No. 98-1949

IN THE SUPREME COURT OF THE UNITED STATES

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

v.

CYNTHIA HERDRICH,
Respondent.

BRIEF OF HEALTH LAW, POLICY, AND ETHICS SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

Filed December 20, 1999

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On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF HEALTH LAW, POLICY, AND ETHICS SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

INTEREST OF AMICI

The *amici* are scholars working in the field of health care policy.[1] They are expert in such matters as the effect of financial incentives on the quality of health care, the operation of cost-containment measures developed by managed care organizations, the ethics and dynamics of the

[1] The *amici* are listed in the Appendix. Pursuant to Rule 37.6 of the Rules of this Court, *amici* state that no counsel for a party authored any portion of this brief and no person or entity, other than the *amici* and their counsel, made any monetary contribution to the preparation or submission of this brief. This brief represents the views of *amici* individually and does not necessarily represent the views of institutions with which they are affiliated.

physician-patient relationship, and the workings of the present health care market. Several of the *amici* were cited in briefs in this Court.

The *amici* have prepared this brief primarily to explain (i) how decisions made by managed care organizations and doctors can, in some circumstances, constitute exercises of fiduciary duty governed by ERISA, and (ii) the consequences for patients, physicians, employers, and health benefit plans of failure to recognize the applicability of ERISA fiduciary duties in those cases to which ERISA does apply.

Counsel for the parties have consented to the filing of this brief. Copies of the consent letters have been filed with the Clerk.

SUMMARY OF ARGUMENT

ERISA fiduciary duties apply, in some circumstances, to health care related decisions made by managed care organizations (MCOs) or the physicians who are their employees and in some cases their shareholders. Specifically, employer-sponsored health benefit plans are generally "ERISA plans," *see* 29 U.S.C. §§ 1003(1), 1004(a), and any person who "has any discretionary authority or discretionary responsibility in the administration" of an ERISA plan is an ERISA fiduciary. 29 U.S.C. § 1002 (21)(A). When an ERISA plan covers "medically necessary" or "medically appropriate" (or similarly defined) health benefits, and grants an MCO the authority to determine whether particular services are within these medically defined categories, the MCO may be making ERISA plan coverage determinations at the very moment that it makes "medical necessity" health care decisions.[2] Such plan coverage decisions are covered by the language and policy of ERISA.

[2] This brief uses the terms "medically necessary" and "medical necessity" to refer to the plan coverage determination.

Furthermore, the delegation of an ERISA fiduciary duty to another person is itself a fiduciary act that may not be taken disloyally or carelessly. When an MCO delegates the "medical necessity" decision to a physician, the MCO has a fiduciary duty, under ERISA, to assure that its delegate does not have an impermissible conflict of interest. A physician's substantial personal financial interest in reducing the amount expended on serving plan beneficiaries may constitute such a conflict of interest.

Failure to recognize the applicability of ERISA to the MCO's decisions in these circumstances would have at least two severe adverse consequences for the health care system. First, it would enable all concerned to immunize many negative plan coverage decisions from legal attack: if an employer plan can define coverage in terms of the broadly discretionary category "medical necessity," and if determinations of medical necessity made by MCOs and physicians are not regarded as fiduciary decisions governed by ERISA, there is no opportunity for legal review either under state law (which is broadly preempted with respect to plan coverage issues) or under ERISA—even if the doctor determining that a patient does not need a particular treatment is directly benefiting from avoiding this particular expense.

Second, a physician who has a systematic incentive to determine that particular services are not "medically necessary" within the meaning of the coverage provisions of a particular ERISA plan will have the same systematic incentive to distort her medical advice to the patient, because the plan coverage determination and the medical advice to the patient occur in the same breath. In traditional fee-for-service medicine, the physician was expected

to give medical advice essentially independent of the patient's ability to pay. Managed care plans have brought the medical advice and the payment decision together, and the real tragedy of awarding the ERISA immunity petitioners seek will be its effect on candor with which doctors advise their patients and the lack of trust this engenders. Absence of judicial oversight would be particularly troubling at a time when the market is rapidly changing.

Finally, *amici* urge the Court not to accept arguments made on the petitioner side that the only way to contain medical costs is to give physicians a clear and substantial incentive to recommend fewer and less expensive services and that no such incentives can constitute an impermissible conflict of interest or a breach of fiduciary duty. There are other means of dealing with costs (and managed-care plans have virtues besides cost-containment). Moreover, the structure of this market is evolving rapidly and that evolution should not be distorted by a broader than necessary ruling about the potential application of ERISA.

