No. 98-1949

IN THE SUPREME COURT OF THE UNITED STATES

CARLE CLINIC ASSOCIATION and
HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

BRIEF AMICUS CURIAE OF THE AMERICAN COLLEGE OF LEGAL MEDICINE, THOMAS W. SELF, M.D. AND LINDA P. SELF, R.N. IN SUPPORT OF RESPONDENT

Filed December 14, 1999

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes and Rules

Other Authorities

STATEMENT OF INTEREST

The American College of Legal Medicine ("ACLM"), and Thomas W. Self, M.D. and Linda P. Self, R.N. (together, "the Selfs"), respectfully submit this brief as *amici curiae* pursuant to Rule 37 of the Rules of the United States Supreme Court. The ACLM and the Selfs do not *per se* support either Petitioners or Respondents in this case, but, rather, write to more clearly define certain issues, and to offer their considerable collective experience with financial incentives provided by managed care organizations ("MCOs"), and the impact of certain incentives on healthcare delivery. These amici file their brief along with Respondent because their position is arguably and indirectly more supportive of Respondent's cause. The ACLM and the Selfs have received the consent of all parties to submit this brief pursuant to the applicable rules of this Court. *See* Appendix A.

Founded in 1960, the ACLM is an organization of professionals concerned with issues arising at the convergence of law and medicine. The ACLM's membership consists of about 1500 professionals, including physicians in most every specialty, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. ACLM Fellows, as well as a significant portion of the college's membership, hold professional degrees in both law and medicine.

Thomas W. Self, M.D. is a Yale and UCLA trained pediatric gastroenterologist, who has practiced medicine in San Diego, California since 1972. Dr. Self recently attained national recognition for a unique lawsuit he filed against the physician group in which he formerly practiced. In that case, Dr. Self alleged that his employment with that group had been terminated because he refused to succumb to "bottom line" financial pressures imposed by the MCOs with which his group was affiliated. Specifically, Dr. Self alleged that he was fired

because, according to these MCOs (and his physician group), he devoted too much time to, and ordered too many tests for, his patients. After a contentious three month trial and eight days of jury deliberation, the jury awarded Dr. Self compensatory damages in the amount of $1.75 million; before the jury was to determine punitive damages, the parties settled the case for $2.5 million. This landmark litigation was the subject of testimony by Dr. Self in 1998 at a bicameral congressional hearing on proposed patients' rights legislation, and also has been profiled in various television and print media.

Linda P. Self, R.N., is a registered nurse and medical administrator, with many years experience both in providing medical care and treatment, and processing patient claims to MCOs. Ms. Self is particularly familiar with MCO cost-containment mechanisms and has witnessed first-hand their adverse impact on healthcare delivery.

The ACLM's and the Self's interest in the instant lawsuit initially derived solely from their collective interest in maintaining the sanctity of the physician-patient relationship, and in eliminating any barriers that harm this relationship, including financial incentives that infringe upon physicians' ability to deliver quality healthcare. These *amici* are particularly concerned that certain cost-containment mechanisms imposed by MCOs compel even the most ethical physicians to consider foregoing potentially appropriate treatment to maintain their affiliations with, and satisfy, MCOs. The ACLM and the Selfs write, in part, to offer their experience as to how the cost-containment mechanism at issue here can, indeed, adversely affect the delivery of quality healthcare.

Review of the briefs filed by Petitioners and some of their supportive *amici*, however, have generated an additional interest of the ACLM and the Selfs. It is posited in these briefs that the court below improperly held that MCOs and physicians are fiduciaries under the Employee Retirement Income Security

Act of 1974 ("ERISA"). The ACLM and the Selfs have a profound interest in ensuring that physicians' clinical obligations to their patients are not confused with, or otherwise hampered by, any purported obligations under ERISA. In this regard, the ACLM and the Selfs write to argue that physicians are not *per se* ERISA fiduciaries, and that the court below did not find, and could not have found, otherwise.

SUMMARY OF THE ARGUMENT

In their brief, Petitioners contend that the two fundamental issues on appeal are (i) whether Petitioners are fiduciaries under the Employee Retirement Income Security Act of 1974 ("ERISA"), and (ii) if Petitioners are ERISA fiduciaries, whether they breached their fiduciary duty under ERISA by paying financial incentives to physicians for minimizing patient care and treatment. Petitioners and their supporting *amici* argue, in essence, that the Seventh Circuit Court of Appeals answered both questions in the affirmative, and that that decision is improper because neither managed care organizations ("MCOs") nor physicians are ERISA fiduciaries.

