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Secrets Don't Make Friends, But They do Make Good Business: Perception Versus Reality in Physician Financial Incentive Plans

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SECRETS DON'T MAKE FRIENDS, BUT THEY DO MAKE GOOD BUSINESS: PERCEPTION VERSUS REALITY IN PHYSICIAN FINANCIAL INCENTIVE PLANS

I. INTRODUCTION

Who can we trust? Even though physicians and patients appear disgruntled over managed care reimbursement, courts recognize that cost-conserving measures are desirable and physician financial incentives may operate as the least restrictive and most effective control. A balance must be struck between the policy to control inflationary health-care costs and physicians' professional and ethical obligations.[1] Forced to decide between two competing policy concerns, United States Courts of Appeals seem willing to accept the risk of lower quality health care in exchange for some constraint on exploding health-care costs.

In bygone years, a patient could trust a physician to act solely in the patient's best interest. However, the complex world of third-party health-care reimbursement has muddled the picture. Jeff, a fifty-five-year-old employee, has worked for Company since he graduated from college thirty-three years ago.[2] In 1971, Jeff chose a local physician who submitted bills directly to his insurance company following treatment. In the 1980s, Jeff saw his deductible and co-pay increase as insurance companies tried to generate enough revenue to offset expenditures. In the early 1990s, Company added a managed care option to its health plan, whereby employees could reduce their out-of-pocket expenditures simply by selecting a health-care provider from an approved list.

Make no mistake, many employees have remained with the same physician throughout the reimbursement transformation. However, in early stages, an incentive existed to provide the best possible care because health-care primarily focused on the patient's health and secondarily on maintaining the physician's practice and reputation. Critics argue that the incentive encouraged too much care and utter disregard for expenses. The institution of managed care changed the health-care landscape because it placed the risk of

1. Oath of Hippocrates as adopted by SAINT LOUIS UNIVERSITY SCHOOL OF MEDICINE, *available at* http://www.ama-assn.org/ama/pub/category/5594.html (last modified Mar. 7, 2002) ("I will carry out that regimen which, according to my power and discernment, shall be for the benefit of my patients; I will keep them from harm and wrong . . . I will maintain the utmost respect for all human life.").

2. Jeff is a fictional character, not intended to represent any one individual.

loss and burden for "unnecessary" treatment on the physician. Today, physicians not only worry about the patient's ailments but also must juggle multiple burdens that impact the physician's own well-being.

Health Maintenance Organizations (HMO)[3] serve a dual purpose in that they provide insurance and medical care under the theory that providing both services through one entity encourages efficient use of scarce health-care resources. HMOs commonly "encourage" their physicians to make decisions that reduce costs to the HMO. Upon meeting objectives set by the HMO, physicians receive a pecuniary bonus or incentive that may introduce competing, if not adverse, interests affecting the physician's treatment decisions. The question therefore arises as to whether HMOs should be liable for concealing information about physician reimbursement incentives while shifting risk and burdens to physicians, all for the sake of profit.

In June 2003, the Third Circuit Court of Appeals issued the most recent appellate decision regarding the extent to which disclosure requirements under ERISA obligate an HMO to disclose financial incentives awarded to physicians, *Horvath v. Keystone Health Plan East, Inc.*[4] *Horvath* involved a beneficiary challenging disclosure practices of her HMO, alleging that nondisclosure at enrollment and continued concealment of physician incentives violated ERISA disclosure rules and diminished the value of the health plan to employees (i.e., a diminished value theory).[5] Horvath urged the Third Circuit Court of Appeals to expand the disclosure requirements under ERISA one step further than courts had previously been willing to go, but the court rejected Horvath's claim because it found that controlling exploding health-care costs outweighed the protection that might be derived from expanding existing ERISA disclosure rules.

Any examination of health law issues necessarily involves a consideration of three elements permeating the analysis: access, cost, and quality. Adjusting practice toward one factor may adversely affect the others. Part II of this Comment will examine cost issues and the historical methods used in health-care reimbursement that may include "out-of-pocket [expenditures], individual health insurance, employment-based health insurance, and government financing."[6] Each of these methods "attempted to solve the problem of unaffordable care for certain groups," but like using your fingers to plug a dam, each attempt created new problems that contributed to the rapid increases

3. An HMO is "[a] group of participating healthcare providers that furnish medical services to enrolled members of a group health-insurance plan." BLACK'S LAW DICTIONARY 737 (8th ed. 2004).

4. 333 F.3d 450 (3d Cir. 2003).

5. *Id.* at 453.

6. Thomas Bodenheimer & Kevin Grumbach, *Reimbursing Physicians and Hospitals*, 272 JAMA 971, 971 (1994).

in health-care costs.[7] Sometimes inadvertently, but often intentionally, traditional third-party payment systems created incentives to provide more care, but payors sought to mold the behavior of the health-care providers. Part III will examine quality issues through non-legal data such as survey and study results examining physician and patient perceptions toward managed care reimbursement. This Part reveals uneasiness, not necessarily toward the reimbursement system, but toward the effects incentives have on physician autonomy and patient trust. The discussion in Part IV focuses on statutory ERISA analysis and common law clarifications for evaluating ERISA conflict preemption and complete preemption for claims to recover benefits due under an employee benefit plan (EBP).[8] This section also examines common law and statutory fiduciary relationships[9] and the reasoning as to why HMOs, unlike traditional insurance, may be regulated as an ERISA fiduciary.

Part V focuses the ERISA discussion by analyzing cases that have reached the appellate level on incentive disclosure issues. United States Courts of Appeals disagree about a fiduciary's duties to disclose under ERISA. The cases are *Shea v. Esensten*,[10] *McDonald v. Provident Indemnity Life Insurance Co.*,[11] *Ehlmann v. Kaiser Foundation Health Plan of Texas*,[12] and *Horvath v. Keystone Health Plan East, Inc.*[13] Part VI analyzes the ramifications of these four decisions and the additional insight that *Horvath* brings to an issue that will likely be resolved by the Supreme Court in the not-so-distant future. Finally, a brief conclusion addresses the balance that must be struck between the social desire to keep health-care costs down contrasted with the risk of

7. *Id.*

8. Employee benefit plans covered by ERISA encompass "written stock-purchase, savings, option, bonus, stock- appreciation, profit-sharing, thrift, incentive, pension, or similar plan solely for employees, officers, and advisers of a company. The term includes an employee-welfare benefit plan, an employee-pension benefit plan, or a combination of those two." BLACK'S LAW DICTIONARY 564 (8th ed. 2004).

9. A fiduciary relationship is:

> A relationship in which one person is under a duty to act for the benefit of another on matters within the scope of the relationship. Fiduciary relationships—such as trustee-beneficiary, guardian-ward, principal-agent, and attorney-client—require an unusually high degree of care. Fiduciary relationships usu[ally] arise in one of four situations: (1) when one person places trust in the faithful integrity of another, who as a result gains superiority or influence over the first, (2) when one person assumes control and responsibility over another, (3) when one person has a duty to act for or give advice to another on matters falling within the scope of the relationship, or (4) when there is a specific relationship that has traditionally been recognized as involving fiduciary duties . . . .

BLACK'S LAW DICTIONARY 1315 (8th ed. 2004).

10. 107 F.3d 625 (8th Cir. 1997).

11. 60 F.3d 234 (5th Cir. 1995).

12. 198 F.3d 552 (5th Cir. 2000).

13. 333 F.3d 450 (3d Cir. 2003).

having uninformed consumers overpaying for coverage and receiving less than ideal benefits from their HMO.

II. INTRODUCTION TO HEALTH-CARE REIMBURSEMENT

A. Traditional Health-Care Reimbursement Structure

In the current health-care market, Preferred Provider Organizations (PPO)[14] enroll about half of all employees.[15] HMOs provide coverage to twenty-six percent of employees, while indemnity insurance covers only five percent.[16] HMOs exist to provide cost-efficient health care by supplying the insurance, acting as administrator, and ultimately supplying medical services. Typically, HMOs provide an employer with a plan for group coverage, with premium payments being withheld from employees' salaries. The relationship between employer and HMO is the focus of this paper.

Physician reimbursement is nearly always determined by contract in one of a number of combinations between doctor, hospital and/or managed care organization. Prior to the rise of third-party insurance, physicians and hospitals were paid under a "charged based" system, by which reimbursement was paid for the services performed on a sliding scale, usually depending on ability to pay.[17] The expansion of health-care coverage following World War II fostered the growth of private insurance, Blue Cross, and Blue Shield.[18] In the 1950s, the "Blues" attempted to regulate health-care costs by shifting from a "charges" system to a system based on "usual, customary, and reasonable reimbursement" (UCR), which paid the lowest of: 1) the actual bill charged to patient (usual), 2) physician's customary charge (customary), or 3) the prevailing charge in that industry in that community (reasonable).[19] In 1965, Medicare and Medicaid adopted UCR reimbursement, but they have since abandoned the system because the incentive under a UCR reimbursement

14. A PPO is "[a] group of healthcare providers (such as doctors, hospitals, and pharmacies) that agree to provide medical services at a discounted cost to covered persons in a given geographic area." BLACK'S LAW DICTIONARY 1217 (8th ed. 2004).

15. HEALTH & RESEARCH EDUC. TRUST, KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2002 SUMMARY OF FINDINGS 3 (2002) [hereinafter EMPLOYER HEALTH BENEFITS].

16. *Id.* at 4.

17. *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 310 (1982).

18. *See id.* at 310–11. Blue Cross provided community insurance plans that covered hospital charges. *Id.* at 313–14. Blue Shield provided insurance coverage for physician services. *Id.*

19. Health Insurance for the Aged and Disabled, 42 U.S.C. §§ 1395w-4(a)–(j) (2000); *see also* ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 13 (1997).

scheme encourages providers to continually increase actual charges, resulting in inflated customary and reasonable charges.[20]

The next financing development implemented fee schedules to pay physicians per procedure.[21] Physicians submit bills under CPT codes,[22] while hospitals use DRG codes.[23] Reimbursement is rendered for procedures, regardless of whether the procedure was performed by a general practitioner or a specialist. Under DRGs the incentive is to release the patient as early as possible, while maintaining the proper standard of care.[24] Lump sum payments encourage efficient treatment because reimbursement is the same whether the patient stays hospitalized for a week or a few hours. In 1992, Medicare implemented payment for physician services based on a Resource-Based Relative Value Scale (RBRVS), which pays on a fee-for-service basis by establishing "a fee schedule for different classes of services adjusted [geographically]."[25] Fee-for-service reimbursement such as CPT, DRG, and RBRVS remain useful forms of reimbursement for non-managed care patients.