ARGUMENT

I. MANAGED CARE ORGANIZATIONS AND PHYSICIANS ARE "ERISA FIDUCIARIES" WHEN THEY (A) MAKE DECISIONS THAT DETERMINE THE COVERAGE OF AN ERISA PLAN OR (B) DELEGATE THE AUTHORITY TO MAKE SUCH DECISIONS

A managed care organization (MCO) or physician does not become an ERISA fiduciary merely by giving medical advice or providing medical services that are paid for by an ERISA plan. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356-57 (3d Cir. 1995); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1329-34 (5th Cir. 1992). State regulation of medical practice, including state tort law, applies to such acts. However, an MCO

or physician is an ERISA fiduciary to the extent that it or she has discretionary authority to determine the coverage of the ERISA plan itself. Moreover, if an MCO has such authority and delegates it to a physician, both the MCO and the physician are ERISA fiduciaries. Any other rules would contravene both the text and the purposes of ERISA and would effectively immunize plan coverage decisions in these commonplace situations and distort the provision of medical advice.

A. MCOs (and Physicians) Are Fiduciaries When They Exercise Discretion Over Plan Coverage Determinations

A person acts as an ERISA fiduciary to the extent that it or she exercises "any discretionary authority or discretionary responsibility in the administration" of an ERISA plan, including determinations of entitlement to benefits. 29 U.S.C. § 1002(21)(A). The statute thus defines ERISA fiduciary status not merely in formalistic terms, but "in *functional* terms of control and authority" over the plan and benefits. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993) (citing 29 U.S.C. § 1002(21)(A)); H.R. Conf. Rep. No. 93-1280, at 323 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5103.

Employer-sponsored ERISA health care plans often designate MCOs as fiduciaries responsible for plan administration. *See, e.g., Libby-Owens-Ford Co. v. Blue Cross and Blue Shield Mut.*, 982 F.2d 1031 (6th Cir. 1993); *Corcoran*, 956 F.2d at 1329; *Greenblatt v. Prescription Plan Servs. Corp.*, 783 F. Supp. 814 (S.D.N.Y. 1992). Insofar as these express responsibilities include discretionary determination of what services a plan covers, the MCO is an ERISA fiduciary. *See* 29 U.S.C. § 1105(c); 29 C.F.R. § 2560.503-1. This is true whether the MCO assigns responsibility for such determinations to adminis-

trative personnel or to physicians in its employ. Moreover, even where the MCO is not formally designated a fiduciary, it is a fiduciary under ERISA insofar as it has the practical authority to make such determinations. *See* 29 C.F.R. § 2560.503-1. To take a common example, if the employer's ERISA plan provides coverage for all "medically necessary" services and gives the MCO the authority to decide what is covered in a particular case, the MCO is exercising discretionary responsibility in the administration of the plan itself (*i.e.*, determining the extent of its coverage) and is an ERISA fiduciary. *See id.*; *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993). *See also Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993); *Corcoran*, 965 F.2d at 1332.[3]

[3] *Amici's* argument does not mean that state medical malpractice law is preempted. Where a single action by a physician constitutes both a clinical decision and a determination that a test or procedure is not covered by an ERISA plan, the action is potentially subject to challenge both under state law as professional negligence and substandard care (insofar as it constitutes a clinical decision) and under ERISA as a breach of fiduciary duty (insofar as it constitutes a discretionary plan coverage determination). *See, e.g.*, *Dukes*, 57 F.3d at 356-57; *In re U.S. HealthCare*, 193 F.3d 151 (3d Cir. 1999). There is nothing anomalous about this: the intertwining of clinical decisions and plan coverage determinations is an artifact of the way managed care arrangements like the one under review are structured. In a traditional fee-for-service arrangement, if a physician advised, for example, whether a tonsillectomy was necessary and an insurance company administrator determined whether a tonsillectomy was covered under an employer-sponsored insurance plan, the physician could be subject to suit under state law and the administrator under ERISA. If the two decisions are combined in a single decision made by one individual, both state and federal law may apply to different aspects of the decision. "ERISA leaves room for complementary or dual federal and state regulation . . . ." *John Hancock Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 98 (1993); *see also Cipollone v. Liggett Group, Inc.*, 505 U.S. 504 (1992) (different aspects of the same cigarette advertising are governed by state and federal law).

