No. 98-1949

IN THE

Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION and HEALTH ALLIANCE MEDICAL PLANS, INCORPORATED,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF *AMICI CURIAE* AMERICAN ASSOCIATION OF HEALTH PLANS, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES IN SUPPORT OF PETITIONERS

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I. STATEMENT OF INTEREST

The American Association of Health Plans (AAHP) is a national association for the managed health care community.[1] Its membership includes health maintenance organizations (HMOs), preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 health plans serving nearly 140 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).[2]

The Health Insurance Association of America (HIAA) is a national association for private health insurance companies and an advocate for the private, market-based health insurance system. Its more than 260 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to 123 million Americans.

The Association of Private Pension and Welfare Plans (APPWP) is a broad based, non-profit trade association founded to protect and foster the growth of this Nation's privately sponsored employee benefit plans. The members of APPWP include both small and large employer sponsors of employee benefit plans, as well as plan support

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[1] Counsel for the Amici were the sole authors of this brief. No person or entity other than Amici made a financial contribution to this brief.

[2] 29 U.S.C. § 1001 *et seq.*

organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans covering more than 100 million plan participants.

The Chamber of Commerce of the United States (the Chamber) is the world's largest business federation, representing an underlying membership of more than three million businesses and organizations of every size, in every sector and region. An important function of the Chamber is to represent the interests of its members in the federal courts in cases addressing issues of widespread concern to the business community. The ability of its member organizations to both provide and purchase affordable, quality healthcare is of vital importance to the Chamber's member organizations.

As representatives of the health plan, health insurance, and business community, Amici, AAHP, HIAA, APPWP, and the Chamber have a strong interest in the federal questions presented by this case under ERISA. The member organizations of Amici provide health benefits to employees or arrange for the provision of health care services to employee welfare benefit plans regulated under ERISA. Furthermore, many of the APPWP's and the Chamber's member businesses are purchasers of health care services.

Amici have joined together to file this brief in support of Petitioners' Brief on the Merits because of the court of appeals' novel interpretation of ERISA and that statute's established body of caselaw, as well as the extraordinarily destabilizing significance of the holding for

sponsors of employee welfare benefit plans, managed care organizations (MCOs), and health insurance issuers. Counsel for Petitioners, Virginia Seitz, Esq., and Counsel for Respondent, James R. Ginzkey, Esq., have given their consent for Amici to file this brief.

The Seventh Circuit's holding that health plan benefit design features, such as an HMO's use of cost-containment measures, can violate the fiduciary duty provisions of ERISA will have a dramatic adverse effect on the ability of the employee benefit plan community and the health care industry to provide quality care at an affordable cost. Creating ERISA liability for common plan design features will unnecessarily and materially drive up the cost of health care coverage, and will discourage employers from providing health care coverage to their employees.

II. SUMMARY OF ARGUMENT IN SUPPORT OF PETITIONERS' BRIEF ON THE MERITS

The holding of the Seventh Circuit Court of Appeals threatens the ability of the Nation's employers to provide comprehensive health benefits to all employees receiving health coverage through their employment. In essence, the lower court's holding, if allowed to stand, subjects normal and necessary cost containment mechanisms included in all health plans to challenge under both state tort law and ERISA, notwithstanding the fact that such cost containment measures are expressly encouraged and often are mandated by both state and federal laws and regulations.

There is no precedent to support the lower court's expansive interpretation of ERISA fiduciary status and of fiduciary conflicts. The decision below does violence to

both the intent and text of ERISA in that it (1) ascribes ERISA fiduciary status to entities that are neither designated as fiduciaries nor engaged in fiduciary conduct; (2) creates a new tort for "breach of fiduciary duty" that not only is without foundation in ERISA, but provides a platform for the award of punitive damages which are not available under the statute; (3) hinders plan sponsors, plan fiduciaries, managed care organizations and physicians from implementing legitimate and necessary strategies to avoid the unnecessary dissipation of a limited pool of health care dollars; and (4) discourages employers and others from maintaining benefit plans, inevitably increasing the ranks of the uninsured.

III. ARGUMENT

A. The Decision Below Contravenes Public Policy Designed to Curtail Health Care Costs

In an unprecedented and legally unsupportable decision, the Seventh Circuit transformed a garden-variety medical malpractice case into a serious threat to the economic viability of all health plans – private and governmental – which utilize managed care precepts to provide comprehensive coverage to Americans. The decision is all the more remarkable because it was unnecessary for the court of appeals to venture into health care policy-making in order to find a remedy for the plaintiff, who had already received a judgment for $35,000 in her malpractice action against her treating physician.

The facts, as alleged by plaintiff Cynthia Herdrich, illustrate a classic example of a physician's improper medical judgment. Lori Pegram, a physician employed by

the Carle Clinic, examined Ms. Herdrich. The Carle Clinic owned the HMO of which Ms. Herdrich was a member by virtue of her husband's employee benefit plan. The court of appeals simply assumed that Dr. Pegram was involved in the administration of the HMO, despite the absence of any allegations asserting that Dr. Pegram's compensation as a physician employee of the Carle Clinic was affected in any way by her treatment decisions specific to Ms. Herdrich, or indeed by patient treatment decisions in general.