B. Managed Care Reimbursement

Managed Care Organizations (MCOs)[26] proliferated in the 1980s and 1990s because of attempts by the insurance industry to contain exploding costs.[27] MCOs implemented three major organizational forms: fee-for-service with utilization review, Preferred Provider Organizations (PPOs), and Health Maintenance Organizations (HMOs).[28] HMOs constitute the most common form of managed care and are characterized as insurers attempting to manage

20. Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 400 (1996).

21. *See* 42 U.S.C. § 1395w-4(c)(2)(C) (billing based on time, intensity, skill, and stress required by the physician to determine payment for a specific treatment).

22. "Current Procedural Terminology" is "[a] medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions." CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH AND HUMAN SERVS., GLOSSARY, *at* http://www.cms.hhs.gov/glossary (last modified July 16, 2004).

23. "Diagnosis-Related Groups" is "[a] classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual." *Id.*

24. *See* BARRY R. FURROW ET AL., HEALTH LAW 693–698 (4th ed. 2001).

25. Latham, *supra* note 20, at 400 n.5.

26. "Managed Care Organizations" (MCO) is an umbrella term for several types of managed care organizations including Preferred Provider Organizations (PPO), Health Maintenance Organizations (HMO), and Point of Service Option (PSO). *See* FURROW, *supra* note 24, at 509–12; *See also* Bodenheimer & Grumbach, *supra* note 6, at 971.

27. *See generally* Pegram v. Herdrich, 530 U.S. 211 (2000).

28. Bodenheimer & Grumbach, *supra* note 6, at 971.

physician behavior through implementation of measures to control costs and limit utilization of medical services.[29]

To understand the dynamics in managed care it is necessary to realize that the largest third of managed care companies enroll eighty-one percent of the HMO beneficiaries, while the smallest third enrolls only three percent of beneficiaries.[30] HMOs reimburse providers most often using capitation, but other forms include negotiated fee-for-service arrangements, global budgets,[31] and staff models.[32]

1. The Preferred Form of Managed Care Reimbursement: Capitation Payments

All managed care organizations depend on influencing physician practice, either directly or indirectly through physician medical directors.[33] HMOs spread financial risk by implementing capitation payment systems, by which providers are paid per enrollee for a specific period, regardless of services rendered.[34] Physicians receive the same payment per patient even if no services are rendered during a period.[35] Capitation in any form encourages physicians to accept healthy patients who require little maintenance and to avoid high risk/high cost patients.[36] To control costs, patients are often required to funnel all non-emergency care through the primary care physician, who acts as a gatekeeper, determining when to refer the patient for specialist or hospital care.[37] Capitation payments may be distributed through either a two or three-tiered reimbursement structure.

Capitation payments under a two-tiered reimbursement system[38] are established by contract between the HMO and individual physician by which the physician receives a fixed payment for each patient under his care enrolled with the HMO, regardless of services rendered.[39] Two-tiered capitation transfers financial risk to the health-care provider because the HMO is only

29. Latham, *supra* note 20, at 401.

30. *See* Joseph P. Newhouse & The Harvard Managed Care Industry Center Group, *Managed Care: An Industry Snapshot*, 39 INQUIRY: THE J. OF HEALTH CARE ORG., PROVISION, AND FIN. 1, 11 (2002).

31. The HMO pays one lump sum payment per period and the physician is responsible for keeping costs under the global budget. *See* Bodenheimer & Grumbach, *supra* note 6, at 976.

32. Staff model HMOs constitute a smaller percentage of managed care whereby physicians are salaried employees of the HMO. Bodenheimer & Grumbach, *supra* note 6, at 971, 975.

33. *See generally* Pegram v. Herdrich, 530 U.S. 211 (2000).

34. *See* Latham, *supra* note 20, at 401.

35. *See id*. at 402.

36. *See Pegram*, 530 U.S. at 218–19.

37. Bodenheimer & Grumbach, *supra* note 6, at 973.

38. *Id*. (discussing that two-tiered capitation accounts for approximately twenty percent of U.S. HMO plans).

39. *Id*.

responsible for capitation payments, subject to a few exceptions.[40] "Generally, a dollar limit is placed on the physician's risk such that excessive costs for an extremely ill patient are covered by the HMO."[41] Two-tiered reimbursement creates the most opportunity for conflicts of interest between physician and patient because the physician's personal income is directly proportional to the amount of services he denies to patients.[42]

In three-tiered reimbursement systems, individual physicians join together to create an Independent Practice Association (IPA), and the HMO pays a lump sum to the IPA each period.[43] Three-tier capitation reduces risk to individual providers because the IPA allocates payment into two funds: primary care services and hospitalization/specialty services.[44] Providers receive capitated payments for their primary practice based on the number of enrollees, but "[t]he lower the use of diagnostic and specialist services, the higher the year-end bonus for IPA physician gatekeepers."[45] Funds remaining in the specialist's fund at the end of a period are disbursed among providers as a bonus, returned withholdings, or profit sharing.

Three-tier systems create fewer opportunities for conflicts of interest than two-tier systems because outlier patients are absorbed into the risk pool and do not wreak financial havoc on the individual physician's personal welfare, only his year-end bonus.[46] Compared to two-tier capitation, three-tier capitation creates a lesser conflict of interest because usually less than twenty percent of the physician's income depends on the amount of diagnostic and specialty services utilized during the year.[47]

Results vary widely for capitation-based practices depending on the number of physicians in the plan, contract language, size and demographic of population served, geographic location, and utilization of resources.[48] Reports indicate that proper utilization of capitated payments allowed physician groups

40. *Id*.

41. *Id*.

42. *See* Bodenheimer & Grumbach, *supra* note 6, at 973.

43. Cicio v. Does 1–8, 321 F.3d 83, 87 n.2 (2d Cir. 2003). The *Cicio* court defined an independent practice association as:

> [A] local physician group . . . comprised of physicians who are active on [a] hospital's medical staff and contract with a health maintenance organization . . . . [where] physicians' services are established with a relatively large number of generally small or medium-sized group practices, with physicians receiving some type of discounted fee-for-service payment from the HMO, rather than . . . salaried reimbursement.

Id. (citations omitted).

44. Bodenheimer & Grumbach, *supra* note 6, at 974.

45. *Id*.

46. *Id*.

47. *See generally id*.

48. *See generally* Steven D. Pearson et al., *Ethical Guidelines for Physician Compensation Based on Capitation*, 339 NEW ENG. J. OF MED. 689 (1998).

switching to capitated reimbursement to increase their income, in one year, to 150–170% of the amount they had earned caring for the same patients under fee-for-service systems.[49]

2. How Physician Financial Incentives Work

In order to encourage physicians to internalize costs for services and referrals, HMOs implement three major types of incentives: bonuses, withholds, and subcapitation.[50] Financial incentives accompanying capitation vary depending on the HMO and individual plan. Physicians receive bonuses, the most common incentive type, for "good case-management technique," by which physicians may be rated in any number of categories including cost-efficiency, patient satisfaction, hours, patient encounters, and malpractice experience.[51] Withhold systems can vary widely but generally retain a percentage of the capitated payment in a risk pool at the beginning of the period that is used to pay for referrals and services beyond the capitated budget.[52] In 1996, seventy-two percent of network and IPA model HMOs utilized bonuses or withholds to pay their primary care physicians.[53] Subcapitation systems constitute the most complex incentives because physicians (in groups or individually) contract with service providers (laboratories, physical therapy) to provide all services at a fixed cost.[54]

The optimal incentive should be structured to avoid intense conflicts of interest while making physicians more cost-conscious in diagnosis and treatment.[55] Several factors help determine intensity, including scope of services included in the incentive, amount of potential financial gain or loss, timing of the incentive, structure, and "stop-loss"[56] provisions.[57] Intensity of

49. Ken Terry, *Surprise! Capitation Can Be a Boon*, MED. ECON., Apr. 15, 1996, at 127–28. *See also* Pearson, *supra* note 48, at 690.

50. Latham, *supra* note 20, at 403.

51. *Id.*

52. *Id.* at 404 (discussing increased effectiveness of withholds where the physician is personally responsible for costs above the withhold); *but cf.* GERALD R. PETERS, HEALTHCARE INTEGRATION: A LEGAL MANUAL FOR CONSTRUCTING INTEGRATED ORGANIZATIONS 420, 421, 424 (1995) (asserting that physicians have "more incentive to perform services than to manage care" when they can charge fees to the withhold without internalizing the cost).

53. Latham, *supra* note 20, at 405 (citing PHYSICIAN PAYMENT REV. COMM'N, 1995 ANNUAL REPORT TO CONGRESS, *reprinted in* MEDICARE & MEDICAID GUIDE (CCH) No. 847, extra ed., pt. 2, at 231–232 (1995)).

54. Latham, *supra* note 20, at 404–05.

55. *See* Pearson, *supra* note 48, at 692–93.

56. "Stop-loss" refers to a limit on financial risk of an individual physician or a physician group accrued in caring for outlier patients with unusually high medical costs. *Id.* at 689. *See also* Latham, *supra* note 20, at 407.

57. Pearson, *supra* note 48, at 689.

incentives can affect the magnitude of physicians' conflicts of interest.[58] A survey of HMO managers found that incentives constituting twenty-five percent of a physician's income created an extreme conflict of interest, but a five to fifteen percent incentive could achieve desired outcomes without compromising physicians' judgment.[59]

Incentives play an important role for budgetary and cost reduction reasons. Budget withholdings allow HMOs and IPAs to estimate earnings and efficiently utilize resources over long periods. Incentives force physicians to internalize the cost consequences of their decisions while maintaining physician autonomy in treatment of individual patients.