The Solicitor General has explained that MCOs become ERISA fiduciaries to the extent that they make discretionary decisions regarding eligibility for access to services and facilities of an ERISA plan. *See* U.S. Br. at 26-27. The determination of "medical necessity" is of course a highly discretionary action, since different benefits administrators or physicians often reach different conclusions about appropriate diagnostic and therapeutic measures for similarly situated patients.[4] "[A]ppraisal of medical necessity is an uncertain enterprise, fraught with ignorance about the comparative efficacy of clinical options and veiled conflict over the balancing of benefits and costs."[5]

Makers of medical plan coverage decisions owe fiduciary duties under ERISA to plan participants and beneficiaries both individually and as a group. These duties include the duty of loyalty, which requires an ERISA fiduciary to exercise its responsibility "solely in the interest of the participants and beneficiaries" and "for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." 29 U.S.C. §§ 1104(a)(1), (a)(1)(A)(i). This duty "has bite . . . it imposes . . . an obligation to act in the participants' interest." *Frahm v. Equitable Life Assurance Soc'y*, 137 F.3d 955, 959 (7th Cir.), *cert. denied*, 119 S. Ct. 155 (1998).[6] *See also Donovan v.*

[4] *See* John E. Wennberg, *Understanding Geographic Variations in Health Care Delivery*, New Eng. J. Med., Jan. 7, 1999, at 52-53; *Dartmouth Atlas of Health Care in the United States* (1998); J. Wennberg & A. Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 Science 1102-08 (1973).

[5] M. Gregg Bloche, *Clinical Loyalties and the Social Purpose of Medicine*, JAMA, Jan. 20, 1999, Vol. 281, No. 3, p. 268, 269.

[6] This Court has already rejected the argument by petitioners' *amici* (Brief of *Amici Curiae* American Association of Health Plans, *et al.*, in Support of Petitioners at 26) ("AAHP Br.") that ERISA's fiduciary standards protect only plans' financial integrity, not individual beneficiaries. *See Varity Corp. v. Howe*, 516 U.S. 489, 507 (1996).

Bierwirth, 680 F.2d 263, 271 (2d Cir. 1982) (fiduciary must make all plan-related decisions "with an eye single to the interests of the participants and beneficiaries") (citations omitted); *accord Krohn v. Huron Mem'l Hosp.*, 173 F.3d 542, 547 (6th Cir. 1999).

B. When an MCO Delegates Its Discretionary Responsibility Over Plan Coverage Determinations to Physicians, Both the MCO and the Physicians Are ERISA Fiduciaries

MCOs are also acting in an ERISA fiduciary capacity when they *delegate* discretionary responsibility in the administration of an ERISA plan to another person, such as a physician. 29 U.S.C. § 1105(c). In such cases, the MCO is subject to ERISA fiduciary duties both in the initial making of such delegation decisions and in continuing those delegations. *See* 29 U.S.C. §§ 1105(c)(2)(A)(i), (iii); *see also Leigh v. Engle*, 727 F.2d 113, 135 (7th Cir. 1984).[7] ERISA applies by its terms not only to the exercise of authority over benefits determinations, but also to the delegation of such authority to others. A fiduciary's decisions about how it delegates its

[7] In this case, petitioners themselves asserted their fiduciary status. In their memorandum opposing Herdrich's motion to remand this case to state court, they stated that Health Alliance "was the administrator and fiduciary of the Plan within the meaning of ERISA," and that Herdrich's claims against Health Alliance and Carle Clinic arose from her participation in the plan and Health Alliance's role as the fiduciary. Resp't's App. C at 24a, 36a-37a. The district court, in its order granting petitioners' motion for summary judgment based on preemption, relied on petitioners' prior representations that Health Alliance, Carle Clinic, and Carle Clinic HMO all functioned as fiduciaries. *See id.* at 9a-10a. After Herdrich amended her complaint to assert an ERISA claim, petitioners changed their tack and now insist that they cannot be subject to fiduciary liability for exactly the same alleged conduct that they had argued was shielded from state law. *See Herdrich v. Pegram*, 154 F.3d 362, 369 n.5 (7th Cir. 1998). *Compare* Resp't's App. C at 6a-10a *with* Pet'r's. Br. 24-26.

authority, and to whom, and under what circumstances, are themselves subject to the same duties of loyalty and prudence as other fiduciary decisions with respect to an ERISA plan. *See* 29 U.S.C. § 1105(c)(2)(A); 29 C.F.R. § 2509.75-8 at FR-13, FR-14; H.R. Conf. Rep. No. 93-1280, at 301 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5082. For example, if a fiduciary allocated discretionary authority to a person whom it knew to have an impermissible conflict of interest, the fiduciary itself could be liable for breach of its duties. *See, e.g., Leigh*, 727 F.2d at 135-36.

Petitioners argue (Br. 43-46) that an MCO's delegation of its plan administration discretion to physicians, together with the creation of a financial incentive structure that may affect the exercise of that discretion, has nothing to do with ERISA. But that cannot be right: if an MCO delegates discretionary authority to physicians to determine what services are "medically necessary" and therefore covered under an ERISA plan, and also creates a structure that rewards physicians for denying medical care, it may well have breached its duty of loyalty to the employee-beneficiaries. ERISA attaches because of the delegation, and a possible claim of fiduciary breach arises because of the incentive system. The breach is the deliberate placement of discretionary authority in individuals whose loyalty to plan beneficiaries is compromised.