The ACLM and the Selfs respectfully submit that Petitioners misstate the Seventh Circuit's ruling and the issues on appeal, and that Petitioners and their supportive *amici* unnecessarily complicate the issues in this case. While the ACLM and the Selfs concur that neither MCOs, nor, in particular, physicians, are *per se* ERISA fiduciaries, these *amici* are compelled to offer some additional insight as to the actual issues on appeal. Specifically, the ACLM and the Selfs do not believe that the court below did find, or even could have found, either physicians or MCOs to be *per se* ERISA fiduciaries – a fact illuminated by clarification on several points critical to this appeal.

First, there is confusion as to the actual identity of the Petitioners themselves. The only Petitioners in this appeal are the Carle Clinic Association ("CARLE") and Health Alliance Medical Plans, Inc. ("HAMP"), neither of which is an MCO or a physician. The ACLM and the Selfs urge this Court to reaffirm this fact.

Second, these *amici* also urge this Court to make certain the ultimate holding of the court below. The briefs of Petitioners and some of their supportive *amici* appear to read the decision from which this appeal is taken as finding MCOs and physicians to be ERISA fiduciaries. The Seventh Circuit did not, should not and could not have rendered such a ruling, because (a) no MCO, and certainly no physician, is a party to this appeal or the appeal to the court below, and (b) such a holding confounds the applicable statutory definition of "fiduciary."

Third, the ACLM and the Selfs note that the fiduciary duties imposed under ERISA are delegable in nature. By statutory definition, ERISA fiduciary status extends to *any* entity or person who has or exercises any discretionary authority, control or responsibility in the management or administration of an employee benefit plan. Whether any entity or person is an ERISA fiduciary, therefore, depends entirely upon their role in the management and administration of a plan, rather than upon their corporate structure, business purpose or personal occupation. The question in this appeal, then, pertains not to MCOs and certainly not to physicians generally, but rather pertains specifically to CARLE and HAMP, and their role in the management and administration of the subject health plan.

Finally, the ACLM and the Selfs note that the district court dismissed Respondent's ERISA claim pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. The actual question on appeal, therefore, is not whether CARLE and

HAMP are, in fact, ERISA fiduciaries, but rather whether Respondent *sufficiently alleged* that these entities are ERISA fiduciaries, *i.e.*, that they had or exercised any discretionary authority, control or responsibility in the management or administration of the subject health plan. If Respondent did, the Seventh Circuit properly reversed the district court's ruling in this regard, and Respondent should be afforded the opportunity to prove her allegations. The ACLM and the Selfs respectfully submit that Respondent satisfied this pleading standard, and, therefore, the Seventh Circuit's ultimate decision on this fiduciary issue should be affirmed.

With respect to the second issue on appeal, the membership of the ACLM and the Selfs offer this court their considerable experience in today's managed care environment, to express just how incongruous the financial incentives at issue in this appeal are with physicians' duty of loyalty to their patients, physicians' mission to provide quality healthcare, and their allegiance to adhere to the precepts of the Hippocratic Oath, *i.e.*, "[n]ever do no harm to anyone." Cost-containment mechanisms are not *per se* detrimental to this cause, and, arguably, are inevitable in a private healthcare system. However, mechanisms which provide cash incentives to physicians that have the affect of minimizing care and treatment most assuredly do not work to the benefit or interest of patients. And, importantly, this particular mechanism does not arise out of balanced contractual negotiations between managed care entities and their affiliated physicians, but, instead, is imposed upon physicians. The ACLM and the Selfs take no position on whether the imposition of the cost-containment mechanism at issue on appeal falls within the rubric of ERISA and the fiduciary responsibilities imposed thereunder. The ACLM and the Selfs strongly believe, though, that the subject financial incentives are contrary to patients' best interests.

ARGUMENT

The ACLM and the Selfs submit that the issues on appeal have been confused and unnecessarily complicated, if not misstated, in the briefs of Petitioners and their supportive *amici*. Petitioners represent that this appeal presents the following two fundamental questions: (i) whether Petitioners are fiduciaries under the Employee Retirement Income Security Act of 1974 ("ERISA"), and (ii) if Petitioners are ERISA fiduciaries, whether they breached their fiduciary duty under ERISA by allegedly imposing a cost-containment mechanism which provides financial incentives to physicians for minimizing patient care and treatment. However, this case reaches this Court on the issue of whether the Seventh Circuit Court of Appeals properly reversed the district court's dismissal of this lawsuit pursuant to Fed.R.Civ.P. 12(b)(6). The issue, then, is not whether Petitioners are ERISA fiduciaries or whether they breached their fiduciary duty by imposing the cost-containment mechanisms at issue in this case, but, rather, whether Respondent Cynthia Herdrich ("Herdrich") *sufficiently alleged* these conclusions as facts in her Amended Count III.

