UNDER STATE FIDUCIARY COMMON LAW

Pegram destroyed the protection from state law that HMOs received under ERISA for administrative malfeasance in medical decisionmaking. "[W]e held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose."[175] *Pegram* had no desire to federalize medical malpractice.[176] Hence, *Pegram* clearly contemplated that state medical malpractice law would be used to regulate HMO health care delivery. However, the practice of medicine in an HMO environment is unlike the practice of medicine in the fee-for-service [FFS] environment that honed and polished the tort of medical malpractice. Financial incentives under FFS directed physicians to provide too many medical services and errors in health care delivery were assumed to be anomalous situations. Under FFS, the frauds that occurred involved the taxpayer and the insurer.[177] In contrast, financial incentives in HMO health care delivery direct the physician to under-treat patients.[178] Fraud which equates to wrongful denial of care for pecuniary gain, results in a fraud that "is more likely to make

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173. The Balanced Budget Act of 1997 specifically authorized the use of HMO structure for the delivery of health care under Medicare. Pub. L. No. 105. 33 § 407 (a).

174. *Pegram*, 120 S. Ct. at 2157.

> It 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 . . . [f]or all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.

Id.

175. *Id.* at 2158 (citing N.Y. St. Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654-55 (1995)).

176. *Id.*

177. John T. Boese, *When Angry Patients become Angry Prosecutors: Medical Necessity Determinations, Quality of Care and the Qui Tam Law*, 43 ST. LOUIS U. L.J. 53, 58 (1999).

178. Richards & McLean, *supra* note 16, at 449.

the patient the primary victim."[179] HMO health care delivery has fueled the media battle over the incidence of errors in the delivery of health care.[180]

HMO health care delivery creates unique mechanisms by which patients are harmed. The concept of injuring a patient by limiting the care options to the patient did not arise under FFS health care delivery, so the traditional tort mechanism for redressing medical injuries has not yet evolved to deal with the new mechanisms of injury ushered in by HMO health care delivery. True, given enough time, medical malpractice law could be modified to cope with denial of care issues. But, stretching a body of law predicated upon misguided or misapplied acts is not necessarily the best application of modern jurisprudence. This is especially true where there already exists a well-formed body of fiduciary common law that is ideally suited to deal with medical errors arising from conflicts of interest.[181] While breach of statutory fiduciary action under ERISA may no longer be used to redress patient harm, nothing in *Pegram* prohibits an action against a physician for breach of common law fiduciary duty.

While most jurisdictions have found physicians to be fiduciaries,[182] none has appreciated that a physician may simultaneously be a fiduciary in more than one capacity. A physician's fiduciary duty applies whether the physician acts in the capacity of a treating physician or as an administrator (medical director), or both. Both types of physicians have intrinsic conflicts of interests, which could serve as the foundations for a breach of fiduciary duty action. Both types of physicians are omnipresent in HMO health care delivery. But the loyalties and obligation associated with the fiduciary relationships of the treating physicians and the medical directors are not identical. Despite wearing the cap of a corporate administrator, the medical director is nonetheless engaged in the practice of medicine whenever the medical director's decisions are based on information about, and affect the care of, a specifically identified patient.[183] Because the

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179. Boese, *supra* note 177, at 58.

180. *See, e.g.*, TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM (Linda T. Kohn et al. eds., 1999) (The well-publicized "IOM report" concludes that as many as 98,000 Americans die each year due to errors which occur in the health care delivery system.); Clement J. McDonald et al., *Deaths Due to Medical Errors Are Exaggerated in the Institute of Medicine Report*, 284 JAMA 93-94 (2000) (disputing the validity of the methodology employed by the IOM). *But see* Lucian L. Leape, *Institute of Medicine Medical Error Figures Are Not Exaggerated*, 284 JAMA 95-97 (2000) (rebuttal to McDonald).

181. Medical malpractice arises when a physician negligently provides an independent medical judgment. But the clinical material that underpins such a judgment must be gained from being at the patient's bedside. Thus, the majority of such medical malpractice cases are ultimately incidental to a physical examination being performed. Hence, the physician or the physician's agent must at some point be at the patient's bedside. In contrast, breach of fiduciary law, the subornation of the patient's interest to the physician's interest, can occur anywhere.

182. Moore v. Regents of Univ. of Cal., 793 P.2d 479, 488 (Cal. 1990).

183. This mirrors the distinction the United States Supreme Court drew between decisions that

medical director does not routinely examine patients–rather medical directors only examine a patient's medical record—it can be difficult to hold a medical director liable for medical malpractice.[184] However, such medical administrative malfeasance can be easily handled under fiduciary common law.