Although a mass was discovered in Ms. Herdrich's abdomen, her physician delayed eight days before providing her with a sonogram, resulting in a ruptured appendix and peritonitis. A divided panel of the Seventh Circuit improperly transformed that state-law based malpractice claim into a cognizable claim for breach of fiduciary duty under ERISA. The majority held that the mere allegation that an MCO uses cost-containment mechanisms that involve the participation of physicians who provide services to ERISA plan members states a claim for breach of fiduciary duty under ERISA.

Currently, over 160 million Americans depend upon privately sponsored employer health and welfare plans subject to ERISA for their health care coverage.[3] Managed care programs have become fundamental to employer

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[3] *See* Peter T. Kilborn, *Insurers Raise Health Coverage Costs to New Highs*, THE TOPEKA CAPITAL-JOURNAL, December 20, 1998; *see also* STEVEN FINDLAY & JOEL MILLER, NATIONAL COALITION ON HEALTH CARE, DOWN A DANGEROUS PATH: THE EROSION OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES 4 (1999) (stating that 61% of Americans receive health care coverage through their employer).

sponsored health plans.[4] "Managed care" is a process by which parties responsible for paying for healthcare services (either directly or through arrangements with providers or independent companies) deliver high quality health care at a competitive price.[5] The lower court's decision not only undermines that complex balancing process, but also has the potential to destroy it completely.

After a period of relatively stable health care costs, employers are once again facing health care inflation, and are beginning to withdraw their economic support of health and welfare plans, or are limiting their contributions to fixed amounts.[6] Low-income workers, who can assume that burden less easily, are disproportionately affected by such employer cutbacks.[7] The result: an increase in the number of Americans who are without health care

[4] In 1995, nearly 75% of all individuals receiving coverage through employer- sponsored plans were enrolled in some form of managed care. *See* HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, GAO/HEHS-98-154, EMPLOYER-BASED MANAGED CARE PLANS: ERISA'S EFFECT ON REMEDIES FOR BENEFIT DENIALS AND MEDICAL MALPRACTICE 7 (1998).

[5] *See* PETER R. KONGSTVEDT, MANAGED CARE HANDBOOK 8 (2d ed. 1993).

[6] KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS, ANNUAL SURVEY 12 (1999) ("KAISER SURVEY"). The survey notes that health insurance premiums for all employers increased an average of 4.8 percent in 1999, while smaller employers (with fewer than 200 employees) saw their premiums increase an average of 6.9 percent. Coverage rates were found to have stabilized at 66 percent, which the Kaiser Survey calls "a surprising finding when a rebound might have been expected given the strong national economy." *Id.* at 30.

[7] *See* R. Kronick and T. Gilmer, *Explaining the Decline in Health Insurance Coverage, 1979-1995*, 18 Health Affairs 30, 33 (1999).

coverage, accompanied by uniformly pessimistic projections that costs will continue to increase if appropriate action is not taken.[8]

Given those projections, the timing of this broadside attack on cost containment mechanisms, which are a core element of this country's health care strategy, is unfortunate. The *Herdrich* decision, if not overturned, will be devastating to current efforts by Congress, the Executive Branch, and the private sector to contain health care costs while attempting to strike the proper balance between cost control incentives and responsibility to patients.

At present, an estimated 43 million Americans remain uninsured[9] and projections are that one million additional people will become uninsured each year, despite the burgeoning growth in the U.S. economy.[10] Economic and political factors have curtailed the availability of alternate governmental sources of health care coverage such as Medicaid and Aid to Families with Dependent Children.[11] As health care costs continue to rise (they are

[8] *See* FINDLAY & MILLER, *supra* note 3, at 5.

[9] *See id.* at 1; WILLIAM S. CUSTER, HEALTH INSURANCE ASSOCIATION OF AMERICA, HEALTH INSURANCE COVERAGE AND THE UNINSURED 3 (1999); *cf.*, KAISER SURVEY, *supra* note 6, at 30 (census bureau estimates that nearly 1 in 5 workers is uninsured).

[10] *See* KENNETH E. THORPE, NATIONAL COALITION ON HEALTH CARE, THE RISING NUMBER OF UNINSURED WORKERS: AN APPROACHING CRISIS IN HEALTH CARE FINANCING 1 (1997); *see also* CUSTER, *supra* note 9, at 5 (estimating that approximately fifty-three million Americans will be uninsured by 2007).

[11] *See* FINDLAY & MILLER, *supra* note 3, at 10.

projected to reach $1.5 trillion annually by 2002),[12] Congress and the state legislatures are desperately searching for alternative ways to assure coverage while simultaneously containing costs. The Seventh Circuit's decision will interfere with that goal because it will severely limit this country's ability to maintain, much less to expand, health care coverage, and to prevent a return to the health care cost hyper-inflation of the 1970s and 1980s.[13] A return to hyper-inflation will be inevitable if health care providers cannot be involved as participants in health care planning, with a meaningful stake in the overall effort to intelligently manage the cost and provision of healthcare services.