III. PERCEPTIONS ABOUT PHYSICIAN FINANCIAL INCENTIVE PROGRAMS

"It is well accepted that patients deserve medical opinions about treatment plans and referrals unsullied by conflicting motives."[60] Ethically, medicine is founded on the collective belief that physicians are competent, compassionate professionals, acting solely for their patients' best interests.[61] However, in a market system, medical resources are scarce, and physicians must treat wisely. Critics of incentive programs argue that paying physicians more to do less may create an irresistible temptation.[62]

The federal government seeks to protect consumers by providing information to encourage informed decision making.[63] In 1996, President Clinton created the Advisory Commission on Consumer Protection and Quality in the Health Care Industry [hereinafter Commission], which advised the President on changes in the health-care system and recommended measures "to promote and assure health care quality and value, and protect consumers and workers in the health care system."[64] The Commission submitted the Consumer Bill of Rights and Responsibilities to the President recommending required disclosure of "network characteristics"[65] and "procedures that govern

58. *See* Alan L. Hillman et al., *HMO Managers' Views On Financial Incentives and Quality*, HEALTH AFF., Winter 1991, at 210.

59. Pearson, *supra* note 48, at 691.

60. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION 1986, § 8.06, at 31 (requiring the patient's best interests to be the physician's primary concern), *available at* http://www.ama-assn.org.

61. Pearson, *supra* note 48, at 689. *See also supra* note 8 and accompanying text.

62. Pearson, *supra* note 48, at 689.

63. HEALTH, EDUC., AND HUMAN SERV. DIV., U.S. GEN. ACCOUNTING OFFICE, PUB. NO. HEHS-98-137, CONSUMER HEALTH CARE INFORMATION: MANY QUALITY COMMISSION DISCLOSURE RECOMMENDATIONS ARE NOT CURRENT PRACTICE 4 (1998) [hereinafter CONSUMER HEALTH CARE INFORMATION].

64. Exec. Order No. 13,017, 61 Fed. Reg. 47,659 (Sept. 5, 1996).

65. "Network Characteristics" consist of "[p]rovider compensation methods, including base payment (e.g., capitation, salary, fee schedule) and additional financial incentives (e.g., bonus,

access to specialists."[66] The Commission advocated disclosure to entitle consumers to "receive accurate, easily understood information and . . . assistance in making informed health care decisions about their health plans, professionals and facilities."[67]

Disclosure regulation became more frequent in the 1990s as the health insurance industry rapidly changed and regulators sought accountability through disclosure.[68] The Commission found that market-based and ethical reasons should govern disclosure because value-based purchasing enables consumers to maximize their dollar by seeking the highest quality care at the lowest price.[69] Patients and providers require disclosure because they rely on plan information in decision making that directly affects the consumer's life and health.[70]

Disclosure is an effective regulatory strategy to expose conflicts of interest when intermediaries or agents are involved.[71] The greatest disagreement between health-care providers and plan providers arises over business relationships and financial arrangements.[72] In a 1998 report to selected Senators, the GAO found that large employers disclosed about half the information recommended by the Commission but did not disclose physician incentives in plan enrollment material.[73] Health plan providers usually resist disclosure because they view utilization review and physician incentives as proprietary information.[74]

withholds, etc.)." ADVISORY COMM'N ON CONSUMER PROT. & QUALITY IN THE HEALTH CARE INDUS., CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES 1, *at* http://www.hcquality commission.gov/final (last modified June 24, 1998) [hereinafter CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES]. *See also* CONSUMER HEALTH CARE INFORMATION, *supra* note 63, at 7–8.

66. CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES, *supra* note 65 at 1.

67. *Id*.

68. *See* Tracy E. Miller & William M. Sage, *Disclosing Physician Financial Incentives*, 281 JAMA 1424, 1424 (1999). *See also* CONSUMER HEALTH CARE INFORMATION, *supra* note 63, at 1.

69. CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES, *supra* note 65 at 1.

70. *Id*.

71. Miller & Sage, *supra* note 68, at 1424–25 (advocating mandatory disclosure only when a market failure results from "incomplete or asymmetric information," the information would be useful to consumers when making health-care choices, and barriers exist to restrict the voluntary disclosure).

72. CONSUMER HEALTH CARE INFORMATION, *supra* note 63, at 6–7.

73. *Id.* at 6.

74. Miller & Sage, *supra* note 68, at 1425.

A. Patients' Views are Mixed About the Financial Incentive Plans

The public's misgivings about managed care focus on "the fear that patient care is influenced by financial incentives."[75] Even though physician financial incentives may not affect the actual administration of care, it may negatively affect the patient's overall perception of health-care quality.[76]

The opportunity for or mere appearance of conflict of interest reduces patient trust and causes patients to scrutinize and second-guess their physicians' decisions.[77] "Regardless of payment method, patients' trust in their health plan or HMOs was lower than trust in their physicians."[78] Patients' trust in their HMO is closely correlated with trust in their physician.[79]

A study of patient and doctor opinions of financial incentive plans in the Journal of the American Medical Association (JAMA) found "the adverse impact of capitation on patient trust may be partially due to differences in physician behavior."[80] The JAMA study found that the presence of financial incentives enhances "discordance between patients' experience and expectations" and may reduce trust in their physician, regardless of whether incentives encouraged more appropriate uses of medical services.[81] A study in the Archives of Internal Medicine confirmed the JAMA study results, finding that although forty-six percent of patients surveyed were uncomfortable with group capitation, trust in their primary care physician was not reduced by such knowledge.[82]

Not only patients but also Congress and consumer rights groups advocate for greater disclosure to facilitate informed decision making by consumers.[83] However, it is important to note that "consumer satisfaction may not always

75. Julie Appleby, *Kaiser to Reveal Incentives for Physicians; Bonuses for Limiting Appointments Dropped*, USA TODAY: MONEY, Jan. 24, 2003.

76. Anne G. Pereira & Steven D. Pearson, *Patient Attitudes Toward Physician Financial Incentives*, 161 ARCHIVE OF INTERNAL MED. 1313, 1313 (2001).

77. *See id.*

78. Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708, 1711 (1998) (finding no association between patients' trust and their perception of capitation compared to fee-for-service payments).

79. *Id*.

80. *Id.* at 1712.

81. *Id.* at 1713; *but see* Mark A. Hall et al., *How Disclosing HMO Physician Incentives Affects Trust*, HEALTH AFF., Mar.–Apr. 2002, at 197, 204 (finding that disclosure of the mere existence of financial incentives negatively affected patients' perceptions, but when patients understood the content of disclosure, their perceptions were positively affected).

82. Pereira & Pearson, *supra* note 76, at 1316.

83. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997) (containing a list of disclosure requirements for private insurers under Medicare + Choice plans). *See also* CONSUMER HEALTH CARE INFORMATION, *supra* note 63, at 5.

correlate with achievement of the desired clinical outcome."[84] Incentive proponents argue that incentives are often complicated and disclosure only distorts the patient's understanding of complex health-care financing.[85] Experts advocate disclosure in some form but disagree about its effectiveness because of the difficulty of conveying complex information and measuring patient reaction to potentially controversial payment structures.[86] Knowledge of positive incentives may dispel negative opinions,[87] but it also risks blurring the fiduciary relationship between physician and patient because patients know their physicians are acting with more than one loyalty.

Patients tended to be more satisfied with the non-financial aspects of fee-for-service coverage[88] but preferred the smaller co-pays and deductibles of HMOs.[89] The potential conflict of interest bothered patients most.[90] Ultimately, patients' concerns about premiums and covered benefits outweighed misgivings regarding payment method and referral policies until they contracted a serious illness or required expensive procedures.[91]

B. Physician Autonomy Constrained by Financial Incentives

Not only are patients less satisfied, but physicians feel their ability to treat patients, using their best judgment, is reduced in capitated systems.[92] Physician financial incentives present the opportunity for conflicts of interest in that the physician's professional medical judgment may become clouded by financial self-interest.[93] The physician-patient relationship often facilitates an atmosphere where the patient is reluctant to initiate conflict or question the physician's judgment because the patient must rely on the physician's professional medical judgment.[94] In the physician-patient fiduciary

84. R. Adams Dudley et al., *The Impact of Financial Incentives on Quality of Health Care*, 76 MILBANK Q. 649, 651 (1998).

85. *See generally* Hall, *supra* note 81, at 204.

86. *Id*. at 202.

87. *See id.* at 203. In January 2003, Kaiser Permanente, the largest managed care provider in the country, agreed to disclose clinical guidelines for treating certain conditions and physician compensation—including physician financial incentives to limit care—as part of a legal settlement. Laura B. Benko, *A Look Inside: Settlement Requires Kaiser Permanente to Publish Info on Doc's Decisionmaking*, MODERN HEALTHCARE, Jan. 27, 2003, at 8.

88. Non-financial aspects of fee-for-service coverage include: choice of provider, no network restrictions, and personal relationship with primary-care physician.

89. Dudley, *supra* note 84, at 673.

90. Pereira & Pearson, *supra* note 76, at 1316.

91. Audiey C. Kao et al., *Physician Incentives and Disclosure of Payment Methods to Patients*, 16 J. GEN. INTERNAL MED. 181, 186 (2001).

92. Kao, *supra* note 78, at 1712.

93. *See* Miller & Sage, *supra* note 68, at 1425.

94. *See id*.

relationship, the physician is obligated to "act exclusively in [the] patients' interests" and "to respect the patients' autonomy."[95]

Primary care physicians reported that quality of care provided "through capitated contracts is inferior to the care" provided under "other forms of insurance."[96] The success of physician financial incentive plans may rest in the contract language that binds primary care physicians' interests to the HMO instead of the patient's welfare. One plan required physicians "not to take any action . . . which undermines . . . confidence of enrollees."[97] Yet the next paragraph of the contract required physicians to "keep the Proprietary Information [payment rates, utilization-review procedures, incentives, etc.] and this Agreement strictly confidential."[98]

In reality, physicians feel restricted by malpractice fears rather than payment systems. Physicians are worried about making the correct diagnosis and cannot keep straight which patients are managed care and which are fee-for-service. Few physicians contract with only one payor and accordingly accept a medley of payment options.[99] Physicians often experience four to five distinct types of third-party reimbursement in a typical day and may spend minimal time with each patient.[100] In practice, physicians treat a variety of fee-for-service, government supported, and capitation arrangements in the same day. Keeping up with which patients are capitated may be a daunting task and one which the physician chooses to avoid completely.