C. Plan Coverage Decisions and Medical Advice Decisions Are Conceptually Distinct, Even Though in an MCO Environment They Are Commonly Inseparable; Failure To Distinguish Them, and Apply ERISA to Plan Coverage Decisions, Would Be Bad ERISA Law and Bad Medicine

In traditional fee-for-service medicine, health care decisions and payment decisions were in principle separate

matters. The physician giving health care advice was expected to consider only the best interests of the patient. How the patient would pay for the recommended services was a distinct question: he might do so through personal resources, or through insurance, or through an employer health plan. The service also might be "financed" through the physician's own charity, but physicians were of course not obligated to provide services without charge merely because they recommended them.

Two features of this traditional system are pertinent to the present case. First, the medical advice and any "plan coverage" decision were distinct. Patients and physicians assumed that the physician's advice about the medical desirability of a particular service did not depend on whether the patient could afford it or his employer's plan covered it. Second, whoever made the plan coverage decision was an ERISA fiduciary.

Under many current ERISA plan arrangements, including the arrangement at issue in this case, the health care decision and the coverage decision—though conceptually distinct—have become one decision. The employer adopts a health plan that offers care by an MCO. The extent of care provided under the plan is defined by terms like all "medically necessary" or "medically appropriate" services. The plan then provides that the determination of "medical necessity" (or "appropriateness") will be made by the MCO itself. The MCO may in turn, like the MCO in this case, delegate that responsibility to the individual physicians.

In such a case, it is very important, for two quite different reasons, to maintain the conceptual distinction between the health care decisions and the plan coverage decisions, and to hold the MCO and the physicians to

ERISA fiduciary standards with respect to the latter.[8] Petitioners' effort to immunize the plan coverage decision from ERISA (or any other) liability is both bad law and bad medicine.

1. *The Plan Coverage Decision*

Failure to recognize the dual role played by gatekeeper physicians effectively immunizes an important category of plan administrative decisions from any legal review whatever. The person who decides whether a particular employer health plan, applied to a particular patient in particular circumstances, covers a particular diagnostic test or procedure (or covers a swifter or more sophisti-

[8] When a physician who is responsible for the patient's care also makes gatekeeping and "medical necessity" determinations, he necessarily makes some decisions that constitute both the practice of medicine and, under ERISA, the discretionary administration of plan benefits. In the former role, the physician is subject to professional standards and state regulation but is not an ERISA fiduciary. *See, e.g., Dukes v. U.S. HealthCare, Inc.*, 57 F.3d 350, 356-57 (3d Cir. 1995). However, when the physician exercises discretion with respect to plan administration by, for example, interpreting plan provisions, denying claims, and determining access to benefits and services promised under the plan, he is an ERISA fiduciary and is subject to liability under ERISA's fiduciary duty provisions. *See id. See also In re U.S. HealthCare*, 193 F.3d 151 (3d Cir. 1999); *Pryzbowski v. U.S. HealthCare, Inc.*, 64 F. Supp. 2d 361 (D.N.J. 1999); *Huss v. Green Spring Health Servs.*, 18 F. Supp. 2d 400 (D. Del. 1998); *Moreno v. Health Partners Health Plan*, 4 F. Supp. 2d 888, 892 (D. Ariz. 1998); *Edelen v. Osterman*, 943 F. Supp. 75, 76-77 (D.D.C. 1996). Different MCOs employ different combinations of centralized administrative review and contractual delegation of benefits decisions to gatekeeping clinicians. These two mechanisms are alternative means of performing the *same function*—administration of health benefits pursuant to the open-ended contractual standard of medical necessity. Robert A. Berenson, *A Physician's View of Managed Care*, 10 Health Affairs 106 (1991). Centralized administrative review and physician gatekeeping in the clinic and at the bedside are thus both fiduciary functions under ERISA.

cated approach than might be warranted under other circumstances) is acting as an administrator of the ERISA plan, but his actions, according to petitioners, fall into a legal limbo. He is not liable under state law because his actions constitute the interpretation of an ERISA plan, not the practice of medicine, and state law is therefore preempted. The MCO also cannot be held liable under state law for decisions interpreting an ERISA plan, or for the manner in which it delegated responsibility for such decisions. But, according to petitioners, the physician and the MCO cannot be held liable under federal law either, because the decision whether a particular test or procedure was "medically necessary" is a medical decision, not an ERISA decision.[9]

One obvious consequence of this view of the law would be to distort the structure of the provision of medical services. The desire of employers, MCOs, and physicians all to escape legal responsibility for the interpretation of the benefits provisions of ERISA plans would create a strong incentive to establish arrangements in which benefits provisions are effectively subsumed within the term "medically necessary" and the highly discretionary decision as to what is medically necessary is immunized from state law liability as an ERISA decision and from federal law liability as a medical decision.