The court of appeals' decision exacerbates the crisis by effectively exempting medical professionals alone from the discipline of the marketplace. Judge Flaum, in dissent from the majority holding, recognizes the economic reality that private and public efforts to contain health care costs are necessary, and that those efforts must include all sectors of the health care industry, including medical professionals.[14] The alternative is unacceptable: a return to "open checkbook" credibility medical reimbursement. The dissent also correctly points out that both federal and state

[12] *See* THORPE, *supra* note 10, at 2. HCFA estimates that total health expenditures will reach $2.2 trillion by the year 2008. HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, NEW PROJECTIONS SHOW NATIONAL HEALTH SPENDING TO GROW MORE SLOWLY THAN PROJECTED LAST YEAR 1 (1999).

[13] *See* CUSTER, *supra* note 9, at 4-5.

[14] *See Herdrich v. Pegram, ("Herdrich")*, 154 F.3d 362, 380-84 (7th Cir. 1998) (Flaum, J., dissenting), *reh'g en banc denied*, 170 F.3d 683 (7th Cir. 1999), (Posner, J., Flaum, J., Easterbrook, J., and D. Wood, J., dissenting), *cert. granted*, 120 S. Ct. 10 (1999).

law are replete with measures allowing and even mandating cost-containment measures, and that supervision of employer-sponsored benefit plans and managed care constitutes a legislative and regulatory function that the courts are administratively ill-equipped to perform.

With the Seventh Circuit's opinion as one of the rare exceptions, the federal courts have wisely refrained from becoming mired in the complicated business of formulating health care laws and regulations, and should continue to follow that policy. The fact that managed care has its vocal critics does not in any way obligate the courts to create a novel application of the laws. Given the intense federal and state regulatory focus on this industry, Amici urge this Court to adopt the position that judicial restraint is the best recourse.

B. The Decision Below Improperly Involves the Federal Courts in Plan Design Decisions

In enacting ERISA, Congress did not intend the federal courts to substitute their views of what constitutes appropriate plan design for the judgments of employers and plan sponsors, who are not by statutory definition plan fiduciaries. The decisions of this Court and of the Courts of Appeal recognize that ERISA neither mandates nor specifies any substantive content for benefit plans.[15]

[15] *See, e.g., Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("[W]e are mindful that ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits."); *Hamilton v. Air Jamaica, Ltd.*, 945 F.2d 74, 78 (3d Cir. 1991) (ERISA does not mandate the substantive content of employee welfare benefit plans, and a court has no authority to draft their substantive content), *cert. denied*, 503 U.S. 938 (1992).

Nothing in ERISA precludes a health and welfare plan benefit design that provides incentives for health care professionals to be appropriately cost-conscious while fulfilling the obligations of their profession.

The *Herdrich* decision embodies the startling view that courts may impose their own opinions of benefit plan design and override the judgments of employers and plan sponsors. ERISA was intended to encourage employers and employee organizations to design and fund benefit plans in accord with their economic capacity.[16] Its ERISA participant protections attempt to ensure that the appointed plan administrators and fiduciaries implement the plan *as designed and as set forth in the plan documents*.[17] Consistent with ERISA's statutory purpose, the focus of its fiduciary provisions has been on plan administration,[18] not design, and the pivotal query has always been: *In administering the plan, has there been a breach of ERISA's fiduciary duties?*

After *Herdrich*, however, there is authority to second-guess plan design as if it were a fiduciary activity. Not only does the Seventh Circuit's decision permit the courts to second-guess plan design and to hold plan sponsors liable as fiduciaries in connection with plan design, but it establishes an unprecedented and dangerous principle of ERISA fiduciary liability for service providers (like Dr. Pegram) and administrative managers -- entities traditionally considered among the class of non-fiduciaries.

[16] ERISA § 1, 29 U.S.C. § 1001.

[17] ERISA §404, 29 U.S.C. §1104.

[18] ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (1974).

As Judge Easterbrook remarked in his dissent from the Seventh Circuit's denial of rehearing *en banc*, the decision has far-reaching consequences:

> If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies). . . are the principal features of HMOs and "preferred provider organizations."[19]

Those features, all designed to control the cost of providing health care benefits, have traditionally not been subject to judicial review. *Herdrich*, however, allows a plaintiff to challenge every single decision made in the context of establishing or administering a health plan as a "breach of fiduciary duty," including:

- Decisions respecting structural and administrative issues. These include routine business judgments, such as the selection of a specific health care delivery system and what form that entity will take.

- Decisions respecting benefit design and delivery. These include interpretations of policy exclusions or limitations, such as limiting benefits to "medically

[19] *Herdrich v. Pegram*, 170 F.3d 683, 687 (7th Cir. 1999) (Easterbrook, J., dissenting), *cert. granted*, 120 S. Ct. 10 (1999).

necessary" care or excluding coverage for cosmetic surgery.