A. Medical Practice and the Obligations of the Treating Physician

Ordinarily, the delivery of medical care is by a treating physician who will provide patient care either in a direct or indirect fashion. Direct patient care is care provided by a treating physician in a "face to face" fashion. Gynecologists, internists, surgeons and the like provide direct, hands-on patient care. In contrast, indirect patient care occurs when a treating physician acts in a consultant capacity. In this regard radiologists, pathologists, and anesthesiologists (collectively the "hospital-based physicians") all provide medical expertise required for specialized medical decisionmaking. Although patients rarely know the names of the hospital-based physicians who participate in their care, patients are generally aware of the existence of hospital-based physicians, and that these physicians also provide care through specialized medical care services. After reviewing the raw data[185] obtained from the patient, the hospital-based physicians memorialize their medical decision in consultative reports found within the body of the patient's medical record, and in bills for services, just as the direct patient care providers do. Because the consultant physicians have rendered a medical judgment that affects the care of the patient, they have been subjected to traditional malpractice liability for their negligent decisionmaking.[186]

Treating physicians are the archetypal "doctors" who enter into what the law terms the "doctor-patient" or "physician-patient" relationship.[187] Traditionally, treating physicians have been proud of their individual autonomy, and have seen themselves as being the patient's advocate. The

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involve individuals and those that involve populations. *See* Londoner v. City & County of Denver, 210 U.S. 373 (1908); *see also* Bi-Metallic Inv. Co. v. State Bd. of Equalization, 239 U.S. 441, 444-45 (1915).

184. Varity Corp. v. Howe, 516 U.S. 489, 514 (1996).

185. Raw data as used herein contemplates the actual examination of a radiographic or pathologic examination.

186. *See, e.g.*, Jenoff v. Gleason, 521 A.2d 1323, 1329 (1987) (holding that indirect providers have a duty to communicate unusual findings, as the communication is as important as the findings themselves); Granado v. Madsen, 729 S.W.2d 866, 874 (Tex. 1987) (holding that indirect providers have a duty to provide patient with information necessary for informed consent); Hiers v. Lemley, 1991 Mo. App. Lexis 1500, *5 (finding pathologists are the ultimate arbitrators of a clinical diagnosis).

187. For all the physicians (direct and indirect patient care providers), the doctor-patient relationship is created when the doctor renders an independent medical judgment (i.e., a decision).

doctor's superior knowledge, as compared to the patient, leads naturally to paternal ideation, while the financial incentives under the FFS reimbursement system encouraged the physician to do everything possible for the patient. When a treating physician exercises such non-reciprocal power by rendering a medical judgment that affects a patient's health care, the physician becomes a fiduciary to the patient.[188]

The medical decision itself is the end result of a reiterative five-step intellectual process. The steps are:

(1) evaluation of patient's complaints and history,
(2) gathering physical and laboratory information,
(3) making a medical decision,
(4) re-evaluation of the outcomes of those decisions, and
(5) the collection of new information about the patient's altered condition.

A treating physician gathers information by taking a history from a patient, the patient's family, or speaking with a fellow health care provider (Step 1). Alternatively, information can be extracted from the patient's medical record. This oral and written information is supplemented through the "laying of hands" on a patient (that is, physical examination) and through obtaining confirmatory laboratory studies (Step 2). Medical decisionmaking results from the physician's mental thought process as the first two steps are reviewed under the aegis of the physician's training and experience (Step 3). Such decisions are two-fold, encompassing a diagnosis and a treatment recommendation. While diagnosis is often seen as the key operational decision by physicians, from the patient's perspective, the treatment recommendation, or lack of one, is more critical.[189] It is the remaking of these medical decisions that is the practice of medicine. Step 4, the evaluation of the outcome of the medical intervention, is the most critical because it closes the loop. If the outcome of treatment is not effective (that is, the patient does not improve), the medical decision must be re-evaluated. If the treatment is effective, the patient must be monitored to assure that the condition stays controlled.[190]

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188. Frankel, *supra* note 106, at 800.

189. Society clearly views the making of a medical decision to be the dominant step in the practice of medicine. Gathering and affirming of medical information has for sometime been an activity which could be delegated to a physician assistant or a nurse. The privilege of making a medical decision, however, remains an activity reserved to physicians in most states.

190. When a medical decision is totally inappropriate due to the failure to properly complete the first two steps (gathering and affirming of medical information) the result is gross negligence. In contrast, "garden variety" medical malpractice results from failure to adequately reassess the impact of a medical decision and correct those decisions which yield an aberrant and adverse

Step 5 begins the process again. Outcome evaluation may be based on follow-up lab tests, patient reports, and subsequent physical exams. These last two steps are most likely to be compromised in managed care, because they require the evaluation of what should be a "well" patient.[191] In *Herdrich*, *Shea*, *Lancaster*, and *Neade*, a subsequent checkup of the patient would have shown that the initial diagnosis was incorrect, allowing time for proper diagnosis and treatment.

As a fiduciary, the common law imposes all of the general fiduciary obligations upon the treating physician, which include:

(1) The requirement to disclose material information.[192]
(2) The use of good faith and fair dealings with patients.[193]
(3) Maintenance of confidentiality.[194]
(4) Formal notice for the termination of the relationship,[195] and

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outcome.