The effects of outliers in one plan can be reduced by increasing the incentive time period or increasing the number of patients or physicians calculated in the incentive.[101] If incentives are paid less often, physicians feel the incentive to ration treatment less intensely with each patient.[102] As much as providers and consumers dislike capitation, it is unlikely to be abandoned in a market-driven health-care system with limited resources.[103]

IV. ANALYSIS OF THE COURT'S INTERPRETATION OF ERISA PROVISIONS

In 1974, Congress enacted the Employee Retirement Investment Securities Act (ERISA) to establish uniform standards for employee benefit plans. [104]

95. *Id. See also supra* note 9 and accompanying text.

96. Dudley, *supra* note 84, at 657.

97. Steffie Woolhandler & David U. Himmelstein, *Extreme Risk — The New Corporate Proposition for Physicians*, 333 NEW ENG. J. OF MED. 1706, 1706 (1995).

98. *Id.*

99. Bodenheimer & Grumbach, *supra* note 6, at 971.

100. *Id*.

101. Latham, *supra* note 20, at 410.

102. *See id.*

103. Pearson, *supra* note 48, at 689.

104. Employee Retirement Investment Security Act, 29 U.S.C. § 1001(a) (2000) [hereinafter ERISA].

Concerned that multi-state employers would be subjected to widely varying obligations, Congress established uniform regulation under ERISA.[105] With ERISA's enactment, Congress sought to promote judicial efficiency and economic stability because federal and state laws messily interact in the area of employee benefits.[106]

The Constitution's Supremacy Clause provides that federal law supercedes state law when Congress so desires.[107] Congress may pre-empt all state law in an area by expressing intent to completely exclude all others from regulating in that area.[108] However, the federal and state laws often coexist when Congress' intent is unclear or it does not completely pre-empt a field. The Court presumes that Congress does not intend to pre-empt state legislation unless there is a clear indication from the language of the statute or purposes of the federal action.[109] Although Congress rarely expresses intent to pre-empt existing state law, parts of ERISA completely pre-empt state law, while others coexist in relative harmony.[110]

A. Fiduciary Relationships Under Common Law

Trust plays a very important role in medical relationships, setting the stage for every treatment decision.[111] At common law, a trustee "is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries."[112] Trust between physician and patient is more complex than other fiduciary relationships[113] because treatment decisions may affect the patient's survival or long-term health.[114] At common law, all fiduciary obligations were imposed on physicians, including requirements to: disclose material information, use good faith and fair dealings with patients, maintain confidentiality, provide notice to terminate the relationship, and avoid divided loyalty.[115] The physician-patient relationship embodies the definition

105. *See id. See also* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990).

106. *See generally* 29 U.S.C. § 1001; GARY CLAXTON, KAISER FAMILY FOUND., HOW PRIVATE INSURANCE WORKS: A PRIMER 7 (2002).

107. *See* U.S. CONST. art. VI., cl. 2.

108. *See id.*

109. *See* Ray v. Atlantic Richfield Co., 435 U.S. 148, 157 (1978).

110. 29 U.S.C. §§ 1001, 1132, 1144 (2000); *see also* CLAXTON, *supra* note 106, at 7 (discussing the nature of interaction between federal and state law regarding employee benefits).

111. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 485 (2002); *see also* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL. POL'Y & L. 661, 661–62 (1998).

112. 2A AUSTIN W. SCOTT & WILLIAM F. FRATCHER, THE LAW OF TRUSTS § 170, at 311 (4th ed. 1987).

113. *See supra* note 9 and accompanying text.

114. *See generally* Hall, *supra* note 111, at 485.

115. Varity Corp. v. Howe, 516 U.S. 489, 506 (1996) (discussing fiduciary's responsibility to disclose material information and use good faith and fair dealing with beneficiary); Hammonds v.

of trust-based relationships because the physician possesses knowledge to act in the patient's best interest and the patient may be none the wiser if the physician breaches the fiduciary relationship.[116]

Courts must be careful to maintain a high level of trust between physician and patient. Courts can view the effect of trust on law in three categories: predicated, supportive, and skeptical.[117] In a predicated view, trust is a factual premise used to impose a particular rule.[118] However, when implementing the supportive attitude toward trust, courts "attempt to increase or sustain trust."[119] Finally, under the skeptical legal attitude, courts examine the "absence or illegitimacy of trust" to establish a legal system institutionalizing distrust.[120]

Courts seek to regulate trustworthiness of physicians and institutions more than influencing patients' trust.[121] Conflicts of interest created by HMO reimbursement systems raise three trust-related legal issues. Under Hall's predicated theory, "the law might view patient trust as creating a fiduciary relationship in which doctors have a duty to avoid or disclose financial conflicts of interest, in order to justify the level of trust that exists."[122] The existence of a fiduciary relationship causes the obligation to disclose to "flow automatically," regardless of positive or negative outcomes associated with disclosure.[123] Implementing a "supportive view" of incentives, a functionalist

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Aetna Cas. & Sur. Co., 237 F. Supp. 96 (N.D. Ohio 1965) (discussing rules for termination of fiduciary relationship); McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 237 (5th Cir. 1995) (explaining the fiduciary's duty of loyalty to the beneficiary); Donovan v. Bierwirth, 538 F. Supp. 463, 469 (E.D.N.Y. 1981).

116. *See* Susan Dorr Goold, *Money and Trust: Relationships Between Patients, Physicians, and Health Plans*, 23 J. HEALTH POL. POL'Y & L. 687, 687 (1998).

> Typically, vulnerability, dependence, and reliance on the part of trustors force them or cause them to choose to trust the trustee. There is a trust object with which the trustee is entrusted: one's health, life, well-being, or children. There are expectations of competence or good outcome, and expectations of agency, beneficence, and good will that apply to the trustee. The trustee, for her part, must accept the trusting relationship and the discretionary power and control that comes with it. With this acceptance come moral obligations of competence, agency, and good will.

Id.

117. Hall, *supra* note 111, at 486.

118. *Id.* (discussing predicated attitudes focused on formalistic reasoning based on the existence of trust and disregarding the effects of trust).

119. *Id*.

120. *Id*.

121. *Id.* at 504 (finding that "[t]rust . . . is an attitude about motivations and expected outcomes" held by the patient, but trustworthiness refers to behavior of physicians and institutions).

122. Hall, *supra* note 111, at 486. "Trust predicates law in a justificatory mode by creating legal rules to vindicate the level of trust that exists or to punish violations of that trust. In the syllogistic mode, legal doctrine arises axiomatically from the existence of trust, through the application of precedents and principles from fiduciary law." *Id.*

123. *Id.* at 486.

court might limit incentives or mandate disclosure because "conflicts of interest created by cost-containment incentives tend to weaken trust by causing patients . . . to question their doctors' motivations."[124] From a skeptical viewpoint, it appears that patients' trust is unlikely to be maintained in the presence of financial conflicts of interest.[125]

B. Fiduciary Relationships Under ERISA

Congress adopted the scope of fiduciary responsibilities in ERISA to govern employee benefit plan[126] administration from the common law of trusts.[127] An individual is a fiduciary under ERISA if he "exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets," or "has any discretionary authority or discretionary responsibility in the administration of such plan."[128] ERISA mandates that private pension plan investments are to be held in trust,[129] used for the exclusive benefit of plan beneficiaries, and administered by one or more named fiduciaries.[130] However, ERISA fiduciary rules focus more on the employer, insurance provider, or managed care organization than the physician-patient relationship and "[u]nder ERISA . . . a fiduciary may have financial interests adverse to beneficiaries."[131]

124. *Id.*

125. *See id.* "Disclosure in such a case would serve as a warning to patients, putting them on guard about how financial incentives might distort or corrupt their physicians' medical judgments." *Id.*

126. Employee benefit plans as defined by ERISA include:

> [A]ny plan, fund, or program . . . established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.

29 U.S.C. § 1002(1) (2000). *See also* McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 236 (5th Cir. 1995).

127. H.R. REP. NO. 93-533, at 11–13 (1973).

128. ERISA § 402(21)(A) (codified as amended at 29 U.S.C. § 1002(21)(A) (2000)). A plan fiduciary need not be a third party and can be an officer, employee, or other party in interest. ERISA § 408(c)(3) (codified as amended at 29 U.S.C. § 1108(c)(3) (2000)).

129. *See* ERISA § 403(a) (codified as amended at 29 U.S.C. § 1103(a) (2000)).

130. *See* ERISA § 402(a)(1) (codified as amended at 29 U.S.C. § 1102(a)(1) (2000)).

131. Pegram v. Herdrich, 530 U.S. 211, 225 (2000) (explaining that employers can be ERISA fiduciaries and take actions which disadvantage employees when acting as employers or plan beneficiaries).

Courts disagree about whether ERISA creates a fiduciary duty for managed care organizations to disclose financial incentives.[132] In order to maintain trustworthiness, ERISA implements a prudent person standard of care in plan administration, requiring fiduciaries to discharge duties solely for the interests of the plan beneficiaries.[133] Fiduciaries must also provide services to beneficiaries and defray costs of administering the plan.[134] Fiduciaries must act with "care, skill, prudence, and diligence" to minimize risk in investments and enforce all portions of the benefit plan in compliance with ERISA.[135] In order for an employee to prove a breach of fiduciary duty under ERISA, he must prove "breach of a fiduciary duty and a prima facie case of loss to the [benefit] plan."[136] Finally, plan fiduciaries violating ERISA are personally liable to the plan beneficiaries for losses incurred by the breach of duty.[137]

C. ERISA Analysis: Created by Congress and Redefined by the Courts

Two types of pre-emption can occur under ERISA: express pre-emption under §514[138] and procedural pre-emption under §502.[139] ERISA § 514 requires courts to employ a three step test to determine whether a state law is preempted by ERISA and should be removed to federal court.[140] ERISA analysis contains three major components: A state law is pre-empted if it "relate[s] to" an employee benefit plan,[141] but it can be "saved" if the claim

132. *See* Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997) (holding that ERISA § 404 required managed care organization to disclose physician incentive plan); *but see* Ehlmann v. Kaiser Found. Health Plan of Tex., 198 F.3d 552, 554–56 (5th Cir. 2000) (holding no broad duty to disclose for HMOs under ERISA).