- Decisions of physicians and other health professionals respecting the appropriate type and level of care. Questions such as whether a person needs to be hospitalized, or whether a less expensive generic drug should be prescribed, can now be considered "fiduciary" in nature.

The Nation's employer-based healthcare system simply cannot function or indeed survive if every treatment decision made while implementing a managed care program is treated as a fiduciary decision made by a presumptively conflicted fiduciary. A significant component of health care costs paid for by ERISA plans consists of medical care providers' fees and charges. If the individuals who generate such charges cannot implement reasonable cost controls because the *Herdrich* decision has transformed such conduct into a fiduciary conflict, the employer-based health care coverage system will be adversely affected, to the detriment of millions of Americans.

C. Financial Incentives in Managed Care Plans Benefit Both Patients and Physicians

Over the last decade, in an effort to control costs, traditional fee-for-service medicine has largely been replaced in the American health care delivery system by a variety of forms of managed care, premised on encouraging both providers and enrollees to use limited health care dollars prudently.[20] Such financial incentives for *providers*

[20] *See supra* note 4.

can involve something as simple as hiring physicians on a flat salary, regardless of the number of medical procedures performed, or as intricate as risk-sharing arrangements, such as payments on a capitated basis (fixed per member per month payment), provider withholds, discounted fees with bonuses, and global rates. For health care *consumers*, they include responsibility for a portion of their medical bills through the almost universal use of deductibles and co-payments, as well as financial incentives to use qualified health care providers who can provide care in an economically efficient manner.

The court of appeals' view that physician incentive arrangements substantially erode the quality of American health care is both historically naïve and contrary to objective studies of the issue. First, the court failed to recognize that financial incentives were not born with the advent of managed care. In fee-for-service medicine, "there is a financial incentive to provide more services"[21] -- perhaps even unnecessary services. More services, however, do not equate to better medical care, since they could be services that subject patients to a significant risk of complications and correlative diseases.[22] Over-utilization of

[21] Fred J. Hellinger, *The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence*, 53 MEDICAL CARE RESEARCH & REVIEW 294, 294 (1996); *see also Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (commenting on the economic interests of treating physicians under a fee-for-service system).

[22] *See* David W. Bates, et al., *Incidence of Adverse Drug Events and Potential Adverse Drug Events: Implications for Prevention*, 274 JAMA 29, 29 (1995) (stating that "over a million patients are injured in hospitals each year, and approximately 180,000 die annually as a result of these injuries").

health care services is a serious problem: the recent report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has estimated that overutilization of medical services might be as high as 30% of the total health care delivered in the United States.[23]

Second, financial incentives are a "win-win" situation for everyone involved -- doctors, their patients, and benefit plan sponsors attempting to make the most of limited health care dollars. Such incentives "preserve the ability of physicians to individualize the care they provide their patients," at the same time they enlist physicians in the battle to control health care costs.[24] Incentives are also far preferable to alternatives, such as caps on specific services, which would limit physicians' ability to tailor their recommendations for care to the needs of the individual patient.[25]

Most critically for patients, incentives have been proven effective in limiting costs[26] without any correlative detriment to the health care received by plan participants. Empirical data uniformly refute the court of appeals' position that reimbursement incentives exert a negative

[23] REPORT TO THE PRESIDENT OF THE ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS (1998).

[24] David Orentlicher, *Paying Physicians More to Do Less*, U. RICH. L. REV. 155, 164 (1996).

[25] *Id.* at 174.

[26] *See* Alan L. Hillman, et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 89 (1989).

impact on overall quality of care. In fact, the opposite is true: "the literature in this area, including large studies of Medicaid and Medicare patients in managed care systems in the 1980s, consistently shows that *costs are lower in managed-care systems, with quality equal to or better than that in fee-for-service care.*"[27]

Statistically, for example, individuals like Ms. Herdrich who suffer from appendicitis fare better in an HMO than when their coverage is a traditional fee for service plan.[28] A study published in the *New England Journal of Medicine* revealed that ruptured appendices occurred in 34.3 percent of uninsured patients, 33.6 percent of Medicaid patients, 29.3 percent of patients with private indemnity insurance and in only 25.8 percent of the patients receiving care through managed care organizations.[29] Thus, the unsupported basis for the court of appeals' opinion -- an assumption that managed care physicians are likely to sacrifice patient care for their pocketbook -- is in direct conflict with the results of this empirical study which found that to a "significant extent, patients covered by fee-for-services plans . . . appear to be at a disadvantage as compared to those covered by capitated private plans."[30]

Another recent study on quality of care in MCOs examined the comparative occurrence of preventable

[27] Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227, 1228 (1996) (*emphasis added*).

[28] *See* Paula Breveman, *Insurance Related Differences in the Risk of Ruptured Appendix*, 331 NEW. ENG. J. MED. 444, 449 (1994).

[29] *See id.* at 446.