191. A major premise in the cost cutting rational of managed care is that after the first three steps in the practice of medicine, subsequent review is unnecessary as the patient is presumed "well." Managed care operates on the assumption that the initial medical decision was presumably a correct decision. If it is incorrect, it is often the patient who must convince the physician, sometimes in the face of fatal opposition, as in *Shea* and *Lancaster*.

192. Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997); *see also* Garcia v. Coffman, 946 P.2d 216, 222 (N.M. Ct. App. 1997) (citing Kern *ex rel.* Kern v. St. Joseph Hosp., Inc., 697 P.2d 135, 139 (N.M. 1985) ("physician's affirmative duty to disclose material information continues beyond termination of the fiduciary relationship")); Hunter v. Brown, 484 P.2d 1162, 1166 (Wash. Ct. App. 1971) ("Whether the failure to disclose was willful or attributable to negligence is immaterial."); *Hunter* 484 P.2d at 1167 (citing Michael J. Myers, Comment, *Informed Consent in Medical Malpractice*, 55 CAL. L. REV. 1396, 1407 (1967)) ("[a] physician is under an obligation to (1) make a full disclosure of all known material risks in a proposed operation or course of treatment except for those risks of which the patient is likely to know or (2) to prove the reasonableness of any lesser disclosure or the immateriality of the undisclosed risk.").

193. Varity Corp. v. Howe, 516 U.S. 489, 506 (1996) (citation omitted); *see also Hunter*, 484 P.2d at 1166 ("At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action."); Moore v. Webb, 345 S.W.2d 239, 243 (Mo. 1961) ("The physician has a duty to act with the utmost good faith.").

194. Brandt v. Medical Defense Assoc., 857 S.W.2d 677 (Mo. App 1992) (holding that the fiduciary duty or confidential relationship between physician and patient implicates a duty to disclose all material information concerning the patient's treatment); *see also Garcia*, 946 P.2d at 222 (citing Keithley v. St. Joseph's Hosp., 698 P.2d 435, 439 (N.M. Ct. App. 1984)) ("[F]iduciary duty or confidential relationship between physician and patient implicates a duty to disclose all material information concerning the patient's treatment."); Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990); Alberts v. Devine, 479 N.E.2d 113, 113 (Mass.), *cert denied*, 474 U.S. 546 (1985); Horne v. Patten, 287 So. 2d 824, 828 (1973); Hammonds v. Aetna Cas. & Sur., 237 F. Supp 96 (N.D. Oh. 1965).

195. *Hammonds*, 237 F. Supp at 99.

(5) Undivided loyalty.[196]

Breach of any of the general fiduciary duties by a physician was actionable at common law. The two most important of the general fiduciary duties for the physician are a duty of "loyalty" and "good faith and fair dealing." *Shea* observed that the "duty of loyalty requires [a physician] fiduciary to communicate any material facts which could adversely affect a plan member's interests."[197] Additionally, good faith and fair dealing imply that the physician-fiduciary may face a civil action for what is known customarily as "dishonesty." Hence, conduct which could potentially trigger liability for breach of fiduciary duty includes: "bait and switch" (a nominal physician's services are actually provided by another; e.g., during surgical residency),[198] where a physician receives a profit in any form for the referral of a patient for an otherwise needed service (specifically, laboratory work),[199] and other forms of self-referral with built in "kickback" mechanisms.[200]

Importantly, at common law, the standard for review in determining whether a breach has occurred is from the patient's perspective. "When an ailing person selects a physician to treat him, he does so with the full expectation that such [a] physician will do his best to restore him to health . . . ."[201] Along these lines the *Shea* Court observed:

> Although the district court acknowledged Medica's duty of loyalty, the court felt the compensation arrangements between Medica and its doctors were not material facts requiring disclosure. We disagree. From the patient's point of view, a

196. Donovan v. Bierwirth, 538 F. Supp. 463, 469 (1981).

197. Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997). The material fact referred to was the insurer's physician incentive plan.

198. Such conduct may also trigger civil liability for the filing of a false claim under the Kennedy-Kasselbaum Bill. Health Ins. Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996); *see also* Richards & McLean, *supra* note 16, at 443.

199. Richards & McLean, *supra* note 16, at 451-52. The physician-fiduciary faces more than civil action for the unlawful acceptance of money. As the majority of states have adopted the Model Penal Code, many states have criminal codes finding the physician to be a fiduciary. Society has yet to declare where the line will be drawn with respect to corruption of the physician-fiduciary with respect to bribery. In this regard, consider the HMO use of a "withhold." A "withhold" is an incentive to keep the physician ever mindful of the cost of medical goods and services. Specifically, the withhold is to give the physician an incentive for denial of care. The withhold in monetary terms may be as much as 25% of the physicians salary. At what point is the withhold large enough to corrupt the physician's judgment sufficient to trigger criminal liability?

200. D.A.B. v. Brown, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997) (Referencing kickbacks: "Although the putative class attempts to frame the issue before us as one involving a breach of fiduciary duty, the gravamen of the complaint sounds in medical malpractice.").