I. ARE PETITIONERS SUFFICIENTLY ALLEGED TO BE ERISA FIDUCIARIES?

The ACLM and the Selfs respectfully submit that an accurate review of the facts on several issues – issues clouded by the briefs of Petitioners and some of their supportive *amici* – demonstrates that Herdrich, in fact, *did* sufficiently allege Petitioners to be ERISA fiduciaries.

A. Who are the Petitioners?

Petitioners and several of their supportive *amici* ask this Court to overturn the Seventh Circuit's decision based on the contention that the appellate court improperly held that HMOs and physicians are *per se* ERISA fiduciaries. The ACLM and

the Selfs would share this concern if they similarly interpreted the Seventh Circuit's ruling; but they do not. A first issue critical to understanding the decision below, and on which there appears to be real confusion, is the actual identity of the Petitioners. The necessary identity of the Petitioners is demonstrated through the procedural history of this case and the pleadings below.

The procedural history of this case is well-detailed in Petitioners' filings in this Court and in the Seventh Circuit's August 18, 1998 opinion. *See* Petition for Writ of *Certiorari* (at pp. 4-8); Brief of Petitioners (at pp. 7-15); *Herdrich v. Pegram*, 154 F.3d 362, 365-367 (7th Cir. 1998). Respondent Cynthia Herdrich ("Herdrich") originally filed in state court a two-count complaint alleging professional negligence against Lori Pegram, M.D. and against CARLE. *Id.* Herdrich then amended her state court complaint to add two new counts (Counts III and IV) alleging state law fraud against both CARLE and a new defendant, HAMP (HAMP being a corporation that (a) operates an HMO known as CarleCare HMO, and (b) is wholly-owned by CARLE). *Id.* CARLE and HAMP removed the case to federal court, based on their contention that the newly added Counts III and IV against CARLE and HAMP were preempted by ERISA, an argument with which the federal district court agreed. *Id.* Thereafter, the district court entered judgement for CARLE and HAMP on Count IV, and it granted Herdrich leave to amend Count III to proceed under ERISA. *Id.*

Herdrich then filed her Amended Count III, alleging that defendants to that count breached their fiduciary duty to plan participants and beneficiaries by implementing a cost-containment mechanism that provided physicians with financial rewards for minimizing certain medical treatment and for minimizing referrals to physicians and facilities outside the HMO network. *Id.*

The identity of the Amended Count III defendants is plainly set forth in that pleading:

> NOW COMES plaintiff, CYNTHIA HERDRICH, by her attorneys, Hayes, Hammer, Miles Cox and Ginzkey complaining of CARLE CLINIC ASSOCIATION, P.C. (hereinafter "CARLE"), HEALTH ALLIANCE MEDICAL ASSOCIATION, P.C. (hereinafter "HAMP") and CARLE HEALTH INSURANCE MANAGEMENT CO., INC. (hereinafter "CHIMCO") as follows:
>
> THE PARTIES
>
> 1. CARLE is an Illinois corporation comprised of owner/physicians and is doing business in the central district of Illinois.
>
> 2. HAMP is a for-profit Illinois Domestic Stock Insurance Company doing business in the central district of Illinois and is a wholly-owned subsidiary of CARLE.
>
> 3. CHIMCO is a for-profit Illinois corporation doing business in the central district of Illinois and is a wholly-owned subsidiary of CARLE.
>
> JURISDICTION
>
> 4. This court has jurisdiction....

Amended Count III at pp. 1-2.[1]

The Count III defendants -- CARLE, HAMP and CHIMCO -- moved to dismiss Amended Count III pursuant to Fed.R.Civ.P. 12(b)(6), which motion the district court granted. *See* Petition for Writ of *Certiorari* (at. P. 6); Brief of Petitioners (at p. 10); *Herdrich*, 154 F.3d 362, 367. Herdrich appealed that dismissal ruling to the Seventh Circuit, which reversed the district court, and now "Petitioners" appeal that decision to this Court.

So, who are Petitioners in this appeal? The ACLM and the Selfs respectfully submit that Petitioners themselves are unclear on this point. Petitioners, in their brief, identify themselves as those parties "listed in the caption of the case." Brief of Petitioners at p. ii. However, the caption on the cover of their brief identifies Petitioners as Lori Pegram, M.D., CARLE and HAMP, and Petitioners continue on in the body of their brief to identify each of these three as "Petitioners." *See, e.g.*, Brief of Petitioners at p. 6 ("through petitioner, [CARLE], doing business as"), at p. 8 ("received from petitioner Dr. Lori Pegram"). Adding confusion, Petitioners also contend that CHIMCO -- an entity not referenced in their caption -- is also a petitioner. Brief of Petitioners at p. 7; *but see Amicus* Brief of the United States at p. 4, fn. 2 ("CHIMCO is not a petitioner in this Court.")

