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NOTE: HMO DOCTORS AS ERISA FIDUCIARIES:

A BANKRUPTCY PERSPECTIVE

I. Introduction

The Supreme Court is currently considering *Herdrich v. Pegram*, [1] in which the Justices will decide whether the physician owners of a health maintenance organization (hereinafter "HMO") may be held liable as fiduciaries within the meaning of the Employee Retirement Income Security Act of 1974 (hereinafter "ERISA"). *Herdrich* presents interesting bankruptcy issues for physician owned HMOs, and also raises bankruptcy questions for HMO doctors who provide care to patients under ERISA plans.

Physicians who work for HMOs and who treat patients under ERISA plans are not currently recognized as ERISA fiduciaries. If the Supreme Court holds the HMO owner/physicians in *Herdrich* liable for breach of fiduciary duty, it will open the door to suits against all HMO doctors treating ERISA plan beneficiaries [2] for breach of fiduciary duty. Because ERISA makes fiduciaries personally liable for their breaches, [3] this could lead to increased physician bankruptcies. Doctors already burdened by excessive insurance costs [4] and tightening HMO compensation policies [5] could be faced with high damage awards which they could neither insure against nor afford.

Additionally, a decision for the *Herdrich* plaintiff could effect the number of physicians willing to work for HMOs or wishing to treat ERISA plan participants. This could force HMOs to compensate physicians at much greater levels in order to attract them, which would dramatically increase HMOs' overhead. Many ailing HMOs would be unable to weather the increased cost of doing business, and could be forced into chapter 11.

This Note will: (1) explore the procedural history of *Herdrich* to demonstrate the typical manner in which claims against HMOs and their physicians proceed; (2) analyze ERISA and explain its fiduciary constructs; (3) examine the statutory gap which exists when plaintiffs assert certain state−law tort claims against doctors providing care to patients covered under ERISA plans; (4) dissect the elements necessary for holding HMO doctors liable as ERISA fiduciaries; and (5) investigate the wisdom of saddling HMO doctors with fiduciary status. This Note ultimately concludes that it is possible to hold HMO doctors liable as ERISA fiduciaries within ERISA's current structure. This Note also determines that ERISA's limitation on damage awards may benefit plans to the detriment of treating physicians, but that plaintiffs will see little individual reward. Lastly, this Note suggests that Congress must re−examine ERISA and amend the statute to bring it into accord with current healthcare practices. Considered legislative revision may be the only way to avoid contorted judicial interpretations that could lead to increased bankruptcies by HMO physicians.

II. Background

A. Procedural History

The Seventh Circuit recently held in *Herdrich* that doctors acting as both primary care physicians and HMO owners could be considered ERISA fiduciaries. [6] The plaintiff, Cynthia Herdrich (hereinafter "Herdrich"), was covered by a medical benefits plan provided by State Farm Insurance Company (hereinafter "State Farm"), which was not a defendant in the action. [7] Under this plan, State Farm contracted with defendants Carle Clinic Association, P.C. (hereinafter "Carle"), Health Alliance Medical Plans, Inc. (hereinafter "HAMP"), and Carle Health Insurance

Management Co., Inc. (hereinafter "CHIMCO") to provide "pre−paid health insurance . . . [and] medical and hospital services . . ." [8] to members of the plan and their spouses. [9] The treating physicians of Carle were also the sole shareholders of HAMP and CHIMCO, making them both the owners of the HMO and the doctors who administered care through it. [10] This fact was at the core of the Seventh Circuit's decision to allow Herdrich's claims to proceed to discovery.

On March 7, 1991, Herdrich was examined by Dr. Lori Pegram ("Pegram"), a doctor who practiced under the HMO plan, [11] and who was Herdrich's primary care physician. [12] Pegram discovered a "six by eight centimeter inflamed mass in Herdrich's abdomen." [13] Pegram decided that an ultrasound was necessary to ascertain the nature of the mass, but concluded that immediate action was not essential. Accordingly, Pegram ordered the ultrasound to be performed eight days later in a "Carle−staffed facility [(hereinafter the "Facility")] more than fifty miles away . . ." from Herdrich's home. [14] However, the ultrasound was never performed because Herdrich's appendix ruptured shortly after the procedure was ordered, resulting in peritonitis. [15] The surgery needed to drain and cleanse Herdrich's ruptured appendix was later performed at the Facility. [16]