201. Hammonds v. Aetna Cas. & Sur., 237 F. Supp 96 (N.D. Oh. 1965).

> financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information. 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 . . . .[202]

Other courts have affirmed this view: "It is well accepted that patients deserve medical opinions about treatment plans and referrals unsullied by conflicting motives."[203]

However, fact patterns that could form the basis of a medical malpractice action could also be used to form the basis of a breach of fiduciary duty. The *Neade* Court concluded that under appropriate circumstances an independent breach of fiduciary duty cause of action could arise from a common set of facts with a medical malpractice claim.[204] The benefit of pleading a case as breach of fiduciary duty rather than medical malpractice is that breach of fiduciary duty may not be subject to medical malpractice caps on recovery.[205] This potential to avoid a medical malpractice cap has not gone unnoticed: "Plaintiffs no doubt crafted craft Count V [involving actual and constructive fraud] with an eye on avoiding this cap."[206] Since much of what constitutes sufficient grounds for medical malpractice against a treating physician can be rephrased as a breach of fiduciary duty, a fair question is just how does one differentiate ordinary or "garden variety" medical negligence from a breach of fiduciary obligations?[207]

Breach of fiduciary duty and medical malpractice can be differentiated by whether the physician has reviewed the raw data [i.e., actually examined

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202. *Shea*, 107 F.3d at 628.

203. *D.A.B.*, 570 N.W.2d at 170 (citing Council on Ethical and Judicial Affairs, Am. Med. Ass'n, *Current Opinions of the Council on Ethical and Judicial Affairs of the Amercian Medical Association*—1986, § 8.06, at 31 (1986) (mandating referrals be made in best interests of patient)); *see also* David Burda, *AMA Toughens Guidelines on Physician Self-Referrals*, 21 MOD. HEALTHCARE 4, 4 (1991).

204. Neade v. Portes, 710 N.E.2d 418, 428 (Ill. Ct. App. 1999).

205. Of course, there is a downside to pleading a breach of fiduciary duty against a physician. Such an action may not be covered by medical malpractice insurance, and at present it would be a rare physician who would have appropriate insurance coverage for breach of fiduciary duty. Judging by the reluctance of physicians to obtain stop-loss insurance as a contingency to deal with the business risks of managed care medicine, it will be some time before the medical community sees the value in insurance for breach of fiduciary duty.

206. Lancaster by Lancaster v. Kaiser Found. Health Plan, 958 F. Supp. 1137, 1150 (E.D. Va. 1997).

207. Varity Corp. v. Howe, 516 U.S. 489, 514 (1996) (commenting on this hypothetical situation).

the patient] and whether the medical decision was well thought out. Medical malpractice ultimately turns on a physician's collection and review of the patient's raw data [Step 2] and the rendering of a medical decision [Step 3]. Implicit in Step 2 is that the physician or physician's agent must come into physical and temporal proximity to the patient. Whether the physician lays his hands on the patient, reviews the patient's radiographic images, or examines the patient's tissue under a microscope, the treating physician's judgment is predicated on an examination of the patient's raw clinical data in a timely manner. The failure to examine the patient properly, or worse, ignoring the patient's raw data, is what forms the bases of a medical malpractice action. Medical malpractice turns on a poorly rationalized decision, that is a "sloppy" decision. Hence a mistaken diagnosis, incompetent surgery, or error of omission in the face of adequate information could be malpractice.

In contrast, a physician's breach of fiduciary duty to a patient does not require a close temporal physical nexus to the patient to occur. In fact, the physician's decision to violate a fiduciary obligation may occur long before[208] or long after[209] the formation of the doctor-patient relationship. Nor does breach of fiduciary duty require that the treating physician review the patient's raw data. What breach of fiduciary duty does contemplate is that an affirmative decision is made to subordinate the patient's best interest to those interests of the physician or some third party.[210] Hence a choice not to do a necessary test, not to collect adequate information, or not to call in a specialty surgeon because of the cost of the tests would ultimately reduce the income of a physician or an insurer, would be a breach of fiduciary duty. Notice that breach of fiduciary duty occurs regardless of how well the science of medicine is rationalized. In fact, a well-rationalized scientific decision may give an index to the degree to which the physician has reached to subordinate the patient's interest.

We realize that an "invisible hand"[211] has always modulated the decisions of physicians regardless of the reimbursement mechanisms or the presence of ERISA protection. While in the managed care environment there are incentives to reduce care,[212] it must be remembered that

208. For example, the physician's conscious decision to receive all of the withhold money under a capitated contract could occur before the physician ever meets any HMO patients.

209. For example, a physician's decision to breach a patient's confidentiality may occur long after the formal doctor-patient relationship has come to an end.

210. In the managed care arena, the physician subordinates the patient's interests to the interests of the physician (e.g., so that the physician receives the maximum bonus or withhold) and the insurance carrier, which attempts to limit expenditures. Richards & McLean, *supra* note 16, at 452.