These *amici* respectfully disagree with Petitioners' characterization of their own identity. First of all, it is clear from the procedural history of this case that the only matter appealed to the Seventh Circuit and, thereafter, to this Court, are rulings on Respondent's Amended Count III; Petitioners

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[1] A majority of the text of Amended Count III is set forth both in Petitioner's brief (at pp. 9-10, fn. 6) as well as in the Seventh Circuit's opinion (154 F.3d at 366, fn. 3), but neither includes this introductory text that identifies the defendants to that count.

admit that. *See* Petition for Writ of *Certiorari* (at p. 5) and Brief of Petitioners (at p. 8) ("On September 1, 1995, Herdrich filed her amended Count III. That count is the subject of the decision at issue here."); *see also Herdrich*, 154 F.3d at 367 ("On appeal [to the Seventh Circuit], Herdrich contends that the district court erred in dismissing the amended count III ....").

Furthermore, there can be no dispute that the only defendants to Herdrich's Amended Count III are CARLE, HAMP and CHIMCO. As the only defendants in this count, CARLE, HAMP and CHIMCO are the only parties with standing to be respondents to Herdrich's appeal to the Seventh Circuit, and, in turn, the only parties potentially to have standing to be Petitioners from the Seventh Circuit's decision. *See, e.g., Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S.Ct. 2130, 2136 (1992) (setting forth standing requirements). This fact is further buttressed by the Seventh Circuit's opinion in which that court specifically named CARLE, HAMP and CHIMCO as defendants-appellees in that appeal. *Herdrich*, 154 F.3d 362, 365.

For the foregoing reasons, it is clear that Petitioners to this Court may be comprised of *only* CARLE, HAMP and CHIMCO. And while Dr. Pegram was a defendant to Herdrich's Counts I and II, it is undisputed that those counts sounded in professional negligence, and, moreover, that Dr. Pegram was *never* a party to Amended Count III. Simply stated, Lori Pegram, M.D., is not, and could not be, a Petitioner, and these *amici* respectfully ask this Court to make this fact clear.

B. Which Parties did the Seventh Circuit Find to be ERISA Fiduciaries?

Although the Seventh Circuit's opinion speaks for itself, there appears to be substantial confusion as to precisely *who* the

court found to be an ERISA fiduciary. Petitioners and several of their supportive *amici* write that the appellate court held Lori Pegram, M.D. to be an ERISA fiduciary. However, as shown above, the Seventh Circuit should not, and could not, have reached such a conclusion because Dr. Pegram was not a party to the Seventh Circuit appeal. It is well-settled that the rights and liabilities of a person or entity cannot be adjudicated in a proceeding to which that person or entity is not a party. *See, e.g., Lujan v. Defenders of Wildlife, supra.*

Furthermore, the ACLM and the Selfs submit that the Seventh Circuit's opinion clarifies that that court did *not* find Dr. Pegram to be an ERISA fiduciary:

> [Taking Herdrich's allegations to be true] ... [w]e can reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims.
>
> * * * * *
>
> Contrary to the defendants' assertion, and the magistrate's conclusion, CARLE and HAMP are, in fact, fiduciaries.

Herdrich, 154 F.3d at 369, 370, 371. At no point in that opinion does the Seventh Circuit state expressly or impliedly that Dr. Pegram, or any other physician, is an ERISA fiduciary.

Furthermore, no where in the Seventh Circuit's decision does that court discuss or ever find CHIMCO – the only other possible Petitioner in this appeal – to be an ERISA fiduciary. Accordingly, since CHIMCO is not subject to an adverse ruling, it has no basis on which to petition this Court, and, therefore, CHIMCO is not and cannot be a Petitioner in this appeal. *See, e.g., Lujan v. Defenders of Wildlife, supra.; see*

also Amicus Brief of the United States at p. 4, fn. 2 ("CHIMCO is not a petitioner in this Court.").

In sum, the only parties to comprise the Petitioners in this appeal are CARLE and HAMP, as these are the only entities which the Seventh Circuit found potentially liable under Herdrich's ERISA claim.