On October 21, 1992, Herdrich filed a two count complaint against Pegram and Carle in Illinois state court which averred medical malpractice against Pegram, and liability for Carle under *respondeat superior*. [17] On February 18, 1994, Herdrich was granted leave to amend the complaint, and added two counts of state law fraud (hereinafter "Count III", "Count IV" or collectively "Counts III and IV") against Carle and HAMP. [18] Count III alleged that Carle violated the Illinois Consumer Fraud Act by: (1) "failing to disclose certain material facts regarding the ownership of HAMP . . . ," and (2) failing to reveal a physician compensation scheme which rewarded doctors for minimizing tests and outside referrals. [19] Count IV averred that HAMP breached its duty of good faith and fair dealing by creating a compensation scheme which encouraged doctors to minimize services. [20] Defendants then moved to remove the action to federal court on grounds that Counts III and IV were preempted by ERISA, and filed a motion for summary judgment as to those counts. [21] The district court granted the motion against Herdrich as to Count IV, [22] but denied the motion as to Count III. [23] Herdrich was granted leave to amend Count III, and on September 1, 1995, filed an amended complaint which averred breach of fiduciary duty. [24] Defendants moved to dismiss under Rule 12(b)(6) [25] for failure to state a claim upon which relief could be granted. The case and the pending motion were assigned to a magistrate judge, who recommended dismissal of Count III with leave to re−plead. [26] The district court followed the magistrate's recommendation to dismiss and denied leave to replead. [27] Counts I and II went to trial, and a jury awarded Herdrich $35,000 in compensatory damages. [28]

Herdrich appealed the dismissal of Count III to the court of appeals, which concluded in a lengthy opinion that she had properly pled her cause of action. [29] Accordingly, the Seventh Circuit reversed and remanded to the district court for trial. [30]

B. Managed Healthcare

Neither the events nor the procedural history of *Herdrich* are uncommon. Managed care has become one of the primary means by which medical treatment is administered in America today. [31] In order to increase profits and minimize expenses, HMOs have instituted a variety of cost containment procedures at the physician/patient level. [32] For instance, many HMOs offer their physicians incentives to reduce the cost of providing patient care. [33] HMOs employ capitation plans, [34] withhold schemes, [35] and referral limitation policies [36] in an effort to reduce treatment costs. These cost reduction mechanisms offer doctors financial incentives to curtail referrals to specialists or non−HMO physicians, [37] to reduce testing, [38] and presumably to choose the least expensive but acceptable form of treatment available.

These cost reduction systems are sanctioned by the courts, [39] and do not have to be disclosed to patients absent direct inquiry. [40] These compensation schemes have given rise to self−interested behavior that has severely injured patients, though. [41] It is not unusual for HMO doctors to deny referrals or neglect to prescribe tests to preserve their bonuses or capitation profits. [42]

Patients injured by some form of doctor negligence face a barrier to recovery, though. Some circuits permit patients to sue doctors for malpractice, provided that the patient's only compliant is the quality of the medical care he received. [43]

However, plaintiffs' claims are superceded by ERISA's broad preemption clause if the complaints relate in any way to the manner in which ERISA plan benefits are distributed. [44] Unfortunately for plaintiffs, most tort and contract claims are preempted by ERISA, [45] which does not provide relief for these claims. [46] Moreover, the majority of circuits do not recognize claims by ERISA beneficiaries that they are injured by the mere existence of HMO incentive schemes. [47]

HMOs are acutely aware that many state law tort claims are preempted by ERISA, and that ERISA may provide no remedy for them. As was the case in *Herdrich*, many plaintiffs begin their cases in state court asserting either mixed claims (both permissible state law claims and preempted ERISA claims), or pure ERISA preempted claims that name both the HMO doctor and the HMO as defendants. [48] Upon receiving such complaints, the HMOs invariably move for removal on grounds that some or all of the claims are preempted by ERISA. [49] Courts regularly conclude that these state law claims relate to ERISA plans and are preempted. [50] For instance, claims that an ERISA beneficiary's injury stems from self−interested physician behavior caused by an incentive plan would be preempted because it relates to an ERISA plan. [51] However, ERISA does not provide relief in many of these cases, so plaintiffs are left without a cognizable claim to prosecute. [52] Accordingly, plaintiffs' cases rarely proceed beyond the pleading stage because courts either dismiss the complaints or grant summary judgment for the defendants. [53] This leaves injured plaintiffs without redress against the parties presumably liable.