133. 29 U.S.C. § 1104(a) (2000).

134. 29 U.S.C. § 1104(a)(1)(A)(i)–(ii). *See also* RESTATEMENT (SECOND) OF TRUSTS § 170(1) (1959).

135. 29 U.S.C. § 1104(a)(1)(B)–(D).

136. McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 237 (5th Cir. 1995).

137. *See* ERISA § 409 (codified as amended at 29 U.S.C. § 1109 (2000)).

138. ERISA § 514 (codified as amended at 29 U.S.C. § 1144 (2000)); *see infra* note 140 and accompanying text.

139. ERISA § 502 (codified as amended at 29 U.S.C. § 1132 (2000)) (providing a private right of action to recover for "benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan").

140. 29 U.S.C. § 1144.

141. 29 U.S.C. § 1144(a) ("provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96–97 (1983) ("[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan"); *see also* Metro. Life Ins. Co. v. Mass., 471 U.S. 722 (1985). A state law "relates to" an EBP if it mandates benefit structure, mandates plan administration, rules out choice of benefit structure or administration of an EBP, or mandates alternative enforcement mechanisms beyond those provided by ERISA § 502. *See* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 645–48 (1995) [hereinafter *Travelers*].

relates to regulation of insurance,[142] unless the plan is provided by a self-insurer, in which case the plan is "deemed" not to be regulated as an insurer.[143] ERISA § 502 is the exclusive remedy "to recover benefits due . . . under the terms of his plan."[144]

1. Conflict Preemption — "Relating To" Doctrine

In 1974, Congress expressed intent to establish uniform regulation of employee benefit plans (EBP) by enacting the Employee Retirement Investment Securities Act (ERISA). Congress created ERISA to "minimize the administrative and financial burden" faced by large insurers and employers and to prevent potential conflicts of substantive law that would require manipulating plans to comply with discrepancies in each jurisdiction.[145] Congress used broad language in structuring ERISA to pre-empt all state statutes that "relate to" an EBP.[146] However, the Supreme Court has continually narrowed the scope of ERISA preemption.[147]

> In trying to extrapolate congressional intent in a case like this, when congressional language seems simultaneously to preempt everything and hardly anything, we "have no choice" but to temper the assumption that "the ordinary meaning . . . accurately expresses the legislative purpose" . . . with the qualification "that the historic police powers of the States were not [meant] to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 365 (2002) (citing *Travelers*, 514 U.S. at 655) (finding that Illinois' mandatory external review did not constitute alternative enforcement measures to ERISA § 502) (citations omitted). The courts have continually narrowed the scope of automatic pre-emption originally envisioned. *Compare* Pegram v. Herdrich, 530 U.S. 211, 224 (2000), *and* Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001) (holding mixed eligibility and treatment decisions as well as strictly treatment decisions are not pre-empted and should be handled through state malpractice actions; however, plan coverage decisions are pre-empted), *with* Estate of Frappier v. Wishnov, 678 So. 2d 884 (Fla. Dist. Ct. App. 1996) (allowing vicarious liability claims, but pre-empting corporate liability claims), *and* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995) (establishing liability for HMO under ERISA § 502 for insufficient quantity of services, but expressing an unwillingness to evaluate the quality of benefits).

142. 29 U.S.C. § 1144(b)(2)(A) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."); *see also* Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 339–342 (2003) (adopting a clarified test for determining whether a state law "regulates insurance").

143. 29 U.S.C. § 1144(b)(2)(B) (creating an exception to the insurance saving clause that an employer's self-insured benefit plan may not "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . of any law of any State purporting to regulate insurance companies, [or] insurance contracts").

144. ERISA § 502 (codified as amended at 29 U.S.C. § 1132 (2000)).

145. Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990) (citing 29 U.S.C. § 1144).

146. *See Travelers*, 514 U.S. at 658. *See also supra* note 141.

147. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (limiting recovery under ERISA to remedies outlined by Congress "without embellishment by independent state remedies"); *McClendon*, 498 U.S. at 138; Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146–

A state-law cause of action is removable when it is based on law that is pre-empted by ERISA and falls within the scope of enforceable remedies under ERISA § 502 provisions.[148] In *Travelers*, the Court redefined a two-prong disjunctive test whereby a state statute triggers ERISA when it expressly makes reference to an EBP or has a direct economic "connection with" an EBP.[149] The Court should look at both Congress's objectives as to the scope of ERISA preemption and to the effect of the state law on ERISA plans.[150] In *Travelers*, the Court held that surcharges mandated by New York law on commercial insurers, but not Blue Cross/Blue Shield, were not pre-empted because the charges only had an indirect economic impact.[151] The Blues accept patients through open enrollment, some of whom commercial insurers would reject.[152] Surcharges on commercial insurers and HMOs make the Blues a "less unattractive" insurance alternative, and the Court reasoned that this indirect economic effect does not have a connection with the uniform administration of employee benefit plans.[153] The *Travelers* Court also held that state law mandating benefit structure, plan administration, or providing alternative remedies to ERISA § 502 would have a connection with employee benefit plans and trigger pre-emption.[154]

In 2000, the Supreme Court ruled that incentive plans do not violate ERISA, but the Court reserved judgment on determining the legality of failures to disclose incentives.[155] The Court outlined a test to settle disagreement about pre-emption of state claims, holding that eligibility decisions are pre-empted, but treatment decisions and mixed questions of eligibility and treatment are not pre-empted.[156] "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose."[157] Herdrich brought claims against Pegram, her doctor, alleging medical malpractice, fraud, and breach of fiduciary duty under

157 (1985); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96–97 (1983); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) (holding that states maintain powers unless Congress expresses "clear and manifest purpose" to supercede).

148. *See* 28 U.S.C § 1331; 28 U.S.C § 1441; ERISA § 502 (codified as amended at 29 U.S.C § 1132 (2000)); *see also* Romney v. Lin, 94 F.3d 74, 78 (2d Cir. 1996).

149. *Travelers*, 514 U.S. at 658.

150. Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A., 519 U.S. 316, 325 (1997).

151. *Travelers*, 514 U.S. at 658–59.

152. *Id.* at 658.

153. *Id*. at 659–60.

154. *Id.* at 658; *see also* Anderson v. Humana, 24 F.3d 889, 891 (7th Cir. 1994) (holding that Anderson's attacks on Humana-Michael Reese's incentive structure was pre-empted because it "relates to" the administration of employer's benefit plan).

155. Pegram v. Herdrich, 530 U.S. 211, 237 (2000).

156. *Id.* at 231–32.

157. *Id*. at 237.

ERISA.[158] The Court determined that Dr. Pegram's decision to delay an ultrasound to detect appendicitis was not pre-empted by ERISA because it was a mixed question of eligibility and treatment.[159]

Applying the *Pegram* analysis, the Second Circuit held that ERISA does not pre-empt a claim challenging an "allegedly flawed medical judgment" because review of an individual patient's symptoms is a question of mixed eligibility and treatment.[160] Federal courts must tread lightly around state medical malpractice law when considering ERISA claims because ERISA's main focus is on protecting contractual rights defined within individual employee benefit plans.[161]

2. Insurance Savings Clause

In order to qualify under the ERISA Insurance Saving Clause, a state law must be "specifically directed toward" the insurance industry and not merely a general law that affects the industry.[162] ERISA's Insurance Saving Clause does not "exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."[163] Prior to 2003, courts applied an unworkable test for determining whether a state law "regulates insurance" by applying a common-sense definition or examining the McCarran-Ferguson criteria.[164] Under McCarran-Ferguson, courts found a state law pre-empted if it met two of the three McCarran-Ferguson factors: whether the practice—"transfer[s] or spread[s] a policyholder's risk; . . .is an integral part of the policy relationship between the insurer and the insured; . . . [and] is limited to entities within the insurance industry."[165]

In 2003, the Court abandoned the McCarran-Ferguson criteria in favor of a two-pronged test to redefine the "regulate insurance" clause, holding that the scope of the Insurance Savings Clause is "specifically directed toward entities engaged in insurance" and "the state law must substantially affect the risk pooling arrangement between the insurer and the insured."[166] The Supreme Court unanimously held that Kentucky's any willing provider law was not pre-

158. *Id*. at 215–16.

159. *Id*. at 229, 231 (defining a mixed eligibility and treatment decision as an "eligibility decision[] [that] cannot be untangled from physicians' judgments about reasonable medical treatment").

160. Cicio v. Does 1–8 et al., 321 F.3d 83, 102 (2d Cir. 2003).

161. *Id.* at 100.

162. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 365–66; *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50 (1987).

163. ERISA § 514 (codified as amended at 29 U.S.C. § 1144(b)(2)(A) (2000)).

164. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 743 (1985).

165. *Id*. at 743; *see also* McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–1015 (1994)).

166. Ky. Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471, 1479 (2003).

empted by ERISA because it was "specifically directed toward entities engaged in insurance," even though the statutes also adversely affected physicians from entering into HMO contracts.[167]

3. The Deemer Clause

In the final step of ERISA analysis, a self-insuring company shall be "deemed"[168] to be exempt from the Insurance Savings clause and not subject to state law regulating insurance, banking, and securities.[169] The Deemer Clause in effect subjects self-insured employers to federal law but exempts them from state laws regulating insurers.