It is, moreover, the case that neither CARLE nor HAMP is an MCO. The text of Amended Count III, the Petitioners' own brief and the Seventh Circuit's opinion make clear that the MCO at issue in the underlying claim is an entity entitled "CarleCare HMO" – which is not a party to Amended Count III, not a petitioner to the Seventh Circuit and not a petitioner to this Court. Accordingly, not only did the Seventh Circuit not find Dr. Pegram or any other physician to be an ERISA fiduciary, it also did not find any MCO to be an ERISA fiduciary. Granted, HAMP is alleged to own and operate CarleCare HMO. But that fact does not transform HAMP, itself, into an HMO. As shown below, this is a critical distinction.

C. What is an ERISA Fiduciary?

It is clear from the definition of "fiduciary" as well as from the duties ascribed to fiduciaries as set forth in ERISA, that such duties are delegable in nature. ERISA's application is certainly limited to employee health plans, but the definition of fiduciary is not so limited. An ERISA fiduciary is *any* entity or person who has or exercises any discretionary authority, control or responsibility in the management or administration of an employee benefit plan.[2] 29 U.S.C. §1002(21)(A). Whether any entity or person is an ERISA fiduciary, therefore, depends

[2] Because many of the briefs filed to date in this appeal fully set forth the language of ERISA defining "fiduciary" and describing an ERISA fiduciary's obligations, these *amici* will not repeat those lengthy statutory provisions.

entirely upon their role in the management and administration of an ERISA plan.

From that statutory definition, fiduciary status may not be *per se* imposed upon employers or MCOs or physicians. The description of an entity's business structure or purpose, like a description of a person's occupation or profession, has no bearing whatsoever on whether an entity or a person is an ERISA fiduciary. As Petitioners and their supportive *amici* accurately aver, the business functions of an MCO, and, assuredly, the clinical duties of physicians, are indisputably separate and distinct from the administration and management of an employee health plan. Consider, for example, that some employers administrate and manage their own health plans. In that circumstance, the employer takes on the role of ERISA fiduciary. That the employer retains an MCO, which, in turn, provides medical benefits through physicians, does not *per se* transfer the plan's administrative or management functions to the MCO or to the physicians.

On the other hand, nothing in ERISA proscribes the delegation of the administration and management of the plan by the employer to some other entity or person. Surely, an MCO or a physician could administer or manage an ERISA plan, just as a plumber, a teacher or an electrician could take on those tasks. But, clearly, the role of plan administrator and manager is separate and distinct from the business functions of an MCO, the clinical functions of a physician, and the occupational functions of a plumber, a teacher and an electrician. It, therefore, would be error to conclude that any entity or person – whether MCO, physician, plumber, teacher, electrician or otherwise – cannot as a matter of law be an ERISA fiduciary, at least without factual information as to what, if any, role that entity or person played in the administration and management of an ERISA plan.

Even assuming *arguendo* that either of the Petitioners is an MCO, Petitioners ask this Court to take an extreme and unwarranted position that, because they are MCOs, they should never be adjudged an ERISA fiduciary. Petitioners are right to argue that the business functions of an MCO are separate and distinct from the functions of administering an ERISA plan. But an MCO, in addition to its business functions, could certainly *also* serve as a plan administrator.

In sum, whether any entity or person is an ERISA fiduciary depends upon their particular role in the management and administration of an ERISA plan, an inquiry which is primarily, if not exclusively, fact-based, and which must be assessed on a case-by-case basis. In the instant case, therefore, whether CARLE or HAMP is an ERISA fiduciary depends upon their role in the management and administration of the subject health plan – an issue which seems difficult to fully and appropriately determine solely upon the allegations of Amended Count III. That one of those entities, *i.e.*, HAMP, owns and operates an HMO, and that the other, *i.e.*, CARLE, owns HAMP, are facts meaningless to the question as to whether they are ERISA fiduciaries. To be clear, the business structure and purpose of an MCO, of an MCO's owner, and of an MCO's owner's parent corporation cannot alone transform any of these entities into an ERISA fiduciary, because that structure and purpose does not *per se* involve the administration or management of an employee benefit plan. Likewise, a physician's professional obligations to a patient cannot itself possibly create ERISA fiduciary obligations, because patient care and treatment is wholly removed from the process of administering and managing an employee health plan.