However, if courts recognize HMO doctors as ERISA fiduciaries, plaintiffs would be provided with a claim upon which relief could be granted. Specifically, if HMO doctors could be labeled ERISA fiduciaries, and if improper medical decisions motivated by personal financial concerns could be deemed to be improper distributions of plan benefits, plaintiffs would be afforded a claim for breach of fiduciary duty. This would provide plaintiffs with a means of recovering on claims that are otherwise dismissed.

As will be seen in the next section, holding doctors liable as ERISA fiduciaries would also expose physicians to significant personal liability. While this is not necessarily an undesirable outcome, since severe penalties would act as strong deterrents to self−serving behavior, it could nonetheless increase the number of physician bankruptcies. Many doctors would undoubtedly be unable to weather large damage awards. Moreover, the doctor's partners would be made liable for his losses, [54] and the HMO might also become liable on the theory of *respondeat superior*. This in turn, could grievously affect HMO liquidity, and could force whole organizations into bankruptcy. However, as will be seen in the remaining sections, establishing that HMO doctors providing care under ERISA plans may be ERISA fiduciaries is an uphill battle which presents formidable obstacles to plaintiffs.

III. Discussion

A. ERISA

ERISA is a complex statutory scheme designed to regulate and protect private [55] employee benefit plans. [56] Congress enacted ERISA in 1976 to ensure that employees received the benefits they were promised under pension and welfare plans. [57] ERISA defines a welfare plan as:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, 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 . . . . [58]

For a plan to qualify as an employee benefit plan, it must be maintained pursuant to a written instrument which names a fiduciary, and which outlines funding, administration, amendment, and payment procedures. [59] However, ERISA does not obligate employers to create plans, or to maintain plan benefits at consistent levels. [60]

Individuals others than those named in the plan can be fiduciaries. [61] ERISA assigns fiduciary status to anyone who:

(i) . . . 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, (ii) . . . renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, [62] or (iii) . . . has any discretionary authority or discretionary responsibility in the administration of such plan. [63]

Accordingly, persons acting in magisterial positions can assume fiduciary status under ERISA simply by exercising discretionary authority in the administration of a plan.

Fiduciaries are held to a prudent man standard of care. [64] This standard requires plan fiduciaries to "discharge . . . duties with respect to a plan solely in the interest of the participants and beneficiaries," and to act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use . . . ." [65] Fiduciary obligations run to both the beneficiaries and the plan since fiduciaries must "provid[e] benefits to participants and their beneficiaries; and . . . defray[] reasonable expenses of administering the plan . . . ." [66] Furthermore, ERISA specifically enumerates certain actions which fiduciaries are forbidden from taking. [67]

ERISA also creates specific remedies for beneficiaries who suffer a breach of fiduciary duty. Fiduciaries who breach their duties are personally liable to the plan for any losses their actions cause, must return any profits made through use of the plan's assets, and "shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary." [68] The action to enforce the obligations imposed under section 1109 may be brought:

(1) by a participant or beneficiary−−

(A) for the relief provided for in subsection (c) of this section, or

(B) 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;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USC § 1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan . . . . [69]

Accordingly, broad enforcement power is given to a large class of plaintiffs once fiduciary status is established. While ERISA appears to grant an extensive range of remedies with its "other appropriate equitable relief language," the range of remedies actually provided for breach of fiduciary duty has been limited by judicial interpretation. [70]

B. Establishing A Claim Against HMO Doctors for Breach of Fiduciary Duty

There are three requirements for establishing a claim under ERISA for breach of fiduciary duty: (1) the defendants must be plan fiduciaries; (2) the defendants must breach their fiduciary duties; and (3) cognizable loss must result as a consequence of the breach. [71] Failing to prove any of the three elements denies the plaintiff recourse. As has already been noted, plaintiffs suing HMO doctors for breach of fiduciary duty face a difficult task in establishing any of the three elements. Because all three elements are equally formidable, each is addressed individually to demonstrate the pitfalls it presents to plaintiffs.