211. ADAM SMITH, THE WEALTH OF NATIONS (1776).

212. Under managed care, physicians may reduce care either by flat out denial or, as the *Shea* line of cases illustrates, by failure to re-evaluate the patient properly. That is, managed care provides

traditional FFS reimbursement provided incentives for excess and hence unnecessary care. With FFS medicine the issue of breach of fiduciary duty generally did not arise because the physician received pecuniary incentives to re-evaluate the patients. That is, the FFS reimbursement system rewarded physicians for increasing the volume of care given. The financial incentives under FFS medicine were such that a physician had no reason to subordinate the patient's interests to the insurer's bottom line. Thus in the FFS environment, patients were harmed when a physician subjected the patient to unnecessary tests, medical treatments or surgery.[213] Medical malpractice was honed to deal with harm caused by excessive and sometimes unneeded medical care that occurred as a discrete event. In contrast, the purpose of managed care is to ration or deny medical care. In managed care medicine a patient may be harmed by a denial of care decision made by a physician the patient does not even know. Moreover, managed care systematically dissuades a treating physician from executing Steps 4 and 5 in the reiterate medical practice cycle. These features of managed care medicine can frustrate the application of traditional tort law because they seek to change the standard of care. Fiduciary law is ideally suited to provide remedies where a fiduciary is systematically corrupted out of the presence of the beneficiary.

B. *Medical Practice and Obligations of Medical Directors*

A medical director is a physician who acts as an administrator and oversees medical care provided by an organization. Conceptually, a medical director should exist whenever a business organization provides medical services on a contractual basis, as state laws generally limit the extent to which corporations may engage in the practice of medicine.[214] Examples of such corporate provided services include: 1) staffing emergency rooms or occupational medical care clinics, 2) medical research involving human subjects, and 3) the administration of insurance. Many large corporations have more than one medical director, with one at the corporate office and one for each region or plant. These corporate medical

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physicians with financial incentive not to proceed to Step 4 in the decision algorithm for the practice of medicine.

213. Elliot S. Fisher & H. Gilbert Welch, *Avoiding the Unintended Consequences of Growth in Medical Care*, 281 JAMA 446-453, 449-50 (1999).

214. Richards & McLean, *supra* note 16, at 445. The prohibition on corporate practice of medicine dates to the 1920's. "Interestingly, [restrictions placed on the practice of medicine] evolved from laws intended to prevent the practice of law by corporations. Their purpose was to protect the independence of the professional's judgment from the pressures triggered by making money for the stockholders of a business." *Id.*

director positions existed long before managed care entered the health care arena.[215]

Medical directors practice medicine. In the spectrum of the practice of medicine, the medical director's form of practice most closely resembles the hospital-based physician's practice, as the medical director does not provide direct patient care. In contrast to the hospital based treating physician, however, the medical director is invisible to the patient, providing neither a consultative report nor a bill. In rendering a denial of care decision the medical director employs, with minor variation,[216] the same reiterating five-step intellectual thought process employed by the treating physicians. But the medical director will only review the filtered reports of the treating physicians and the patient's medical records. In actual practice, many of these "denial-of-care" decisions are not made by a physician but are delegated to nurses or other physician extenders to be made by standard protocols.[217] Legally, however, as only physicians may make medical decisions in most states, the responsibility for a nurse or physician extender's medical decision flows back to the physician.[218]

Form, not substance, in the practice of medicine is what differentiates the medical director's practice of medicine from the treating physician's practice. Key to understanding liability of HMOs is the fact that their medical directors' decisions are medical decisions,[219] while the medical director's administrative authority, exercised on behalf of the HMO, makes the HMO vicariously liable for the decisions. The medical director directly

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215. This article focuses on the medical director within the insurance industry.

216. Procedurally, the medical director does not collect and affirm clinical information personally, as a treating physician would (i.e., the medical director does not personally execute Steps 1 and 2 above), rather, the medical director generally relies on the information gathered by the treating physicians. But after making a medical decision involving patient care (Step 3) the medical director collects further information (Step 4) and makes remedial decisions (Step 5). The major difference between a treating physician's medical practice and medical director's medical practice is the latter generally makes a decision about a population of patients rather than individual patients. However, whenever the medical director makes an individual patient decision, the medical director's practice of medicine is identical to the treating physician's practice. Accordingly, where a medical director intervenes in a particular patient's care, the medical director should be as liable for treatment decisions as the treating physician.

217. An HMO usually does the initial screening for denial-of-care on the basis of an opinion rendered by a masters-level nurse or occasionally by a registered nurse. The nurse generally denies care because it is deemed unnecessary and/or not covered by the patient's policy. Routinely, the nurse's decision may be appealed to the medical director whose decision is generally final. *See* Jass v. Prudential Health Care Plan, 88 F.3d 1482, 1488-89 (1996).

218. In California, if a physician wishes to supervise a physician assistant, the supervising physician is required to have a written "Delegation of Medical Services" document on file. 66 MED. BD. OF CAL. ACTION REP. 4 (July 1998).