[30] *Id.* at 449.

hospitalizations in managed care and fee-for-service populations. The study revealed that, with respect to four out of five medical conditions, the quality of care delivered by MCOs equaled or exceeded that delivered by fee-for-service plans. Of particular note with respect to the court of appeals' decision is the study's finding that the rate of hospitalization for a perforated appendix was lower for patients receiving care in a MCO.[31]

The court of appeals, however, selectively cites articles attacking managed care, while by-passing the many studies that credit managed care entities, especially for their effectiveness in preventive care and disease management. Studies published in the *Journal of the American Medical Association*, for example, indicate that HMO members receive more preventive care and more health-promoting activities than those using fee-for-service medical plans do.[32] For especially vulnerable populations, including the poor or elderly, managed care has *improved* access and continuity of care as compared with traditional fee-for-service arrangements. For example, one study examining the impact of capitated payment arrangements on pregnant women and their newborns revealed that women whose obstetrical services were provided by physicians participating in a capitated arrangement were "*less* likely to have a low-birth weight baby and *not* more likely to have

[31] *Quality of Care for Managed Care and Fee-for-Service Patients Based on Analysis of Avoidable Hospitalizations*, 2 VALUE IN HEALTH (1999).

[32] *See* Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1516 (1994).

other adverse pregnancy outcomes" than those receiving obstetrical care through a fee-for-service arrangement.[33]

Yet another study demonstrated that Medicare participants in HMOs were diagnosed with cancers such as breast, cervix, colon, and melanomas at an earlier stage than participants with fee-for-service coverage:

> Most preventive services are not covered under Medicare fee-for-service . . . The greater availability of screening services in HMOs may be particularly important for the elderly because elderly women use screening mammographies and Pap smears less frequently than do younger women.[34]

Perversely, the lower court believed that it was carrying the banner of physician responsibility "in determining what is the best course of treatment and therapy for their patients."[35] Its holding, however, works to create exactly the opposite result, effectively outlawing the very cost containment measures that cast physicians in the central role of directing, managing, and supervising medical care in the context of universally limited health care budgets. A significant benefit of a capitated system is that it transfers more control over medical decision-making to the hands of treating physicians, rather than leaving such decisions to the financing entity. Studies show that financial

[33] Gerald F. Riley, *Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees*, 84 AM. J. PUB. HEALTH 1602 (1994).

[34] *Demographic Predictors of Mammography and Pap Smear Screening in US Women*, 83 AM. J. PUB. HEALTH, 53-60 (1993).

[35] *Herdrich*, 154 F.3d at 377.

incentives in MCOs give physicians greater clinical autonomy to make decisions about how to reduce costs, while at the same time helping them to maintain quality.[36]

The court of appeals' assumption that financial incentives will motivate physicians to cast aside their professional and ethical obligations does a disservice to the profession. The American Medical Association itself has guidelines that recognize that financial incentives are a fact of life, as long as they are interpreted to "promote the cost-effective delivery of health care and not the withholding of medically necessary care."[37] If we assume that physicians engage in acts that could constitute medical malpractice on the basis of financial motives, as the court of appeals has, then we should also abolish the fee for service system as a basis of compensation to health care providers, since it may also hold out a financial carrot to physicians to provide marginally appropriate treatments, or even unnecessary care.[38]

D. Federal and State Law and Policy Mandate Cost Containment Measures in Health Plans

Neither Congress nor the states share the court of appeals' distaste for cost containment mechanisms. The

[36] *See* Orentlicher, *supra* note 24, at 164, 174-75; *see* Miller & Luft, *supra* note 32, at 1516.

[37] *American Medical Association, Council on Ethical and Judicial Affairs*, 273 JAMA 331 (1995); *see also* M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268 (1999). James C. Robinson, *Blended Payment Methods in Physician Organizations Under Managed Care*, 282 JAMA 1258 (1999).

[38] *See Herdrich*, 154 F.3d at 382 (Flaum, J. dissenting).

forms of financial risk sharing condemned by the court of appeals are all firmly grounded in legislative policy designed to eliminate the inflationary incentives of "open checkbook" medicine. Systems for the achievement of cost-savings in health care coverage and delivery have constituted the keystone of federal and state health care programs since the passage of the Federal Health Maintenance Organization Act of 1973,[39] which required employers with at least 25 employees to offer a federally qualified HMO as an option to their employees and which expressly authorizes HMOs to "make arrangements with physicians . . . to assume all or part of the financial risk."[40] ERISA itself specifically mandates that welfare plan fiduciaries are subject to a duty to act prudently and preserving and maintaining plan assets.[41] Yet the court of appeals' decision would deny ERISA plans the ability to avoid wasteful expenditures of plan assets through cost control systems expressly sanctioned by federal and state laws.

Congress more than a decade ago shared the court of appeals' bias against MCO cost containment practices, and, at one time, prohibited prepaid health care organizations that contracted with Medicare and Medicaid from having incentive based payment arrangements with physicians.[42] Research studies by the Department of Health

[39] 42 U.S.C. § 300(e) (1973).

[40] 42 U.S.C. § 300e(c)(2)(D) (Supp. 1999).

[41] ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1).