The irony is that the decisions at issue are exactly the sort to which fiduciary standards are traditionally thought to apply. The determination of what tests or treatment is appropriate for a particular patient in a particular situation is an inherently discretionary decision—*i.e.*, one for which the relevant parties, the employee-patient, the employer, the MCO, and the physician, *cannot* satisfactorily provide in advance by contract, no matter how detailed a contract they try to write.[10] That is precisely the kind of situation in which the traditional solution is to hold the persons who will make the discretionary decisions to a fiduciary standard of responsibility.[11] The potential for self-serving in the making of discretionary decisions is a central problem in health care economics precisely because contracts for medical care and coverage are necessarily incomplete—they cannot avoid conferring great discretion on physicians and other administrators to determine medical necessity [12]—and because purchasers of medical care and coverage (those with the incentive to detect misappropriation) know less about diagnosis and treatment of disease than do physicians.[13]

9 Both halves of this are wrong. The decision is subject to state law as a medical decision and to ERISA as a plan coverage decision. *See supra* note 3.

2. *The Health Care Decision*

Allowing ERISA plan coverage decisions to be immunized from liability by coupling them with health care decisions under the blanket of "medical necessity" also has

10 *See generally* Oliver E. Williamson, *Transaction Cost Economics: The Governance of Contractual Relations*, 22 J.L. & Econ. 233 (1979) (arguing that in contractual situations in which all possibilities cannot be anticipated, one needs to develop workable governance mechanisms to address ongoing uncertainty in order to instill trust on the part of the parties).

11 *See* Tamar Frankel, *Fiduciary Law*, 71 Cal. L. Rev. 795 (1983); Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. Rev. 1045 (1991).

12 In his dissent below (on petition for rehearing), Judge Easterbrook acknowledges that "[f]iduciary duties are vital when contracts are incomplete," 170 F.3d at 686, but he then ignores the discretionary nature of medical care contracts when he claims that there is no question about whether the contract here was incomplete.

13 Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941 (1963).

an even more serious consequence: it creates a strong incentive for the physician to distort his health care advice to his patient. If the physician has a personal economic incentive to deny ERISA plan coverage, and his vehicle for doing so is a discretionary determination that a particular test or procedure is not "medically necessary," there is an obvious risk that the patient will be denied not only the economic benefit promised by the plan, but candid health advice.

Patients' expectations when they seek medical care derive from the 2500 year old Hippocratic ethic of physician loyalty to patients. This ideal is deeply embedded in both patients' understanding [14] and the law applicable to medicine.[15] Moreover, as explained in a now-classic article by Nobel laureate economist Kenneth Arrow, this ethic is essential if patients are to trust medical judgment and such trust is in turn essential to the operation of health care systems because most patients lack the medical knowledge to evaluate physicians' recommendations.[16] There is a large body of scholarly commentary to the effect that patient trust and physician trustworthiness make diag-

[14] *See* Talcot Parsons, *The Social System* 428-447 (1951). "As late as 1969, the philosopher Hans Jonas could assert that 'the physician is obligated to the patient and to no one else. . . . We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.'" David J. Rothman, *Strangers at the Bedside* 1 (1991) (internal citation omitted).

[15] *See, e.g.*, 73 Ill. Comp. Stat. 5/8-802 (Illinois evidence statute provides testimonial privilege for physician-patient communications); *State v. Perry*, 610 So. 2d 746, 751-53, 769 (La. 1992) (relying on ethical duty to act only for patient's well-being in holding that involuntary medication to render inmate competent for execution violated state constitutional proscription of cruel and unusual punishment).

[16] Arrow, *supra* note 13.

nosis and treatment more effective [17] and enable the sick to take comfort and draw strength from their doctors during their most anxious and fearful moments.[18] Arrangements that create incentives for physicians to declare tests or procedures not "medically necessary" in order to save the cost of providing them have the potential to compromise that trust and should be subject to review under ERISA to determine whether they are permissible.[19]

Because patients typically form deeper, more enduring relationships with their primary care physicians than with other health care providers, the dual loyalties of "gatekeeping" primary caretakers are especially troublesome:

> The more powerful the message of fidelity conveyed within a clinical relationship, the more compelling a social purpose should be to justify departure from the

[17] *See, e.g.*, David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 Milbank Q. 171, 176 (1996); David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. Health Pol., Pol'y & L. 661 (Aug. 1998); Marc A. Rodwin, *Medicine, Money and Morals: Physicians' Conflicts of Interest* (1993); Arthur L. Caplan, *Am I My Brother's Keeper?: The Ethical Frontiers of Biomedicine* (1998); Arnold Relman, *The Impact of Market Forces on the Physician-Patient Relationship*, J. Royal Soc'y Med. 1994; 87 Supp. 22: 22-4.