219. Murphy v. Bd. of Med. Exam'rs, 949 P.2d 530, 536 (Ariz. Ct. App. 1997) ("There is no other way to characterize Dr. Murphy's decision: it was a 'medical' decision.").

influences patient care when a particular patient is denied care upon the request. When a medical director makes a decision which determines (at least in part) which providers, what services, and what products will be potentially available to all patients under the corporate contract with the employer, the medical director indirectly influences the care of patients. In some plans, the medical director will even change medications ordered directly, without operating through or with the knowledge of the treating physician. In short, the medical director has authority over both treating physicians and their patients.

By exercising control over a patient's medical care, either directly or acting through a treating physician, the medical director becomes a common law fiduciary, independent of a direct physician-patient relationship.[220] Unlike a treating physician, who at least when operating in the traditional FFS environment did not have to answer to a corporate master, the medical director of necessity renders medical decisions under a requirement of dual loyalties. The dual loyalties of the medical director create a situation that is intrinsically antagonistic to the fiduciary doctor-patient relationship, which at common law demanded undivided loyalty.[221] Nowhere is the tension between the dual loyalties of the medical director clearer than in making the decision to deny medical care. Daily, medical directors must make the difficult decision of whether to deny care and hence favor the corporate master or provide the patient a treatment with a low probability of success at a high cost and hence favor the patient.[222]

In practice, what distinguishes the medical director's decisions from the treating physician's decisions are three factors. First, the medical director's prime interests are the administration of a group of patients rather than the care provided to an individual patient. Second, the medical director's decision is final[223] and, consequently, such decisions are more important

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220. There are no rituals or talismanic expressions which create a physician patient relationship. Objectively, the creation of the physician-patient relationship occurs when a contract has been formed; that is, when the patient asks for assistance and the physician accepts the patient. *See, e.g.*, Clanton v. von Haam, 340 S.E.2d 627, 630 (Ga. Ct. App. 1986); Davis v. Weiskoff, 439 N.E.2d 60, 64 (Ill. Ct. App. 1982). But this begs the question how the parties to such a contract recognize the process of offer and acceptance. From a practical point of view, the physician and patient recognize that a relationship is formed when the physician offers an independent medical decision or judgment and the patient relies on the physician's decision. This reliance is the basis for the physician-patient relationship and the accompanying fiduciary obligations. For many cases, the relationship arises from status relationships, such as the physician agreeing to treat all patients in a health plan or to treat all patients entering an emergency room.

221. Donovan v. Bierwirth, 538 F. Supp. 463, 469 (E.D. N.Y. 1981).

222. If the treatment under review by a medical director had a high probability of providing a cure (i.e., it was well accepted by the medical community as appropriate) then it is assumed that the issue of denial-of-care would not arise.

223. For ERISA self-insured plans, medical care and decisions made by an insurer-administrator can ultimately be appealed directly to the employer.

to the patient than the treating physician's decision. And third, the medical director only examines a patient's medical record, never the patient. Unlike treating physicians, when a patient is harmed by a medical director's decisionmaking which results in a wrongful denial of care and the patient sustains bodily injury, the patient may not have a "garden variety" medical malpractice remedy against the medical director.

If the patient-plaintiff filed a traditional medical malpractice action against a medical director, the plaintiff would face several hurdles. The plaintiff would have to demonstrate a doctor-patient relationship. Other than the opinion in *Murphy v. Board of Medical Examiners*,[224] there is not clear case law that places a medical director in a doctor-patient relationship. Also, a plaintiff suing the medical director would have a causation problem. Arguably, the treating physician's conduct might be viewed as an independent act which "cut off" the medical director's liability. In contrast, if the medical director was sued for breach of fiduciary duty, all that would have to be shown is that the medical director's decision impacted that plaintiff and in forming that decision the medical director subordinated the patient's interest. The latter is simple to understand because the medical director, by necessity, operates in a world of divided loyalties. After the fact, when a patient has sustained an injury because a medical service was denied, it will be very difficult to demonstrate that the medical service was unnecessary where it is also shown that the medical director was serving more than one master.

In short, the medical director is actively engaged in the practice of medicine, and, like the treating physician, the medical director may make bad decisions based on either incompetence (that is medical malpractice), or the medical director may make decisions that subordinate the patient's interests to the plan's interest (i.e., breach of fiduciary duty). When a physician assumes a medical director's position, he or she does not cease to be a physician. The common law fiduciary duties are no less onerous on a physician because the physician functions as a medical director rather than a treating physician. The importance of the medical director's position for purposes of HMO litigation lies in the ubiquitous nature of the position itself. The medical director position exists whenever a corporation oversees medical services. As such, the medical director position is the legal nexus between all HMO plans and their patients and should provide a common path for regulation, irrespective of the organizational structures of the plan.[225] The medical director's position serves as a portal for

224. 949 P.2d 503, 536 (Ariz. Ct. App. 1997).

225. Thomas W. Waldron, *Rehrmann Backs Effort on HMO Discipline*, BALT. SUN, June 11, 1998, at 6B. "The General Assembly defeated a bill . . . to put medical directors of HMOs under the same disciplinary scrutiny as doctors." *Id.* Subsequently, Maryland has placed medical directors under the control of the insurance board. *See* MD. CODE ANN. § 15-10c-02(1)(1999).

assigning liability to virtually any business organization for breach of fiduciary duty based upon administrative malfeasance.