[42] Omnibus Budget Reconciliation Act (OBRA) of 1986, Pub. L. No. 99-509, § 9313, 100 Stat. 2002 (1986). The Omnibus Budget Reconciliation Act (OBRA) of 1990, Pub. L. No. 101-508, §§ 4204(a),

and Human Services, however, "failed to find a link between the quality of care provided under the Medicare and Medicaid programs and the structure of physician incentive plans."[43] Recently, based on empirical studies rather than uninformed supposition, the federal government released *Medicare and Medicaid Programs: Requirements for Physician Incentive Plans in Prepaid Healthcare Organizations,* in which it aggressively promotes for inclusion in the Medicare and Medicaid programs the very cost containment methodologies that would be outlawed by the Seventh Circuit.[44]

In the 26 years since the passage of the HMO Act, Congress has passed a series of acts and amendments with one goal: to regulate and to foster the growth of managed care programs in all forms of government sponsored health care delivery systems. For example, in 1981, the Omnibus Budget Reconciliation Act (OBRA '81)[45] helped foster managed care contracting with state Medicaid programs, an innovative approach which had at its core Medicaid's need to supply quality health care at a cost-effective price. The following year, the Tax Equity and Fiscal Responsibility Act (TEFRA)[46] allowed MCOs participating in the

1388-236 (1990), repealed the prohibition on physician incentive plans in Medicare and Medicaid HMOs.

[43] 57 FED. REG. 59,024 (proposed Dec. 14, 1992); Requirements for Physician Incentive Plans, 42 C.F.R. § 417.479 (1997).

[44] Social Security Act, 42 U.S.C. § 1395mm (Supp. 1999) (Medicare managed care); 42 U.S.C. § 1396b(m) (Supp. 1999) (Medicaid managed care); 42 U.S.C. § 1395w (Supp. 1999) (Medicare+Choice).

[45] OBRA of 1981, Pub. L. No. 97-35, 95 Stat. 357 (1981).

[46] TEFRA, Pub .L. No. 97-248, 96 Stat. 324 (1982).

Medicare program to enter into risk sharing contracts with health care providers. Since then, enrollment in MCOs with risk sharing arrangements by Medicare insureds has increased 10 times over,[47] to over 2 million members.[48]

The question of whether and how best to further regulate commercial health plans is currently very visible on Congress's radar screen, with rigorous debate over methods to protect enrollees while at the same time encouraging provider incentive programs and other cost-containment mechanisms. The "Norwood-Dingell Bill," [49] for example, passed by the House of Representatives in October of 1999, would regulate physician incentive arrangements by extending to all commercial health plans the requirements that are now imposed only on health plans that contract with Medicaid. In addition, Congress has already limited the use of one common cost-containment mechanism -- pre-existing condition exclusions -- through the Health Insurance Portability and Accountability Act of 1996.[50] Further recent legislation has been aimed at

[47] DOUGLAS A. HASTINGS ET AL., NATIONAL HEALTH LAWYERS ASS'N, FUNDAMENTALS OF HEALTH LAW 252 (1995).

[48] Managed care is also a critical element of the Federal Employees Health Benefits Program as well as the Civilian Health and Medical Program of the Uniformed Service ("CHAMPUS"). In 1988, for example, CHAMPUS beneficiaries were given the ability to choose among various forms of managed care, as well as the traditional indemnity programs.

[49] H.R. 2990, 106th Cong., 1st Sess., (1999)(including H.R. 2723)("Bipartisan Consensus Managed Care Improvement Act of 1999," or the "Norwood-Dingell Bill")

[50] Health Insurance and Accountability Act ("HIPAA") of 1996, Pub. L. No. 104-191, 110 Stat. 2945 (1996); ERISA § 701, 29 U.S.C. § 1171; Public Health Service Act, §§ 2701, 2741, 42 U.S.C. §§ 300gg, 300gg-41.

prohibiting physician incentives that may have the effect of limiting care in specified situations.[51]

In addition to existing and proposed regulations, the managed care industry itself has developed well-regarded self-regulating mechanisms, which employers and other consumers of health care can consult when purchasing health plans. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), for one example, mandates that HMOs have in place rigorous quality assurance programs. JCAHO standards encompass 410 individual benchmarks, including education, leadership, management of human resources and performance improvement.[52]

As is evident, there are few more highly regulated and monitored areas of the United States economy than employer-sponsored health care plans and the managed care industry. Issues relating to how to provide medical care for both the insured and uninsured, while simultaneously controlling medical spending, is at present a subject of the most intense public debate, and presents numerous intertwined (and sometimes conflicting) policy issues.

Yet the Seventh Circuit has concluded that all of the legislative, regulatory, and industry safeguards pertaining to an MCO's contracts with ERISA plans are inadequate to protect consumers appropriately. Its opinion disregards the considered judgment of federal and state legislatures and regulatory agencies that hold that physician incentives to control over-utilization and eliminate unproductive expenditures are appropriate and, indeed, necessary to sustain a health care system that employers and society can support. On the basis of undocumented assumptions about the alleged adverse impact of managed care cost containment practices, the court has turned a virtue -- the duty of an ERISA fiduciary to be financially prudent -- into a punishable sin, with dire consequences for the limited health care dollars of every plan.