D. Complete/Procedural Pre-emption

Complete pre-emption under ERISA § 502 arises when a beneficiary seeks "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."[170] Remedies mandated for ERISA plans do not allow for tort or punitive damage awards and only allow injunctive relief and incidental damages occurring from denial of benefits under an EBP.[171] ERISA § 502 requirements[172] must be strictly adhered to and will completely pre-empt any state law to the contrary, providing a defendant the right to remove to federal court if a claim for benefits is filed in state court.[173] ERISA plaintiffs are not entitled to trial by jury.[174]

ERISA § 502 creates statutory legal rights, which when infringed upon provide beneficiaries with standing and satisfy the actual or threatened injury

167. *Id.* at 1475–76, 1479.

168. 29 U.S.C. § 1144(b)(2)(B).

169. A mandatory benefits statute affecting a self-insuring company's EBP will be pre-empted because it "relates to" employee benefits. However, the plan will be "saved" because it relates to insurance and will be subject to state statutes. One further exception exists (the Deemer Clause) in that self-insured employers are "deemed" not to be regulated by state statutes as an insurance company or under insurance contracts and therefore pre-empted by ERISA. *See generally* 29 U.S.C. § 1144 (2000).

170. ERISA § 502(a)(1)(B) (codified as amended at 29 U.S.C. § 1132(a)(1)(B) (2000)).

171. 29 U.S.C. § 1132(a)(3)(A).

172. 29 U.S.C. § 1133(1)–(2) (2000). Requirements include: a full and fair internal review because an employee has the right to know reasons behind a Managed Care Organization's decision; a written denial explaining the reason; time limits for decisions (Urgent–72 hours, Concurrent–sufficiently in advance, Pre-service–15 days, Post-service–30 days); the provision of an "Appropriate Health Care Professional" on appeal to aid in decision; and exhaustion of internal review before plaintiffs can file a claim in federal court. *Id.*; *see also* 29 C.F.R. § 2560.503-1(f)(2)(i)–(iii) (2003).

173. 29 U.S.C. § 1132; *see also* 29 U.S.C § 1441 (2000).

174. 29 U.S.C. § 1132(a).

requirement of Article III.[175] The Ninth Circuit Court of Appeals even held that plaintiffs do not have to allege actual injuries to prosecute ERISA violations because fiduciaries are liable for breaches of duty even when no actual injury exists.[176] Plaintiffs may seek equitable relief under ERISA § 502 but may not bring an action for legal relief unless actual harm can be proven.[177]

ERISA § 502 requires plaintiffs to exhaust all pre-filing requirements before pursuing litigation.[178] Plaintiffs possess a statutory right to have a full and fair internal review, but if that comes back against the patient, states can enact binding external review, which will stand up against ERISA preemption.[179]

Courts will give deference to plan administrators' decisions and review § 502 claims using an arbitrary and capricious standard as long as plan administrator is given the discretionary authority to determine or construe the terms of the plan.[180] However, where a plan administrator has a conflict of interest, the court will give less deference and weigh the conflict as a "factor in determining whether there is an abuse of discretion."[181] In *Doe v. Group Hospitalization & Medical Services*, Blue Cross administered the benefit plan, but the Fourth Circuit Court of Appeals found that a conflict of interest existed because Blue Cross (an insurer) profited less if more medical services were approved.[182] After determining the existence of a conflict of interest, the court looks to see whether the contract is ambiguous.[183] If a conflict of interest exists and the contract is ambiguous, the court should construe terms in the patient's favor.[184]

175. Warth v. Seldin, 422 U.S. 490, 499 (1975); *see also* U.S. CONST. art. III, § 2, cl. 1.

176. Ziegler v. Conn. Gen. Life Ins. Co., 916 F.2d 548, 552 (9th Cir. 1990) ("not all ERISA actions for breach of fiduciary duties require an occurrence of harm before they will accrue"); *see also* ERISA § 404(a) (codified as amended at 29 U.S.C. § 1104(a)) (A fiduciary who fails to perform for the exclusive benefit of participants violates ERISA).

177. Horvath v. Keystone Health Plan E., Inc., 333 F.3d 450, 456 (3d Cir. 2003); *see also* Larson v. Northrop Corp., 21 F.3d 1164, 1171 (D.C. Cir. 1994).

178. 29 U.S.C. § 1132(a)–(b). Exhaustion of pre-filing requirements entails obtaining written denial explaining the reason for denial and a full and fair internal review. *Id.*; *see also supra* note 172.

179. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379–380 (2002) (allowing external reviewer to determine what constitutes "medically necessary," thus providing expanded opportunity for recovering on a claim for benefits due under an employee benefits plan, but still limited to remedies under ERISA); 29 U.S.C. § 1133(1)–(2) (2000).

180. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 111 (1989) [hereinafter *Firestone Tire*]. However, if deference is not given to the plan administrator, claims will be reviewed de novo. *Id.* at 115.

181. *Id.* at 115 (quoting RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)).

182. 3 F.3d 80, 85–87 (4th Cir. 1993).

183. *Id.* at 88–89.

184. *Id.* at 89 (noting that if no conflict of interest exists or the contract is not ambiguous, then the plan administrator is given wide discretion and the courts will only review for abuse).

V. CIRCUIT COURTS OF APPEALS DISAGREE ABOUT FIDUCIARIES' DUTY TO DISCLOSE UNDER ERISA

Whether an HMO has a duty to disclose information regarding physician financial incentives and is classified as an ERISA fiduciary depends on the contract language of the individual plan and the federal court in which the action is initiated.

A. Cases Finding Requirement in ERISA for HMOs to Disclose Physician Financial Incentives as Material Information

1. The Eighth Circuit Court of Appeals: *Shea v. Esensten*

In 1997, the Eighth Circuit employed a functionalist approach in *Shea v. Esensten*, broadly interpreting the ERISA § 514 "relates to" test.[185] Shea's husband died after reporting chest pain to his primary-care physician.[186] She had standing under ERISA to pursue the claim because Mr. Shea's employer contracted with Seagate HMO to provide medical coverage.[187] The physician refused to give a referral to a cardiologist even when the decedent offered to pay for the visit out of pocket.

The *Shea* Court reasoned that the outcome of the case would affect administration of the employee benefit plan and accordingly "related to" an EBP.[188] State laws relating to ERISA must be interpreted broadly and pre-empted because if administrators have to amend their benefit plans for each state, the result would be contrary to Congress's intent for "nationally uniform administration of employee benefit plans."[189]

The Eighth Circuit Court of Appeals held that Seagate HMO breached its fiduciary duty because it did not disclose "material information" regarding its physician incentive program which encouraged rationing care and minimizing specialist referrals.[190] "From the patient's point of view, a financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information."[191] The court reasoned that if Mr. Shea had known his physician was receiving

185. *See* Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997); *see also* ERISA § 514 (codified as amended at 29 U.S.C. § 1144(a) (2000)).

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

187. *Id.* at 626–27.

188. *Id.* at 627; Jordan v. Fed. Express Corp., 116 F.3d 1005 (3d Cir. 1997) (holding that breach of fiduciary duty occurs when harm results from non-disclosure material information to the beneficiary); *see also* 29 U.S.C. § 1144(a).

189. 29 U.S.C. § 1101(a) (2000); *see also* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990).

190. *Shea*, 107 F.3d at 628. *But see* Pegram v. Herdrich 530 U.S. 211, 231 (2000) (discussing Congress' intent for treatment of HMOs in mixed eligibility decisions).

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

financial kickbacks for not referring patients to specialists, he would have scrutinized his physician's decision more closely and sought a second opinion.[192]

The *Shea* rationale for evaluating ERISA claims survives after *Pegram's* "mixed eligibility" test because the Eighth Circuit decided this case on the basis of the HMO's fiduciary duties under ERISA § 404. *Shea* would no longer be viable if the Eighth Circuit had relied on an examination of the physician's treatment decision and the HMOs administrative decision because the case would have remained in state court, on the original malpractice claims, under the "mixed eligibility" test.[193] ERISA issues would then be brought into state court actions through supplemental jurisdiction.[194] However, the Eighth Circuit ruled on fiduciary duty grounds, thus providing multiple avenues for holding HMOs liable for nondisclosure under ERISA.

2. The Fifth Circuit Court of Appeals: *McDonald v. Provident Indemnity Life Insurance Co.*

The Fifth Circuit found that fiduciary duties imposed under ERISA § 404 required disclosure of "material information" such as a change in the plan's rate schedule that resulted in "prohibitive premiums."[195] To prove breach of fiduciary duty, the plaintiff must show "a breach of fiduciary duty and a prima facie case of loss to the plan."[196] The burden then shifts to the fiduciary to prove that losses to the plan were not caused by breach of fiduciary duty.[197]

In *McDonald*, the plaintiff owned a small construction business and challenged the premium increases, imposed by the defendant, which forced McDonald to cancel coverage for employees.[198] French, the fiduciary, breached his fiduciary duty when he failed to inform McDonald and its employees of rate adjustments planned by Provident, motivated at least in part by marketing considerations.[199] The Fifth Circuit Court of Appeals found that

192. *Id.* at 629.

193. *Pegram*, 530 U.S. at 223–24, 231; ERISA § 404 (codified as amended at 29 U.S.C. § 1104(a)(1)(A) (2000)).

194. *See* 28 U.S.C. § 1367 (2000) and corresponding state statutes.

195. McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 237 (5th Cir. 1995). "Section 404(a) imposes on a fiduciary the duty of undivided loyalty to plan participants and beneficiaries, as well as a duty to exercise care, skill, prudence and diligence. An obvious component of those responsibilities is the duty to disclose material information." *Id.*; *see also* 29 U.S.C. § 1104(a).

196. *McDonald*, 60 F.3d at 237.

197. *Id.*

198. *Id.* at 236.