[18] *E.g.*, Jay Katz, *The Silent World of Doctor and Patient* (1984).

[19] There is also, of course, a disclosure problem. When physicians are acting in a dual role, as both medical caregivers and benefits gatekeepers, their patients may not be aware of both roles. Absent clear communication from a health plan to its subscribers that plan physicians will not be held to the Hippocratic ethic of loyalty to patients, and indeed will be encouraged to depart from it for the sake of frugal stewardship of plan resources, subscribers are entitled to expect their physicians to adhere to this ethic—and to expect the plan to administer benefits in a manner that does not suborn its breach. A health plan's promise of "medically necessary" treatment does not even hint at the scheme of dual clinical loyalties introduced by financial incentives to gatekeeping physicians to withhold plan benefits.

> ethic of undivided loyalty. Health plans that make primary care physicians into gatekeepers, with strong incentives to deny access to beneficial care, pose a special problem in this regard.
>
> * * * *
>
> These concerns bear greatly on the legal controversies that have marked the rise of managed care. . . . [T]hey merit judicial recognition of professional duties of loyalty and patient advocacy vis-a-vis health plans.[20]

The loss of patient-physician trust is of course not the direct concern of ERISA, but it is a consequence of misinterpreting ERISA. Medical advice and health plan coverage are both inherently discretionary functions. It is not necessarily wrong to combine them and apply a standard of "medical necessity" to both. What is essential is to remember that the combined decision contains a plan determination decision, and if an MCO creates a structure (particularly a structure not necessarily disclosed to patients) that gives physicians a strong personal economic incentive to make one decision rather than another, that structure must be subject to testing under ERISA fiduciary standards.

II. THE INCENTIVE STRUCTURE AT ISSUE IN THIS CASE CREATES AT LEAST A TRIABLE ISSUE OF BREACH OF FIDUCIARY DUTY

This case is in this Court following the defendants' successful motion to dismiss for failure to state a claim. Whether the plaintiff will be able to prove her claim is not at issue at this point, and *amici* take no position on that question. The incentive structure described in the complaint, however, clearly creates a triable issue as to

20 Bloche, *supra* note 5, at 273.

whether the defendants have breached their fiduciary duty.

As described in the complaint, the structure created by the defendants (i) delegates to physicians the authority to make certain health care related decisions and, at the same time, (ii) gives the same physicians a substantial financial incentive, in the form of year-end cash distributions, for minimizing the use of diagnostic tests, facilities not owned indirectly by the MCO, and referrals to independent physicians. Although the complaint is not artfully pleaded, it appears to make out a claim that the MCO has delegated its ERISA fiduciary responsibility for determining the tests and other services available to an employee-patient, such as respondent, to physicians to whom the MCO has itself offered a financial incentive that is inconsistent with the ERISA duty of loyalty to the employee. If these allegations are correct, the MCO may have violated ERISA fiduciary duties by delegating them to persons with a clear and substantial conflict of interest, and the physicians may have violated ERISA fiduciary duties by exercising such responsibilities despite the conflict. Respondent should be given an opportunity to prove that claim.

Amici are not suggesting that either health care decisions or plan coverage decisions can—or even that they should—always be made without consideration of cost and without any economic incentive influencing the physician. The problem of how to contain health care costs is real, and *amici* support ongoing creative efforts to solve it in ways that are fair to employee-patients. But there is a difference between general, widely shared, structural incentives to cut costs and an incentive that is so pointed and substantial that it would plausibly influence the "medical necessity" judgment in an individual case.

Petitioners argue (Br. 46-47) that some conflicts of interest are inevitable in any method of providing and financing health care.[21] For example, Judge Easterbrook's dissent below noted (170 F.3d at 684) that in traditional fee-for-service medicine the physicians had an incentive to recommend marginal or unneeded services in hopes of earning a fee. But such abuses were, in principle, subject to challenge as malpractice. The kind of incentive alleged in this case, where the "gatekeeper" physician assertedly received economic benefits specifically tied to decisions of the kind at issue—is inconsistent with the duty of loyalty imposed by ERISA.