D. Are CARLE and HAMP Sufficiently Alleged to be ERISA Fiduciaries?

As noted above, this case reaches this Court on the propriety of the Seventh Circuit's reversal of the district court

dismissal under Rule 12(b)(6) of Herdrich's Amended Count III. The actual issue on appeal, therefore, is not whether CARLE and HAMP are, in fact, ERISA fiduciaries, but, rather, whether Herdrich *sufficiently alleged* that these entities are ERISA fiduciaries, *i.e.*, that they had or exercised any discretionary authority, control or responsibility in the management or administration of the subject health plan. The only way in which to reverse the Seventh Circuit on this issue, therefore, is if this Court determines that Herdrich failed to satisfy the federal pleading requirements in her Amended Count III, or if this Court concludes that, regardless of her allegations, neither CARLE nor HAMP can be an ERISA fiduciary as a matter of law. The ACLM and the Selfs aver that this Court should not make either of those findings.

In Herdrich's Amended Count III, as set out in the Petitioners' brief and the Seventh Circuit's opinion, she alleged the existence of an ERISA health plan (at ¶6), the employer's delegation of the function of administering the plan to the Amended Count III defendants (at ¶¶6 and 7), those defendants' discretionary authority and control over claims management, property management and asset management and the administration of the plan (¶¶7 and 8), and the charge that the defendants are, in fact, plan fiduciaries through the discharge of various tasks (¶11). The ACLM and the Selfs respectfully submit that Herdrich has satisfied liberal federal pleading requirements.

Finally, this Court should *not* find that CARLE and HAMP cannot be ERISA fiduciaries as a matter of law. As shown above, any entity or person who has or exercises any discretionary authority, control or responsibility in the management or administration of an ERISA plan is an ERISA fiduciary. Whether CARLE or HAMP possessed such authority, control or responsibility is a question of fact which

should not be resolved on the pleadings alone under a Rule 12(b)(6) motion to dismiss.[3]

E. Conclusion

For the foregoing reasons, the ACLM and the Selfs respectfully submit that the first issue on appeal is whether Herdrich sufficiently alleged that CARLE and HAMP are ERISA fiduciaries – a question which, at this stage of her lawsuit, should be answered in the affirmative.

II. THE SUBJECT COST-CONTAINMENT MECHANISM DIVIDES PHYSICIANS' LOYALTY TO PATIENTS

> In the course of treatment, the physician is obligated to the patient and to no one else.... He is not the agent of society, nor of the interests of medical science, nor of the patient's family, nor of his co-sufferers, nor of future sufferers from the same disease.... The physician is bound not to let any other interest

[3] Notwithstanding Petitioners' argument to this Court, the fact that CARLE and/or HAMP may be ERISA fiduciaries is significantly advanced by their own prior pleadings in this case. After the Amended Count III defendants removed the case to federal court, Herdrich filed a motion to remand to state court. In response to that motion, Petitioners filed a brief arguing in favor of preemption, and thus, removal, in which brief they *admitted* that they are ERISA fiduciaries: "[HAMP] was the administrator and fiduciary of the Plan within the meaning of ERISA ... [and] it is clear that the plaintiff's claims relate to the Plan administered by [HAMP]. But for the existence of the Plan, Cynthia Herdrich's participation in that Plan and [HAMP's] serving as administrator/ fiduciary of that Plan, there would be no relationship whatsoever between Cynthia Herdrich and [HAMP], and thus no lawsuit." See Memorandum in Opposition to Plaintiff's Motion to Remand, "Synopsis of Relevant Facts" (emphasis supplied). Petitioners, or at least Petitioner HAMP, is hard-pressed to argue now that, as a matter of law, it cannot be an ERISA fiduciary.

> interfere with that of the patient in being cured.... We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.

Jonas, H., "Philosophical Reflections on Experimenting with Human Subjects," *Contemporary Issues in Bioethics* 432, 438 (T.L. Beauchamp and L. Walters, eds., 3rd ed. 1978).

> In contrast to traditional fee-for-service medicine, "managed care creates a new adversarial relationship between the health care system and the patient." Patients want to know not only that the doctor is in, but which side the doctor is on.

Sage, W., "Physicians as Advocate," 35 *Hous.L.Rev.* 1529, 1534 (Spring, 1999), *quoting* Mehlman, M.J., "Medical Advocates: A Call for a New Profession," *Widener L.Symp.J.* 299, 305 (1996).

The ACLM and the Selfs believe firmly that the financial incentives at issue in this appeal necessarily infringe upon a physician's duty of loyalty to patients, and, in turn, hinder a physician's obligation to provide quality healthcare. It is simply implausible that any physician, regardless of his or her ethical standards, is unimpeded in medical decision-making where that physician will receive a cash reward for rendering less treatment, whether that reward is earned by omitting a diagnostic test or by not referring the patient to a specialist or treatment facility outside that physician's MCO network.