E. The Decision Below Misconstrues The Rights and Remedies Available under ERISA

The court of appeals' decision creates a new class of fiduciary breach. It holds that physician incentives to manage health costs "*can* rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists. . . ."[53] Apparently, a fiduciary need not actually have engaged in conduct that constitutes a breach of fiduciary duty in order for a court to find liability for such a breach. All that is required is an allegation that a plan participant no longer

[51] *See* Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (1996); Women's Health and Cancer Rights Act, Pub. L. No. 105-277, § 902, 112 Stat. 2681 (1998) (prohibits issuers from offering providers incentives to provide a patient with care that is inconsistent with the terms of the Act).

[52] *See also,* National Committee on Quality Assurance (NCQA) "Surveyor Guidelines for the Accreditation of MCOs," UM 11.5 (Effective July 1, 2000-June 30, 2001); *The NCQA's Quality Compass: Evaluating Managed Care in the United States*, 17 Health Affairs 152 (1998). The NCQA evaluates HMOs based on internal quality processes, and requires complete disclosure of any incentives regarding utilization of medical services.

[53] *Herdrich*, 154 F.3d 373 (emphasis added).

has faith in the fiduciary's ability to fulfill his or her statutory duties.

A participant's mere concern that a fiduciary *might* breach a duty, whether or not justified, does not constitute an actual breach under ERISA.[54] Despite an absence of evidence that Dr. Pegram engaged in any fiduciary activity, and despite the fact that ERISA does not govern physician-patient relationships on any level,[55] the court of appeals created this novel form of what is in effect an anticipatory hypothetical fiduciary breach.

The lower court's mistaken holding is based upon profound conceptual errors regarding the nature of the ERISA-based identities and relationships between the parties. First, the court confused the HMO with the plan sponsor of the ERISA-governed employee welfare benefit plan in which Ms. Herdrich participated. Second, it confused Dr. Pegram's activities, all of which involved patient care, with ERISA plan administration. Even if Dr. Pegram performed any administrative function (which is unlikely), action that consists of the ministerial implementation of a plan is not a fiduciary function.[56] These conceptual errors led to the erroneous conclusion that compliance with plan design can constitute a breach of fiduciary duty, and that the HMO's doctors participated in that breach because their compensation was based, in part,

[54] 29 U.S.C. §§ 1104 and 1109.

[55] *See Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 249 (5th Cir. 1990) (ERISA governs relationships between employers, plans, participants, beneficiaries and plan fiduciaries).

[56] 29 C.F.R. § 2509.75-8, Q&A D-2.

upon implementing cost saving mechanisms that were included in the plan's design.[57]

Apparently, the Seventh Circuit based its conclusion that the HMO and the Clinic physicians were fiduciaries upon its finding that they exercised discretion in the claims adjudication process,[58] despite a complete absence of evidence that they were fiduciaries for claims adjudication or for any other purpose. Fiduciary status is not an all-or-nothing proposition. A person is a fiduciary only to the extent that the particular activity performed is a fiduciary function.[59] Thus, as Judge Easterbrook noted in dissent from denial of a rehearing, the appropriate question should not have been whether the HMO and Dr. Pegram *ever* performed a fiduciary function, but whether they were performing as fiduciaries when they participated in the design of a plan that contained financial incentives to implement cost saving measures.[60] The answer must be no: implementation of the plan as designed and as set forth in the plan documents is not a fiduciary function.[61]

[57] Plan design is not a fiduciary act. *See Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996) (employers do not act as fiduciaries when they adopt modify or terminate plan); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995) (same).

[58] *Herdrich*, 154 F.3d at 370.

[59] *See, e.g., Coyne & Delany Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996).

[60] *Clemmons v. Delo*, 177 F.3d 680, 687 (8th Cir.) *reh'g denied and petition for cert. filed sub nom. Clemmons v. Bowersox*, __ S. Ct. __, No. 99-6533 (U.S. Nov. 15, 1999).

[61] *Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608 (7th Cir. 1995).

The court of appeals' decision improperly marries two very different concepts: (1) statutory violations of ERISA and (2) personal injury compensable under state tort law. ERISA provides a remedy when a fiduciary improperly denies a benefit expressly provided for in a plan, while state tort law provides relief when a physician renders substandard care, just as damages were awarded to Ms. Herdrich in this case.[62] Numerous state and federal courts have recognized that distinction, holding that claims which challenge the quality of medical services delivered through managed care organizations are cognizable under malpractice law, but that it is inappropriate to invoke ERISA as a basis for such claims.[63]

The *Herdrich* decision stretches ERISA's language beyond recognition by converting ordinary tort claims into tort-based "breach of fiduciary duty" claims. This is not a benign invention. A fiduciary duty is owed to the plan members *in the aggregate*.[64] Elevating the fiduciary duty owed to the individual participants of an employee benefit plan far above the duty owed to the plan as a whole, the decision literally prevents fiduciaries from fulfilling their statutory duty to preserve and maintain plan assets.[65] The result: fiduciaries will be compelled to breach their

[62] *Herdrich*, 154 F.3d at 367.