1. Fiduciary Status

As noted above in Section A, persons not named as fiduciaries in the plan documents may nonetheless be saddled with fiduciary status if they, "i) . . . exercise[] any discretionary authority or discretionary control respecting management

of such plan or exercise[] any authority or control respecting management or disposition of its assets, . . . [or] (iii) . . . [have] any discretionary authority or discretionary responsibility in the administration of such plan." [72] Because of the liability exposure to plan fiduciaries, it is unlikely that treating physicians would acquiesce to being named fiduciaries. Therefore, the most likely means of establishing physicians as plan fiduciaries is to prove that they have discretionary authority or control in either the administration of the plan, or the management and disbursement of its assets.

a. Discretionary Authority

Employers act as fiduciaries when they manage plans because they have discretionary control over how the plans are administered, and how the assets are dispensed. [73] HMO doctors share these same powers of management and administration when tailoring treatments for plan beneficiaries because they choose between different care regimes based on which is most cost effective for the plan and for themselves. [74] Doctors are given discretionary authority to determine what treatments to pursue based on their own balance of patient benefit versus medical cost. They contemplate what care is best suited to meet patient needs while still preserving their own bonuses and minimizing plan administration expenses. [75] These cost−benefit analyses in which HMO doctors engage generally determine what care is provided. Accordingly, HMO doctors can, in their independent judgment, withhold care or provide lesser therapy if they deem such a course of action to be the most cost effective option for themselves and the plan.

Therefore, doctors exercise discretionary authority when deciding what treatments to prescribe because they independently weigh the necessity of a procedure against its cost to the plan provider. The result of this balancing act directly affects how plan benefits (healthcare in the case of healthcare benefit plans) are distributed to plan beneficiaries. If an HMO doctor concludes that the cost of performing a test immediately outweighs the benefits of doing so, the doctor postpones the test. [76] This denies patients and plan beneficiaries the healthcare benefits they are entitled to under their ERISA plans. It is irrelevant that the doctors may exercise medical judgment in reaching their conclusions because the entire decision process is tainted by personal conflicts which affect how plan assets are distributed. Accordingly, because an HMO doctors' treatment decisions are discretionary, and because the treatment plans which result from these decisions directly affect how plan assets are administered and distributed, HMO doctors act as ERISA fiduciaries. [77]

Similarly, health insurance providers act as ERISA fiduciaries when administering benefits appeals under ERISA plans. [78] Health insurance providers are ERISA fiduciaries when acting in this capacity because they are given discretionary authority to grant or deny benefits claims. [79] Claims administrators grant or deny claims by weighing the necessity of a suggested treatment against its cost and expense to the plan and the insurer. [80] While treating physicians rarely possess ultimate authority to grant or deny claims, [81] they do exercise considerable discretion in the first instance concerning what tests to administer, what referrals to make, and what treatments to pursue. [82] As *Herdrich* demonstrates, these treatment decisions are often guided by both personal financial concerns and plan reimbursement policies. [83] Accordingly, HMO doctors act like claims administrators when constructing patient treatment plans because they discretionarily weigh the cost (oftentimes to themselves) of the regimen in question against its necessity. [84] The doctor either grants or denies the plan beneficiary certain plan benefits by deciding what care to provide. This type of discretionary authority in the administration of plan benefits is precisely the behavior that ERISA’s fiduciary duties are aimed at. [85]

It is, therefore, irrelevant that an internal appellate procedure may exist within the plan to review physician decisions, because the doctors' choices are rarely challenged until after a bad outcome has resulted. [86] Patients generally comply with their doctors’ orders and do not avail themselves of plan appellate processes. [87] By the time an unfortunate event has occurred, the benefits determination has already been rendered by the treating physician, and any internal appellate avenues are effectively closed. [88] This makes treating physicians plan administrators for all intents and purposes, and makes them ERISA fiduciaries as well.

It is also immaterial to the fiduciary analysis that doctors are conflicted by the need to contain medical expenses when tailoring treatment regimes. Cost control is a legitimate concern, [89] and is one of the recognized purposes of HMOs. [90] Moreover, ERISA contemplates and even sanctions some conflicts of interest for fiduciaries. [91] However, the conflicts of interest that ERISA permits generally arise in the context of pension plans or plans administered by the sponsoring employer. [92] ERISA ordinarily tolerates only those conflicts which encourage employers to create benefit plans. [93]

ERISA does not forgive those conflicts when they result in self−interested behavior that damages plan beneficiaries though. [94]