Notwithstanding the fact that the physician-patient relationship and a physician's obligation to the patient are genuinely unique and not easily amenable to analogy, consider the following:

Both physicians and jurists possess a fundamental duty of loyalty to their constituents – be they patients or litigants – to make fair and impartial decisions, and both are entrusted with significant responsibility by the systems in which they practice their craft. Now, imagine that, to off-set sky-rocketing costs of the federal justice system, Congress, or the federal judiciary itself, enacted a cost-containment mechanism pursuant to which the government paid a bonus to federal district court judges for minimizing the number of cases on their dockets. The goal of such a mechanism could be described as reasonable, if not noble, since the fewer cases there are to clog the justice system, the swifter justice could be for all litigants – just as the goal of cost-containment in managed care is reasonable, not only due to the for-profit, private nature of the system, but also because, in managed care, reduced costs for any particular patient is supposed to reduce the overall cost to all patients.

Now, in the analogy, what judge, in hearing a particular lawsuit, could wholly eliminate from contemplation a cash bonus to be earned if he or she renders a ruling that concludes the lawsuit? The ACLM and the Selfs do not for a moment suggest that some, most or all federal judges are vulnerable to such a proposed "incentive" program, nor that they would place personal financial gain over the administration of justice. Similarly, these *amici* feel confident that the vast majority of physicians are not driven by financial gain over patient care. However, complete disregard of a possible cash incentive by either group of professionals seems highly improbable, if not impossible.

Would such an incentive, whether for the physician or the jurist, influence every situation? Surely not, as both judges and physicians face what might be labeled "black and white" situations. Making the right decision in those cases is likely easy for the ethical physician or jurist. But consider the "gray area" cases, which may constitute the majority of cases for

doctors and judges. The ACLM and the Selfs submit that, even for the most ethical physician or jurist, it would be literally impossible to wholly disregard the fact that a cash bonus hinged on a professional decision.

Furthermore, the cost-containment mechanism at issue in this lawsuit essentially transforms physicians into health insurers. Where a physician decides to order a diagnostic test, or to bring an "outside" physician into the treatment process, the physician ultimately pays for that care by foregoing whatever cash incentive would have been earned without the test or referral. This analogy similarly illustrates how it would be virtually impossible to disregard the financial consequences to the physician of ordering a test or making a referral.

To be clear, the ACLM and the Selfs do not thrust their criticism generally upon all cost-containment mechanisms utilized in managed care. In this regard, the Seventh Circuit did *not* hold that cost-containment mechanisms *per se* violate ERISA:

> Our decision does not stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists.

154 F.3d 362, 373. MCOs, like most if not all businesses, employ a variety of methods to reduce or eliminate unnecessary costs. However, mechanisms which reward physicians for *minimizing* care and treatment are simply in another category, and gnaw at the very core of physicians' professional obligation to their patients. As one physician-commentator recently noted:

> The profit incentives underlying proposed cost cutting mechanisms have gradually, yet substantially, displaced the patient's best interest. ... [T]he key restraint for physicians ... is the limitation placed on the autonomy of their clinical judgment, a limitation which alters their role from serving as agents for the patient's welfare to balancing the patient's needs against the need for cost control. [T]hese recent developments place the essential element of the physician-patient relationship, advocacy, at risk of being permanently disrupted.
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> * * * * *
>
> [M]anaged care entities critically rely upon the physician gatekeepers for their profit margins and overall financial stability. ... [G]rowing influence by MCOs over a physician's delivery of health care, as well as the latter's own financial incentives to underutilize medical resources, may bias physicians' judgment and risk the inappropriate denial of necessary services.

Gonzalez, J.L., "A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World," 35 *Hous.L.Rev.* 715, 717-18, 732 (Fall, 1998).

There should be no doubt that cash rewards paid to physicians to minimize care and treatment most assuredly work against the interest of patients.[4]

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[4] Interestingly, in a recent six-year comprehensive study involving of 3500 renal disease patients, a team of scientists determined that there are increased mortality rates and decreased rates of placement on waiting lists for renal transplants at *for-profit* dialysis facilities as compared to their *not-for-profit* counterparts. Garg, P., *et al.*, "Effect of the Ownership of Dialysis Facilities on Patients' Survival and Referral for Transplantation," 341 N.Eng.J.Med. Vol. 341, No. 22 at pp. 1653-1660 (Nov. 1999).