Petitioners also argue (Br. 39-40) that physician economic participation is essential to effective cost-containment,[22] but that is not true. Risk-sharing incentives are

[21] Petitioners also contend that ERISA allows a single entity to have "dual loyalties" and that ERISA's fiduciary duties do not preclude decisionmaking based on business factors. Br. 43-45. But Petitioners rely on a series of cases dealing solely with the role of employers in establishing and designing benefit plans. *See, e.g., Hughes Aircraft Co. v. Jacobsen*, 525 U.S. 432 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *Curtiss-Wright v. Schoonejongen*, 514 U.S. 73 (1995). These cases are inapposite because the "dual loyalties" permitted to employers do not come into play here. Recognizing that employers necessarily consider business factors when making basic decisions regarding plan establishment and design, this Court has held that ERISA's fiduciary duty provisions do not apply to employer decisions to establish, amend or terminate plans. *See Hughes Aircraft Co.*, 525 U.S. 432; *Lockheed*, 517 U.S. at 893-94; *Curtiss-Wright*, 514 U.S. 73. Here, the relevant employer, State Farm (which is not a defendant), established the ERISA plan in this case, and petitioners cannot rely on the special allowance for employers' dual loyalties. Moreover, the "dual loyalties" cases do not exempt employers from potential ERISA fiduciary liability for conflicts of interest. *See, e.g., Varity Corp. v. Howe*, 516 U.S. 489 (1996).

[22] *See also* AAHP Br. 3, 8, 17.

only one of many ways MCOs achieve their savings. Network development, management and coordination of practice, review of whether physicians are making appropriate decisions and referrals, the integration of group practices, and other techniques of managed care also reduce costs.[23] MCOs are developing more sophisticated physician compensation methods to incorporate measures of quality, patient satisfaction, and efficiency (achieving the same result at less cost), rather than simply reward reduced costs.[24] Thus, MCOs will have a variety of means to control their spending even if limits are placed on the use of some kinds of physician risk-sharing incentives.

The reason why MCOs create financial incentives for physicians to reduce levels and expenses of service is that they do indeed reduce costs. But they achieve this by inducing physicians to make intertwined coverage and health care decisions different from those they would make if their only concern were the employee-patient. As Judge Easterbrook noted, "The HMO structure differs substantially from traditional fee-for-service medicine in giving the HMO an incentive to skimp on care once an illness is discovered." 170 F.3d at 684.

The very purpose of ERISA is to assure that persons making discretionary benefits decisions act under a duty of loyalty to the beneficiary. *See* H.R. Conf. Rep. No. 93-1280, at 297, *reprinted in* 1974 U.S.C.C.A.N. at 5078 (the

[23] Development of provider networks both empowers health plans to win price concessions from providers and creates incentives for providers to conform their clinical practice styles to network norms (in order to sustain or increase flows of patients). Ching-to Albert Ma & Thomas G. McGuire, *Network Incentives in Managed Health Care* (Oct. 1999) (unpublished paper on file at the Boston University Dep't of Economics).

[24] Neil Schlackman, *Evolution of a Quality-Based Compensation Model: The Third Generation*, 8 Am. J. Med. Quality 103 (1993).

written plan must identify the named fiduciary with ultimate authority over and liability for plan administration, including the making of payments from the plan).[25] The statute was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983) (citations omitted); *accord Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989). It protects employee and beneficiary interests " 'by establishing standards of conduct, responsibility, and obligation for fiduciaries . . . and . . . providing for appropriate remedies . . . and ready access to the Federal courts.' " *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996) (quoting ERISA § 2(b)) (alterations in original). This Court has said that Congress expected the courts to interpret ERISA's fiduciary standards "bearing in mind the special nature and purpose of employee benefit plans." *Id.* at 497 (citation omitted). *See also Firestone Tire & Rubber Co.*, 489 U.S. at 113-14. Contrary to petitioners' suggestion (Br. 34) that ERISA narrowed the scope of traditional fiduciary obligations, Congress determined that the common law of trusts did not offer *enough* protections. *See Varity*, 516 U.S. at 497; H.R. Conf. Rep. No. 93-1280, at 295, 302 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5038, 4650. This Court should not accept petitioners' invitation to immunize an important mechanism for determining the coverage of an ERISA health-care plan from review under ERISA fiduciary standards.

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25 *See also* 29 U.S.C. § 1103(2) ("appropriate named fiduciary" must be in charge of final benefits claims decisions); *id.* § 1102(a) (each plan must specify its named fiduciaries in writing); *id.* § 1102(b)(4) (each plan must specify in writing the method for making payments out of the plan); 29 C.F.R. § 2560.503-1(g) (appeals of benefit denials must be made to a named fiduciary).