There are few ERISA policy reasons for limiting an HMO doctor's fiduciary liability. [95] It is not likely that employers would shy away from creating plans if HMO doctors were held as ERISA fiduciaries. An employer is not exposed to any liability for an HMO doctor's breach because ERISA makes the fiduciary personally liable for his misconduct. [96] Nor is it apparent that any legitimate plan proliferation policies are furthered by allowing doctors with discretionary control over plan administration to act in a fashion which places their own concerns above those of plan beneficiaries. [97] Employers merely provide health benefit plans and are divorced from the actions of those administering it. Accordingly, employers will be neither more nor less willing to create health plans for their employees if treating physicians are exposed to liability for breach of fiduciary duty. [98]

b. Varity Corp. Factors

The Supreme Court has also enumerated a non−exhaustive list of factors to aid in deciding when a party with dual interests acts in its fiduciary capacity. In *Varity Corp. v. Howe*, [99] the Court confronted whether or not a corporation which intentionally deceived its employees about its ERISA plan could be liable for breach of fiduciary duty. The first issue the Court resolved was the offending corporation's fiduciary status. [100] The Court looked to three factors to conclude that the defendant corporation had acted in its fiduciary capacity when defrauding its employees: (1) the factual context in which the dishonest behavior occurred; (2) the "plan−related nature of the activity. . .;" and (3) the fact that the parties engaging in the offending behavior had "plan−related authority to do so." [101]

The factual context of the breach of fiduciary duty in *Varity Corp*. suggested that the corporation acted in its fiduciary capacity primarily because it discussed plan benefits in a manner calculated to induce detrimental reliance by the corporation's employees. [102] The Varity Corporation held a meeting to encourage employees to transfer to a new company division. [103] At this meeting, the corporation discussed with employees the effects transferring would have on their plan benefits. [104] The factual context of this meeting led employees to believe that their employer was recommending transfer after taking into account their plan benefits. [105] Therefore, the corporation acted in its fiduciary capacity under these circumstances because it recommended a course of employee action, while suggesting that this action was beneficial in light of the employees' plan benefits.

Similarly, the factual context in which HMO doctors prescribe care to their patients suggests that they are ERISA fiduciaries. Patients follow their doctors' advice [106] because patients assume that their HMO doctors reach treatment decisions by exercising both their medical expertise and their knowledge of plan benefits. [107] Patients further presume that these decisions are in their best interest in light of the care their HMOs entitle them to [108] since neither HMOs nor their doctors have a duty to volunteer information about their cost containment measures in most circuits. [109] Accordingly, the factual context of HMO doctors prescribing care to their patients suggests that the doctors act as ERISA fiduciaries because patients reasonably surmise that the doctors' medical decisions are reached through consideration of both patients needs and the care their plans allow. [110]

The second factor, the plan−related nature of the activity, was satisfied in *Varity Corp.* by communicating information regarding the future of the plan. [111] The Court concluded that because there was no appropriate definition of management or administration in ERISA, the law of trusts was the appropriate guide for determining when communication regarding the future of plan benefits suggested fiduciary status. [112] Subsequently, the corporation was held to have administered the plan by "[c]onveying information about the likely future of plan benefits, thereby permitting beneficiaries to make . . . informed choice[s] about continued participation . . . ." [113] This was deemed to be "an exercise of a power 'appropriate' to carrying out an important plan purpose." [114] Accordingly, the corporation acted as a fiduciary by conveying information about plan benefits in order to permit beneficiaries to make informed decisions about certain courses of action.

HMO physicians suggest different courses of treatment to ERISA beneficiaries so that the beneficiaries may make informed choices about their medical care. This care constitutes the benefits to which these beneficiaries are entitled under their health benefit plans. Accordingly, HMO doctors act as ERISA fiduciaries when presenting treatment options to patients because they communicate with plan beneficiaries about the availability and viability of certain

plan benefits. [115] Therefore, HMO doctors act as ERISA fiduciaries when discussing treatment options with plan beneficiaries because these discussions are plan−related activities. Hence, the second *Varity Corp.* factor is satisfied.

The third factor requires the party committing the act which gives rise to the breach to have "plan−related authority to do so." [116] In *Varity Corp*., this occurred because the victims of the fraud could have reasonably believed that the corporation was acting in its administrative capacity when deceiving the participants. [117] The Court stated that "reasonable employees . . . could have thought that Varity was communicating with them *both* in its capacity as employer *and* in its capacity as plan administrator . . . [and] might not have distinguished consciously between the two roles." [118] The Court applied a reasonable man standard to the listener. [119] It also determined that because the employees may not have distinguished between the dual roles of the employer, and because the circumstances and importance of the communication suggested that the employer was acting in its administrative capacity, it was reasonable for the employees to assume the speaker had plan related authority to assure them of the security of their benefits. [120]

Similarly, plan participants may be unable to distinguish between the dual roles of HMO doctors. It is reasonable for beneficiaries to conclude that doctors exercise both their medical expertise and their knowledge of plan entitlements when tailoring treatment regimes. Moreover, beneficiaries could plausibly infer that their doctors administer plan benefits in the manner best suited to their needs because people expect doctors to act as advocates on their behalf. Accordingly, because beneficiaries and plan participants can reasonably conclude that HMO doctors have plan−related authority to administer plan benefits, the third *Varity Corp*. factor is satisfied.