199. *Id.* at 237.

plaintiffs' claim failed the second step of the analysis because they could not prove loss to the plan.[200]

B. Cases Finding No Enumerated Duty in ERISA for HMOs to Disclose Physician Financial Incentive Plans

1. The Fifth Circuit Court of Appeals: *Ehlmann v. Kaiser Foundation Health Plan of Texas*

In 2000, the Fifth Circuit Court of Appeals adopted a formalistic approach in deciding that no duty to disclose physician financial incentives existed under ERISA.[201] In *Ehlmann*, the plaintiffs alleged that under ERISA § 404,[202] Congress intended for a disclosure requirement to be imposed on plan fiduciaries.[203] The *Ehlmann* Court recognized the issue as one of first impression and strictly construed ERISA's statutory requirements.[204] To impose such a disclosure requirement would go beyond the scope of duties Congress imposed on fiduciaries under ERISA and "this court will not encroach on that authority by imposing a duty which Congress has chosen not to impose."[205] The Fifth Circuit adopted an *expressio unius est exclusio alterius* rationale in holding that the absence of disclosure requirements shows that Congress and the Department of Labor intentionally omitted such requirements.[206]

The court held that only "material information" must be disclosed to plan beneficiaries[207] and information regarding a financial incentive plan was not considered "material" in the Fifth Circuit.

200. *Id.* at 237–38; ERISA § 409(a) (codified as amended at 29 U.S.C. § 1109(a) (2000)); *see also* Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 142 (1985) (holding that the loss must be to the plan and not simply to individual beneficiaries).

201. Ehlmann v. Kaiser Found. Health Plan of Tex., 198 F.3d 552, 555 (5th Cir. 2000).

202. *See* ERISA § 404 (codified as amended at 29 U.S.C. § 1104 (2000)).

203. *Ehlmann*, 198 F.3d at 555.

204. *Id.* at 554–55. *But see* Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997); Swinney v. General Motors Corp., 46 F.3d 512, 518–19 (6th Cir. 1995); Varity Corp. v. Howe, 516 U.S. 489, 531–32 (1996).

205. *Ehlmann*, 198 F.3d at 554–55.

206. *Id.* at 555–56. "A canon of construction holding that to express or include one thing implies the exclusion of the other, or of the alternative." BLACK'S LAW DICTIONARY 620–21 (8th ed. 2004).

207. *Compare Ehlmann*, 198 F.3d at 556, *with Shea*, 107 F.3d at 628, *and* McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 237 (5th Cir. 1995) (distinguishing between cases finding nondisclosure of material information that breached the fiduciary duty and cases lacking a specific inquiry or special circumstances to rise to the level of material information warranting disclosure).

2. The Third Circuit Court of Appeals: *Horvath v. Keystone Health Plan East*

In June 2003, the Third Circuit Court of Appeals issued the most recent appellate decision, examining a new twist on liability for nondisclosure of physician financial incentive plans. The opinion discussed the extent to which ERISA § 404 fiduciary requirements obligate an HMO to disclose financial incentives awarded to physicians.[208] In *Horvath*, the plaintiff attempted to stretch ERISA's fiduciary duty requirements one step beyond where courts had previously been willing to go.[209]

Horvath proceeded, not on the traditional "material information" theory of *Shea* and *McDonald*,[210] but instead sought injunctive relief for disclosure of physician financial incentives and restitution or disgorgement for the "diminished value" of the employee benefit plan.[211] Horvath alleged that nondisclosure of Keystone's physician financial incentives to the plan administrator (Horvath) violated the HMOs fiduciary duty to plan members under ERISA and that restitution should be awarded for amounts overpaid by employees.[212] Beneficiaries contested paying into a plan that rewarded physicians for rationing treatment while enrollees believed the physicians were acting solely for benefit of patients, free from the conflicted influence of financial incentives.[213] Plaintiffs claimed the cost of the plan was overly burdensome considering that physicians were receiving kickbacks to limit care.[214]

A private cause of action exists for breach of fiduciary duty under ERISA[215] because "appropriate equitable relief"[216] must be granted "directly to

208. *See* Horvath v. Keystone Health Plan E., Inc., 333 F.3d 450 (3d Cir. 2003), *see also* ERISA § 404 (codified as amended at 29 U.S.C. § 1104 (2000)).

209. *See Horvath*, 333 F.3d at 450.

210. Strategically, Horvath's decision not to proceed on the material information theory may have been well-advised because the Fifth Circuit Court of Appeals had already ruled formalistically in *Ehlmann* that nondisclosure of physician financial incentives was not material information. *Ehlmann*, 198 F.3d at 556.

211. *Horvath*, 333 F.3d at 453. Under the "diminished value theory" Horvath alleged damages resulting from the difference between the employees' perceived value of a plan including physician financial incentives versus a plan without incentives for rationing care. *Id.*

212. *Id.* at 453.

213. *Id.*

214. *Compare Id.* at 456–57, *with* McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 237 (5th Cir. 1995) (attempting to analogize the kickbacks in *Horvath* with the undisclosed rate increases in *McDonald*).

215. *See* Bixler v. Cent. Pa. Teamsters Health & Welfare Fund, 12 F.3d 1292 (3d Cir. 1993) (holding that failure to disclose "material information" upon request of beneficiary constituted breach of HMOs fiduciary duty).

216. ERISA § 404(a) (codified as amended at 29 U.S.C. § 1104(a) (2000)), ERISA § 502(a)(3) (codified as amended at 29 U.S.C. § 1132(a)(3) (2000)).

a participant or beneficiary."[217] Neither party to this case heavily contested whether Keystone qualified as a fiduciary under ERISA.[218] A beneficiary need not request information from the fiduciary before fiduciary duties under ERISA are imposed.[219] The Third Circuit Court of Appeals regarded Keystone as an ERISA fiduciary and accordingly held that Horvath and other employees were entitled to certain rights: 1) "to receive particular information" and 2) "to have Keystone act in a fiduciary capacity."[220] The Third Circuit previously held that an ERISA fiduciary must disclose "material facts, known to the fiduciary but unknown to the beneficiary" and that must be known for beneficiary's protection.[221]

Horvath's claim for injunctive relief demanded that employees receive information regarding physician financial incentive plans when deciding whether to enroll.[222] She claimed Keystone's concealment of details regarding its physician incentive plans interfered with her duties as plan administrator.[223] "Congress' purpose in enacting the ERISA disclosure provisions [was to] ensur[e] that the individual participant knows exactly where he stands with respect to the plan."[224] Keystone claimed that it fulfilled ERISA's fiduciary duties because it provided a directory of physicians covered by the plan and sent a letter to Horvath outlining its policy of "attempting to 'control the increase of health care costs through negotiated agreements with health care providers, doctors, hospitals, pharmacy, and ancillary providers.'"[225]

Horvath sought equitable and legal relief in the form of "restitution, disgorgement and an injunction barring Keystone from continuing to omit information regarding physician incentives from its disclosures to plan members."[226] Horvath's monetary damages for restitution and/or

217. 29 U.S.C. § 1104(a).

218. *Horvath*, 333 F.3d at 453 n.2.

219. Glaziers & Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Sec., Inc., 93 F.3d 1171 (3d Cir. 1996) (holding that disclosure must occur when fiduciary is on notice as to certain information, disclosure of which would prevent a beneficiary's misinformed or harmful decision regarding an ERISA plan, but rejecting requirement that beneficiary make specific inquiry).

220. *Horvath*, 333 F.3d at 456.

221. *Glaziers*, 93 F.3d at 1182; McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 237 (5th Cir. 1995); Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997).

222. *Horvath*, 333 F.3d at 453; CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES, *supra* note 65 (emphasizing initial disclosure of benefit plan information to consumers because initial choice of plan has significant impacts on future choices such as physicians, facilities, and treatment options); *see also* 29 U.S.C. § 1104.

223. *See Horvath*, 333 F.3d at 456; *see also* 29 U.S.C. §§ 1104, 1132(a)(3) (2000).

224. Gillis v. Hoechst Celanese Corp., 4 F.3d 1137, 1148 (3d Cir. 1994) (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 118 (1989)).

225. *Horvath*, 333 F.3d at 453.

226. *Id.* at 455.

disgorgement were dismissed by the court because she could not demonstrate individual loss resulting from Keystone's failure to disclose, nor could she establish an amount she and other employees overpaid as a result of non-disclosure.[227]

The Third Circuit proceeded to the merits of the injunctive relief claim because violation of ERISA § 404 fiduciary duties entitles a plaintiff to relief and satisfies Article III injury requirements.[228] The court previously held that a claim could be sustained if the plaintiffs established a "tangible economic harm" and could show that "health care they received under [the] plan actually was compromised or diminished as a result of . . . management decisions challenged in the complaint."[229]

The Third Circuit held that Horvath could not sustain a cause of action against her HMO for breach of fiduciary duty for failure to disclose physician financial incentives because the HMO had no duty to disclose that information.[230] ERISA imposes no disclosure requirements on HMOs regarding physician incentives unless a plan participant requests such information or circumstances exist to put the HMO on notice that disclosure of such information may prevent the participant from making a harmful decision with respect to her health-care coverage.[231] Absent evidence she was harmed as a result of not having such information disclosed, Horvath's claim must fail.[232] Horvath did not properly request information regarding physician incentive plans, and accordingly Keystone could not have known that the information was necessary to avoid harm.[233] Following a similar decision in the Fifth Circuit,[234] the court refused to add physician financial incentives to the list of disclosures required by ERISA, but in doing so the court ignored Eighth Circuit decisions to the contrary.[235]

227. *Compare Horvath*, 333 F.3d at 457, *with* McDonald v. Provident Indem. Life Ins. Co., 60 F.3d 234, 237 (3d Cir. 1995). In order to sustain a claim for misrepresentation by an ERISA fiduciary, a plaintiff must claim that: defendant was acting as a fiduciary, defendant made a misrepresentation, the misrepresentation was material, and plaintiff relied on the misrepresentation to her detriment. *See* Daniels v. Thomas & Betts Corp., 263 F.3d 66, 73 (3d Cir. 2001).

228. *Horvath*, 333 F.3d at 456; *see supra* notes 177–79 and accompanying text.

229. Maio v. Aetna, Inc., 221 F.3d 472, 488 (3d Cir. 2000) (discussing physician financial incentive plans challenged under RICO, but utilizing the same analysis); *see also* Shea v. Esensten, 107 F.3d 625, 627 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997).

230. *Horvath*, 333 F.3d 462–63.

231. *Id.*

232. *Id.*

233. *Id.*

234. *See* Ehlmann v. Kaiser Found. Health Plan of Tex., 198 F.3d 552 (5th Cir. 2000).