III. THE HEALTH CARE MARKET IS CONTINUOUSLY AND RAPIDLY CHANGING, AND RULES OF LAW SHOULD NOT BE FIXED FOR THE FUTURE BASED ON TODAY'S PRODUCTS

Neither the majority nor the dissent in the court below correctly described the role of financial incentives in managed care and cost-containment or the effect of financial incentives on physician behavior. If the Court considers the implications of such incentives in health policy in analyzing the legal issues in this case it should do so on a sound basis:

> Many policies that give physicians incentives to withhold services originate from private institutions and government agencies as responses to the distortions of fee-for-service medical practice. A simple syllogism has governed policy: giving physicians incentives to perform services produces undesirable effects. Ergo, eliminate these problems by giving physicians incentives to refrain from performing services. Only one thing was overlooked: rewarding physicians for using resources frugally does not eliminate financial conflicts of interest. It creates new conflicts with different effects.[26]

Physicians have generally been compensated for their work and thus financial incentives have always been part of health care. Until early in the 20th century most doctors, hospitals, and other medical providers were paid a fee for each service they provided, except when providing charity care. This form of payment encouraged doctors to increase the services provided. Starting in the 1930s, experiments with prepaid group practice, a precursor of HMOs, paid doctors a salary in part to counter the per-

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26 Rodwin, *supra* note 17, at 135 (internal citations omitted).

verse effect of fee-for-service payment, in part to reduce the cost of providing medical care. Pre-paid group practice and HMOs that paid physicians a salary reduced the performance of unnecessary services, particularly surgery, and cut health care spending.[27] More recently, MCOs have introduced newer forms of incentives including physician risk-sharing. Risk-sharing is achieved by paying physicians per capita for providing all services necessary to a particular patient and through a wide array of financial reductions and bonuses. A common feature of risk-sharing is that it makes doctors bear some of the financial cost for the services they themselves provide; more recent risk-sharing models make doctors financially responsible also for the services they recommend or order through referrals, tests, or use of hospitals.

The aim of risk-sharing incentives for physicians under managed care is undisputed: to make physicians consider the financial implications of the clinical choices they make. In using this approach MCOs hope to enlist physician help in controlling health care spending. Quite explicitly, risk-sharing incentives ask doctors to consider their own financial interest in making diagnoses, choosing what tests or medications to prescribe and evaluating competing treatments. MCOs use such incentives because the discretionary judgments of doctors in providing patient care have an enormous influence on resource use and thus affect the financial status of organizations that contract to provide services for a set premium.

Although benefit packages for MCO and indemnity insurance typically exclude a few benefits, they generally state that they will cover all medical care that is "medically necessary" or "medically appropriate." As discussed

[27] *See generally* David Mechanic, *From Advocacy to Allocation: The Evolving American Health Care System* (1986).

above in Section I.C.1., such terms are not clearly defined in contracts (and cannot be because medical standards change). Like legal principles, terms like "medical necessity" must be applied to facts to yield specific results. It is doctors who make such determinations on a case-by-case basis, and it is to influence such decisions with the hope of preserving resources for the organization or its owners that doctors are given financial incentives.

A substantial body of research demonstrates that fee-for-service payment of physicians correlates closely with higher utilization of hospital and other clinical services and that capitation and other incentives to withhold care correlate closely with lower utilization.[28] It is not known at what point such incentives lead to undertreatment of patients or whether or to what extent MCO quality assurance programs can ensure quality and prevent undertreatment, but there is reason to be concerned that such incentives will produce effects at least as perverse as fee-for-service payment.[29]

Managed care does have several desirable goals independent of containing medical costs, including promoting the use of evidence-based medicine, improving medical care, and coordinating medical services more rationally. Limits on physician incentives that MCOs use might affect the way managed care is practiced today, but the managed care of today is quite different from the managed care of a decade and a half ago and the managed care of tomorrow will be different again. Managed care is not now and has never been one distinct idea or method but rather a variety of approaches to managing medical care. And it

[28] *See* Thomas Rice, *Physician Payment Policies: Impacts and Implications*, 18 Ann. Rev. Pub. Health 549 (1997).

[29] *See* Norman Daniels & James Sabin, *Accountability for Reasonableness, Professionalism, and the Ethics of Physician Incentives* (unpublished paper on file at the Tufts University Dep't of Philosophy).

is rapidly changing in response to markets, legislation, and the intervention of private and public payers of medical services that are setting constraints on how managed care operates. The Court has been invited by the opinions below to legislate bright-line rules about fiduciary status and fiduciary breaches under managed care. The Court need not draw bright lines excluding all cost-containment measures and all physician decision-making from judicial review in order to preserve the ability to control health care costs.

CONCLUSION

The judgment of the Court of Appeals for the Seventh Circuit should be affirmed.

Respectfully submitted,

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