C. *Damages for Breach of Common Law Fiduciary Duty*

Under the common law, remedies for breach of fiduciary duty were equitable and "endeavor[ed] as far as possible to replace the parties in the same situation as they would have been in, if no breach of trust had been committed."[226] Historically, equitable remedies were differentiated from legal remedies. "Money damages are, of course, the classic form of legal relief,"[227] whereas equitable remedies are classically "injunctions or restitution."[228] The issue, then, is when a patient sustains injury due to medical director's or treating physician's breach of fiduciary duty, what is the appropriate relief for such patients?

1. Equitable Relief for Breach of Fiduciary Duty

Equitable relief is "limited to those remedies that were typically available in equity, i.e. injunctions, mandamus and restitution."[229] Classically then, equitable remedies were non-pecuniary orders or awards which were granted in order to make an aggrieved party "whole." A listing of the more common equitable remedies available for breach of fiduciary duty include:[230]

(1) Injunctive and declaratory relief.
(2) Pre-judgment interest and attachment of assets.
(3) Forfeiture of beneficial interest by breaching fiduciary.
(4) Imposition of a constructive trust.
(5) Compulsion of payment owed.
(6) Restitution of misappropriated funds.

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226. Mertens v. Hewitt Assocs., 508 U.S. 248, 264 (1993) (White, J., dissenting) (quoting J. Hill, Annotation, *Remedy at Law Available to Beneficiary of Trust as Exclusive Remedy in Equity*, 171 A.L.R. 429 (1947)).

227. *Id.* at 255 (citing Curtis v. Loether, 415 U.S. 189, 196 (1974)); *see also* Teamsters v. Terry, 494 U.S. 588, 570-01 (1990); D. Dobbs, *Remedies* § 1.1 p.3 (1973).

228. *Mertens*, 508 U.S. at 225.

229. 29 U.S.C.S. § 1132 note (1997) (citing Cunningham v. Dun & Bradstreet Plan Servs., 889 F. Supp. 932 (N.D. Miss. 1995)).

230. This compilation was extracted from Francis M. Dougherty, Annotation, *What constitutes "other appropriate equitable relief" under §§ 502(a)(3)(b), 502(a)(5)(B) of the Employee Retirement Income Security Act (29 U.S.C.S. §§ 1132(a)(3)(B), 1132(a)(5)(b)) which may be obtained to redress violation or to enforce provisions, of [the] Act*, 98 A.L.R. 705 (1997).

(7) Removal of fiduciary.

Implicit in this enumeration of equitable remedies is that to be effective in providing relief for breach of fiduciary duty the contents of the trust must not only be identifiable, but the contents of the trust also must be recoverable or replaceable. That is, for equitable relief to make the party "whole," the property in question needs to be fungible. Not surprisingly, equitable remedies have worked well where a fiduciary has defrauded a trust, such as a pension fund or where the trustee has breached the confidence of the beneficiary for profit,[231] because in both of these circumstances the asset in question (money) is both seizable and fungible. However, equity cannot, by itself, make whole a party who has sustained either bodily injury or wrongful death because judicial fiat cannot replace life or limb; neither life nor limb tangible or fungible. Accordingly, in the HMO environment, when breach of fiduciary duty leads to wrongful death or bodily injury, if the remedies are limited to those found in equity, then a worthy plaintiff's remedies are tantamount to no remedy at all.

2. Compensatory Monetary Awards for Breach of Common Law Fiduciary Duty

The common law of equity's aversion to granting monetary awards for breach of fiduciary duty has never been absolute.[232] Under many situations an "equity court could 'establish purely legal rights and grant legal remedies which would otherwise be beyond the scope of its authority.'"[233] While equity recognized that monetary awards only need to be calculated with mathematical precision,[234] monetary awards were often needed to "make the victims of the breach whole."[235] Accordingly, compensatory monetary awards have been provided for breach of fiduciary duty arising under protean circumstances.[236] Although money may not make the victim

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231. Coming regulations promulgated under authority of the Kennedy-Kasselbaum Act, Pub. L. No. 104-191, 110 Stat 1936 (1996) are expected to have civil and criminal penalties for breach of confidentiality associated with data contained in electronic medical records that are mandated by this Act.

232. *See, e.g.*, United States v. Mitchell, 463 U.S. 206, 226 (1983) (mandating compensation for violations of fiduciary duties).

233. *Mertens*, 508 U.S. at 256 (quoting 1 JOHN N. POMEROY, EQUITY JURISPRUDENCE § 181, at 257 (5th ed. 1941)).

234. *In re*: Club Dev. & Mgmt. Corp. v. Leonard, U.S. App. LEXIS 6175, *9 (1991).

235. *Mertens*, 508 U.S. at 266 (White, J., dissenting).