[63] *See, e.g., DeLucia v. St. Luke's Hosp.*, No. 98-6446, 1999 U.S. Dist. LEXIS 8124 (E.D. Pa. May 24, 1999); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Santitoro v. Evans*, 935 F. Supp. 733 (E.D.N.C. 1996).

[64] ERISA §404(a)(1).

[65] *See Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *see also, Central States, Southeast & Southwest Areas Pension Fund v. Central Transp., Inc.*, 472 U.S. 559, 569-70 (1985).

statutory duties, as they are forced to provide health care coverage arrangements without cost containment measures to appease individual plan members and to avoid liability for damages under this new judicially-created ERISA tort action. In the long run, of course, such an approach is counter-productive, as it depletes plan assets and inevitably places the health care benefits of those same plan members at serious risk.

There is no basis whatsoever in the text of statute or this Court's prior opinions for this novel tort-based "breach of fiduciary duty" claim, and this Court should not allow a court of appeals to create one. Although Ms. Herdrich purported to bring her claim "on behalf of the Plan,"[66] no financial loss to the plan flowed from Dr. Pegram's delay in scheduling Ms. Herdrich for medical services, and her personal loss provides no basis for remedial relief for the plan under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Nor can Ms. Herdrich rely on Section 409 of ERISA, 29 U.S.C. § 1109, which allows participants to bring claims against a plan fiduciary who causes injury to the plan, and requires that the breaching fiduciary "make good to such plan losses to the plan." Nowhere in Ms. Herdrich's complaint does she allege that *any* action on the part of the HMO caused a financial loss to "the Plan," and indeed she cannot. The plan would have realized a financial gain rather than a loss if it functioned as Ms. Herdrich alleged. Any cost savings realized as a result of physician incentives would necessarily *reduce* rather than *increase* the costs to the plan for purchasing health benefits.

[66] *See Herdrich*, 154 F.3d at 362.

By creating a cause of action for an anticipatory fiduciary breach, the lower court has engrafted new remedies onto the text of ERISA in violation of this Court's strict mandate to apply the language of the statute as written. This Court recently reaffirmed its prior teaching: "ERISA is a 'comprehensive and reticulated statute'...and is 'enormously complex and detailed...' [and] it should not be supplemented by extra-textual remedies."[67] Just as this Court has refused to adopt a "strained interpretation" of ERISA in the interest of fulfilling the statute's purpose of protecting plan members,[68] so it should refuse to allow the Seventh Circuit to invent a form of fiduciary breach that does not require conduct constituting a fiduciary breach, no matter how laudatory its motives.[69]

The creation of a new fiduciary standard unsupported by ERISA is not a harmless aberration that will be recognized as such by other courts. The *Herdrich* decision can be invoked to support a claim for breach of fiduciary duty any time cost-saving mechanisms -- the essence of employer-sponsored health care plans and managed care -- are in place.[70] Yet health plan enrollees

[67] *Hughes Aircraft v. Jacobson*, 525 U.S. 432 (1999).

[68] *Mertens v. Hewitt Associates*, 508 U.S. 248, 261 (1993).

[69] *See also Mertens*, 508 U.S. at 251 ("[V]ague notions of a statute's 'basic purpose' are nonetheless inadequate to overcome the words of its text regarding the *specific* issue under consideration").

[70] *Herdrich* has already been relied upon to allow a breach of fiduciary duty claim against an HMO doctor on the basis of the perceived financial tension between the doctor's and clinic's financial well being and the patient's welfare. *See Neade v. Portes*, 710 N.E.2d 418, 424-25 (Ill. App. Ct. 1999); *see also, Petrovich v. Share Health Plan of Illinois*, 1998 U.S. Dist. LEXIS 8454 (E.D. Ill. Sept. 30, 1999).

already have a remedy for inadequate quality of medical services in medical malpractice law,[71] and ERISA provides ample judicial remedies, including the availability of immediate injunctive relief.[72] The court of appeals' unnecessary construct of a hybrid consisting of both ERISA fiduciary standards and medical malpractice tort principles must be rejected. The decision also constitutes impermissible "judicial policymaking" by repudiating the express policy determinations of Congress, the Executive Branch, and state legislatures mandating the provider risk sharing methodology at issue in this case. Most significantly, it irreparably harms the ability of ERISA fiduciaries, employers, plan administrators, and MCOs to sustain our current system of employer-based health coverage on which millions of Americans depend.

IV. CONCLUSION

For the above reasons, Amici, HIAA, AAHP, APPWP and the Chamber, respectfully request that this Court reverse the decision of the Court of Appeals for the Seventh Circuit.

[71] *See DeLucia*, 1999 U.S. Dist. LEXIS 8124, at *10.

[72] *See* 29 U.S.C. §1132(a)(1)(B).

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