235. *See* Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997).

VI. ANALYSIS OF DISCLOSURE DECISIONS BY THE FEDERAL COURTS OF APPEALS

Horvath v. Keystone Health Plan East, Inc. was the latest decision in a string of cases outlining the duties of HMOs to their beneficiaries.[236] *Horvath* involved a disclosure issue where a beneficiary challenged the disclosure practices of her HMO, alleging that nondisclosure at initial enrollment and continued concealment of physician incentive plan violated ERISA disclosure rules and diminished the value of the health plan to employees.[237] *Horvath* urged the Third Circuit Court of Appeals to expand the disclosure requirements under ERISA, but the court rejected her claim because it found that controlling exploding health-care costs outweighed the protection which might be derived from expanding existing ERISA disclosure rules.

The *Horvath* Court acknowledged that HMOs exist to establish cost-containment measures for providing medical coverage to employees and are not inherently wrong.[238] Relying on the *Pegram* analysis, the court found that cost-controlling measures are balanced by the physicians' "professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest."[239] However, the court accepted the conflict of interest inherent in managed care, recognizing that a physician's incentive under a HMO is to provide patients with less care, not more.[240]

The Third Circuit Court of Appeals erred in deciding Horvath's case on grounds other than fiduciary duty responsibilities. "ERISA does require, however, that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions."[241] The *Horvath* Court's analysis should have focused on whether disclosure of Keystone's physician incentive plan was a "material fact[], known to the fiduciary but unknown to the beneficiary," [242] that Horvath and other employees should have known about for their pecuniary protection.[243]

The *Horvath* Court ruled against the plaintiff because she failed to request information from Keystone, Keystone was not on notice that disclosing information was necessary to prevent plaintiff from making a harmful decision, and the plaintiff failed to show how information on physician incentives was

236. *See Horvath*, 333 F.3d at 450.

237. *Id.* at 453.

238. *Id.* at 454 (citing Pegram v. Herdrich, 530 U.S. 211, 219 (2000)).

239. *Id.* (citing *Pegram*, 530 U.S. at 219).

240. *See id.*; *see also Pegram* 530 U.S. at 219; Doe v. Group Hosp. & Med. Servs., 3 F.3d 80 (4th Cir. 1993).

241. *Pegram*, 530 U.S. at 225; *see* Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 443–44 (1999); Varity Corp. v. Howe, 516 U.S. 489, 497 (1996).

242. Glaziers & Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Sec., Inc., 93 F.3d 1171, 1182 (3d Cir. 1996).

243. *See supra* text accompanying notes 217–27.

material because her employer only offered one option for insurance coverage.[244] However, Supreme Court jurisprudence should put Keystone on notice that non-disclosure of information that is essential to assist beneficiaries in evaluating the quality of their health-care coverage may cause economic harm.

It is likely that the United States Supreme Court will take up the issue of physician financial incentives and the scope of ERISA's disclosure rules. The Court should look at the differing standards established by the Federal Courts of Appeals and adopt a factors test to determine whether disclosure is necessary in a particular situation. Establishing a bright-line test for mandatory disclosures is unworkable because many different factors may come into play in a court's final decision. Factors considered by Federal Courts of Appeals included the materiality of the information,[245] whether a request was made for information,[246] whether concealment of the incentive plan caused the beneficiary to make a health-care decision adverse to their health,[247] the occurrence of any adverse effects resulting from improper administrative decisions,[248] and schedule changes affecting the employer's ability to provide coverage.[249] A factors test that weighs the many variables that determine whether nondisclosure of physician incentive plans is appropriate will provide the most flexibility for interpreting ERISA § 404 disclosure rules and will allow the trial court to evaluate the merits of each case with a set of criteria to weigh facts against.

244. *Horvath*, 333 F.3d at 462

245. Shea v. Esensten, 107 F.3d 625, 627 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997); Jordan v. Fed. Express Corp., 116 F.3d 1005 (3d Cir. 1997) (holding that breach of fiduciary duty occurs when harm results from non-disclosure material information to the beneficiary); *Varity Corp*., 516 U.S. at 506 (1996) (discussing fiduciary's responsibility to disclose material information and use good faith and fair dealing with beneficiary); Hammonds v. Aetna Cas. & Sur., 237 F. Supp. 96 (N.D. Oh. 1965) (discussing rules for termination of fiduciary relationship); McDonald v. Provident Indem. Life Ins. Co. 60 F.3d 234, 237 (5th Cir. 1995) (explaining the fiduciary's duty of loyalty to the beneficiary); Donovan v. Bierwirth, 538 F. Supp. 463, 469 (E.D.N.Y. 1981).

246. *Horvath*, 333 F.3d at 461; *Glaziers*, 93 F.3d at 1181–82; Bixler v. Cent. Pa. Teamsters Health & Welfare Fund, 12 F.3d 1292 (3d Cir. 1993) (holding that failure to disclose "material information" upon request of beneficiary constituted breach of HMOs fiduciary duty).

247. *Compare Horvath*, 333 F.3d at 461, *with Glaziers*, 93 F.3d at 1181.

248. *See* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995) (establishing liability for HMO under ERISA § 502 for insufficient quantity of services, but expressing an unwillingness to evaluate the quality of benefits); *see* Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001) (holding mixed eligibility and treatment decisions as well as strictly treatment decisions are not pre-empted and should be handled through state malpractice actions, but plan coverage decisions are pre-empted); *see also* Pegram v. Herdrich, 530 U.S. 211, 224 (2000); Estate of Frappier v. Wishnov, 678 So. 2d 884 (Fla. Dist. Ct. App. 1996) (allowing vicarious liability claims but pre-empting corporate liability claims).

249. *McDonald*, 60 F.3d at 234.

The Court's factors test may also include an examination of positive incentives implemented by HMOs or administrators to encourage positive outcomes in patient treatment. A new movement has been sweeping through employer benefit plans whereby participating plans pay physicians bonuses for improving the health of employees.[250] Landro explained that physicians receive yearly bonuses for adequately measuring and controlling a diabetic's blood pressure, blood sugar, and lipid levels.[251] General Electric, Ford Motor Company, UPS and Verizon were listed as employers participating in such a plan.[252] Positive physician incentive plans support the core concept behind HMO's: reducing costs by promoting healthy lifestyles through preventative measures.

With the narrowing scope of ERISA pre-emption, state legislatures are beginning to respond with initiatives to circumvent ERISA. California recently enacted the California Health Insurance Act of 2003, which requires all employers with fifty or more employees to offer employees and dependents group health insurance or pay into a state health insurance pool.[253] The fee is waived for companies who provide at least a percentage of health insurance coverage to employees.[254] California's statute is innovative because it skirts the edges of ERISA jurisprudence. The California Health Insurance Act of 2003 does not regulate plan administration or mandate benefits; it merely requires employers to provide coverage. Like the surcharges in *Travelers*, the California Health Insurance Act of 2003 may only have an indirect economic connection to employee benefit plans because it makes providing group health coverage to employees a "less unattractive" option and may ultimately prove more cost effective than paying into the state insurance pool.[255] Even if the California Health Insurance Act of 2003 is pre-empted, it may be saved in the second step of the ERISA analysis.[256] The Act may be saved if it is

250. *See* Laura Landro, *Health Plans Try 'Pay for Performance' Rewards for Doctors*, WALL ST. J., Sept. 17, 2004, at A1.

251. *Id.*

252. *Id.*

253. California Health Insurance Act of 2003, 2003 Cal. Stat. 673, S.B. 2 (requiring California employers to pay a fee to the state to provide health insurance unless the employer provides coverage directly, in which case the fee is waived).

254. *Id.*

255. *See* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). For example, buying into a spouse's insurance policy may become more attractive (or less unattractive) if the financial incentives diminish the value of a plan to the point where payment into the employee's plan is no longer desirable. *See supra* notes 151–56 and accompanying text.

256. Ky. Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471, 1478–79 (2003); *see supra* text accompanying notes 164–69.

"specifically directed toward entities engaged in insurance" and "substantially affect[s] risk pooling arrangements between the insurer and the insured."[257]

Even though physicians and patients are disgruntled about managed care reimbursement, the Federal Courts of Appeals recognize that cost-conserving measures in a health-care system with limited resources are desirable, and physician financial incentives may be the least restrictive and most effective control.[258] The Third Circuit Court of Appeals was willing to accept the risk of lower quality health care in order to constrain health-care costs and allow employers to provide insurance at a reasonable cost. [259]

VII. CONCLUSION

The mere presence of financial incentives is not necessarily troubling. However, the presence of financial incentives ought to be disclosed to employees. Without information regarding their physician's outside influences, patients cannot be informed consumers and remain unable to fully evaluate a situation that may affect their long-term health. Like *Travelers*, the presence of financial incentives may make one employee benefit plan "less unattractive" than others. Unless incentive plans are disclosed at enrollment, the consumer will continue to be disadvantaged in his ability to evaluate costs and benefits associated with each benefit option.

A balance must be struck between the policy to control inflationary health-care costs and maintaining physicians' obligations to "carry out that regimen which, according to my power and discernment, shall be for the benefit of my patients; I will keep them from harm and wrong."[260] Even though the courts have not yet embraced the potential value of *Horvath*'s "diminished value" theory, medical journals indicate that patients and medical professionals appreciate that the appearance of a conflict of interest can cause as much of a negative impact as an actual conflict. *Horvath* showed us just beyond where the court was willing to go but outlined criteria that may be beneficial to sustaining a diminished value theory in future litigation. To be sure, so long as health-care costs skyrocket, courts, as a policy matter, will remain willing to accept the risk of reduced quality health care in order to keep an eye on the bottom line.

MATTHEW J. MORRIS*

257. *Id.*

258. Pegram v. Hendrich, 530 U.S. 211, 213 (2000).

259. *See* Horvath v. Keystone Health Plan E., Inc., 333 F.3d 450 (3d Cir. 2003).

260. Oath of Hippocrates as adopted by SAINT LOUIS UNIVERSITY SCHOOL OF MEDICINE, *available at* http://www.ama-assn.org/ama/pub/category/5594.html (last modified Mar. 7, 2002).

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