The foregoing argument may lead one to wonder why the ethical physician would ever agree to such a financial incentive. While it is true that such incentives are set forth in contracts between MCOs and physicians or physicians groups, it must be emphasized that these are far from negotiated terms arising out of evenly balanced contractual negotiations between managed care entities and their affiliated physicians. It is well-documented that MCOs dominate these negotiations, due primarily to the facts that economic survival requires physicians to affiliate with MCOs,[5] and that many MCOs are enormous, and can afford simply to offer physicians "take-it-or-leave-it" contracts.[6] Rarely, if ever, does a physician request that a portion of compensation be paid in the form of a bonus for minimizing treatment. These incentives are imposed upon physicians as a term of doing business with a particular MCO.

The ACLM and the Selfs take no position on whether the imposition of the cost-containment mechanism at issue in

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[5] In 1988, 61% of all physicians in the United States were contractually affiliated with at least one MCO – a percentage which rose to 75% in 1993, to 81% in 1996, and to 92% in 1997. "The Impact of Managed Care on Physicians," *Health Care Management Review*, Vol. 24, No. 2, p. 44 (March 22, 1999); "Managed Care Accounts for Greater Share of Physicians' Incomes," *Strategic Medicine*, Vol. 2, No. 5 (May, 1998).

[6] *See, e.g.*, various articles addressing MCOs' dominance over physicians in structuring their contractual affiliation: "Rebellion in White: Doctors Pulling Out of HMO Systems," *New York Times*, sec. 1, p. 1 (January 10, 1999); "Fiercer Aetna Sets its Sights on Dominating Health Care," *New York Times*, sec. C, p. 1 (December 14, 1998); "Insurers Tighten Rules and Reduce Fees for Doctors," *New York Times*, sec. 1, p. 1 (June 28, 1998); "Doctors v. Aetna: Win a Battle, Lose the War?" *Medical Economics*, Vol. 75, No. 10 at pp. 52-70 (May 26, 1998); "Managed Care Contracts: Some Progress, But Problems Linger," *American Medical News*, Vol. 41, No. 3 (January 19, 1998); "Whose Calling the Health Care Shots?" *Business & Health*, Vol. 15, No. 10 at pp. 30-35 (October, 1997).

this appeal falls within the rubric of ERISA and the fiduciary responsibilities imposed thereunder. The ACLM and the Selfs strongly believe, though, that the subject financial incentives are contrary to patients' best interests – a conclusion which, if the incentives are imposed by an ERISA fiduciary, suggests some relation to that fiduciary's duties under ERISA. For example, at section 404(a), ERISA expressly requires fiduciaries to discharge their duties "solely in the interest of the participants and beneficiaries." 29 U.S.C. §1104(a)(1). This Court, in *Varity Corp. v. Howe*, 516 U.S 489, 506-515, 116 S.Ct. 1065, 1074-79 (1996), interpreted this phrase to create for a plan participant a cause of action for breach of fiduciary duty under ERISA for decisions premised upon financial gain to the fiduciary at the expense of plan participants. That is at least analogous to the instant situation, where the subject cost-containment mechanism is clearly intended to create financial gain to the alleged fiduciary, and is imposed at the potential expense of plan participants.

The ACLM and the Selfs also reject Petitioners' argument that healthcare is a mere *indirect* benefit of a health plan. Mere membership in a plan is of no benefit whatsoever to a plan participant. The only purpose for which a participant enrolls in (and pays for) a health plan is to receive the benefit of healthcare. Accordingly, patient care is a *direct* benefit of an ERISA health plan, thereby further implicating ERISA in the instant issue.

The ACLM and the Selfs again emphasize that the subject mechanism may be inclusive of a breach of fiduciary duty under ERISA. Clearly, a plaintiff, here Herdrich, must prove that the alleged injury was proximately caused by the financial incentives, but that fact is plainly alleged in her Amended Count III (at ¶13). Because Herdrich's ERISA claim was dismissed on a Rule (12(b)(6) motion to dismiss, if this Court determines that the imposition of the subject financial incentives even plausibly falls within the rubric of ERISA, then

Amended Count III should be reinstated to afford Herdrich the opportunity to prove her allegations.

CONCLUSION

For all the foregoing reasons, *Amici Curiae* American College of Legal Medicine, Thomas W. Self, M.D. and Linda P. Self, R.N. respectfully request that this Honorable Court (i) affirm the Seventh Circuit Court of Appeals' finding that Respondent Cynthia Herdrich sufficiently alleged Petitioners Carle Clinic Association and Health Alliance Medical Plans, Inc. to be ERISA fiduciaries so as to survive a Fed.R.Civ.P. 12(b)(6) motion to dismiss, and (ii) consider the adverse impact that the subject cost-containment mechanism has on healthcare delivery, in ruling on whether the imposition of this mechanism may give rise to an ERISA claim for breach of fiduciary duty.

Respectfully submitted,

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