236. Thayer v. Domiano, 511 P.2d 84 (Wash. Ct. App. 1973) (holding that monetary damages may be collected for misrepresentations); *see also* Gilbert v. Meyers, 362 F. Supp. 168 (1973) (holding that notice that application of a constructive trust can provide a vehicle for compensatory monetary award for violation of the security law); Clancy v. State Bar of Calif., 454 P.2d 329, 336 (Cal. 1969) (ordering attorney to provide a restitutionary monetary award for breach of fiduciary

of bodily injury or wrongful death whole, money is a more appropriate form of equitable relief where there is bodily injury or wrongful death.

If compensatory monetary damages are to be awarded for patients injured by a medical director's breach of fiduciary duty, then the question arises as to how such damages should be calculated. We would favor determination of monetary awards for administrate malfeasance resulting in bodily injury or wrongful death to be determined in a manner analogous to tort law,[237] because such a policy would minimize the need to redress a medical malpractice action as a breach of fiduciary duty for treating physicians. Conversely, even if a medical malpractice case were redressed as a breach of fiduciary duty cause of action, by granting a monetary award in a manner similar to medical malpractice, the discrepancy in awards would be minimized. Such a policy would also make a medical director liable to the same extent as a treating physician for a similar injury. Moreover, having a strong deterrent in place to check the medical director's behavior would serve to remind the medical directors that they are first physicians and their decisions have the potential to cause real physical harm.

IV. CONCLUSIONS

Physicians as primary treating physicians are liable when their decisions violate state medical malpractice standards or their state common law fiduciary duties. *Pegram* makes clear that physicians who also have administrative roles in HMOs are not covered by ERISA when making medical decisions and thus are also subject to the same liability as primary treating physicians. To the extent that treating physicians and medical directors are controlled by an HMO, or are found to be ostensible agents of an HMO, the HMO will share in their liability.[238] Thus HMOs and other

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duty); Local no. 92, Int'l Ass'n of Bridge, Structural & Ornamental Iron Workers, AFL-CIO v. Norris, 383 F.2d 735 (5th Cir. 1967) (allowing monetary damages in addition to attorney fees); R.C. Gluck & Co. v. Tankel, 211 N.Y.S.2d 602 (N.Y. App. Div. 1961) (holding that even absent fraud, beneficiary may receive a monetary adjustment after fiduciary provides an accounting).

237. The common law also allowed for the potential granting of punitive damages. "Although many older cases state that courts lack power in equity actions to award punitive damages, this increasingly [is an] antiquated view." Schoenholtz v. Doniger, 657 F. Supp. 899, 913 (S.D.N.Y. 1987) (citations omitted); *see also* Weems v. Jefferson-Pilot Lite Ins. Co., 663 So. 2d 905, 914 (Ala. 1995). In principle, we would favor the awarding of punitive damages in egregious cases where a physician's breach of fiduciary duty led to bodily injury. However, a discussion of punitive damages for breach of fiduciary duty is beyond the scope of this Article.

238. Recently, *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756 (Ill. 1999), has extended *Lancaster's* allowance for vicarious liability to reach all health plans. In *Petrovich*, the plaintiff alleged that the physician was negligent in failing to make a proper referral. *Id.* at 760. After experiencing intra-oral pain, the plaintiff went to see his PCP, who then referred the plaintiff to an ENT specialist. *Id.* at 761. Although the specialist recommended a further work-up, in what

managed care organizations that attempt to control medical care decisionmaking will have increased liability through the liability of their physicians. This should create pressure to improve patient care. At the same time, it will give plans that stay within the court's notion of the reach of ERISA an economic advantage through continuation of the ERISA preemption of state law regulation. Such plans must give up their control of physician decisionmaking, which reduces their ability to reduce costs, and must not hold the physicians out as their agents, which can hurt them in marketing. If the cost of litigation is too high, then there will be an incentive for plans to forgo the benefits of managing physician decisionmaking. Plans that choose this route will not give up cost controls. They will shift the cost of insurance to the physicians through capitation agreements that do not involve the plan in the decisions about individual patients. If they then though forgo medical director review of the decisions, that is, forgo quality control, they will escape state liability by explicitly ignoring quality of care issues. This threat must be addressed by state insurance regulators to avoid the paradox of avoiding liability by giving up quality control.

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is at present a recurrent pattern of conduct for PCPs in the managed care environment, the PCP overruled the specialist and clinical evaluation was terminated. *Id.* Over a year later, the plaintiff was found to have carcinoma of the tongue, which had spread into the pharynx and thereby, compromised any potential curative surgical procedures. *Id.* The court concluded that absent ERISA preemption protections, an HMO "may be held vicariously liable for the negligence of its independent-contractor physicians under both the doctrines of apparent authority and implied authority." *Id.* at 775. This HMO liability is not based upon improper administrative action of the HMO, but rather the conduct of the physician providing medical service for the plan. ERISA preemption applies to harm to patients as a result of the administrative action. In contrast, delivery of medical service is not covered under ERISA. Thus, to the extent that a plan integrates administrative and medical services, it will be vicariously liable for the negligence of the medical service providers. This should extend to all plans with "branded" medical groups or other forms of integration of medical and plan administrative functions.