Thus, HMO doctors act as ERISA fiduciaries because they have discretionary authority to determine how plan assets are administered and what treatments to pursue, and their actions satisfy *Varity Corp.'s* three factors for determining fiduciary status. Accordingly, because these HMO doctors can act as ERISA fiduciaries under certain circumstances, plan beneficiaries who are improperly denied benefits have a cause of action against these doctors for breach of fiduciary duty. [121] However, this determination only gets plaintiffs over the first hurdle. As will be seen, proving both breach of that duty and cognizable loss is still a formidable challenge.

2. Breach of Fiduciary Duty

Simply establishing that HMO doctors may have fiduciary duties when treating plan participants merely opens the door to physician liability. For doctors' ERISA fiduciary status to have meaning to potential plaintiffs, it must be clear when those duties have been breached. This section raises some of the evidentiary and procedural difficulties plaintiffs will encounter.

Under ERISA, fiduciaries are liable for breach if they fail to satisfy statutorily mandated standards. [122] As noted above, however, fiduciaries are entitled to take actions which residually benefit themselves, provided their decisions are "made with an eye single to the interests of the participants and beneficiaries." [123] It is an easy case if doctors' treatment decisions are clearly self−serving, and have little benefit to patients. [124] A difficult situation will arise, though, when HMO doctors prescribe courses of treatment designed to benefit both the patient and the doctor, but which end with tragic results.

Whether or not doctors breach their fiduciary duties in those circumstances will turn on the facts of the case. ERISA is clear about the fiduciary's duties, and should not be interpreted to permit actions which harm beneficiaries to the fiduciary's advantage. [125] However, because ERISA expects fiduciaries to have some conflicts of interest, [126] the motivation guiding doctors' decisions will become a highly litigated issue. Whether options were chosen because they were economical (a permissible decision), or whether actions were taken for personal financial gain will be matters for the trier of fact to determine.

Plaintiff beneficiaries will bear a heavy burden in these proceedings. In most circuits, the mere existence of a physician compensation scheme is insufficient to prove conflict of interest or breach of fiduciary duty. [127] The existence of incentive plans is relevant, however, and would certainly be considered as evidence suggestive of a breach. [128] Procedurally, an accusation of breach of fiduciary duty accompanied by something more than mere bare−bones allegations would at least be sufficient to survive a Rule 12(b)(6) [129] motion or motion for summary

judgment. [130] Nevertheless, beneficiary plaintiffs asserting claims against HMO doctors for breach of fiduciary duty will face significant evidentiary problems. Plaintiffs face many of the same evidentiary problems in negligence actions though, and still prevail. There is little reason to think that plaintiffs could not successfully prove a breach. Even if they do so, however, they still face the specter of proving that cognizable loss has resulted.

3. Cognizable Loss and Damages

The final obstacle plaintiff beneficiaries must negotiate is proving that a cognizable loss was suffered because of the fiduciary breach. [131] While this would appear to be the simplest of the three burdens the plaintiff bears, proving loss for which the plaintiff may recover is quite difficult because of ERISA's complicated statutory structure.

a. Extra−Contractual Damages

ERISA authorizes plan beneficiaries to bring actions against plan fiduciaries who breach their fiduciary duties. [132] The starting point for collecting damages for breach of fiduciary duty is 29 U.S.C. § 1109. [133] Under section 1109(a):

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries . . . shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate . . . . [134]

Consequently, section 1132(a) provides the civil remedies necessary for enforcing section 1109. Section 1132 generally provides that participants and beneficiaries may sue for wrongfully denied benefits, a clarification of rights under the plan, enforcement of section 1109's rights, injunctive relief, or "other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan." [135] Section 1132 clearly permits a beneficiary to sue a fiduciary who has violated section 1109, [136] and constitutes the "exclusive remedy for rights guaranteed under ERISA." [137]

The availability of "other appropriate equitable relief" [138] has been the source of some debate, since the term's meaning is vague. [139] A major question has been whether "other appropriate equitable relief" entitles beneficiaries to extra−contractual damages. [140] Recognizing Congress' intent that actions for breach of fiduciary duty be brought to benefit the plan as a whole and not individual participants or beneficiaries, [141] courts have held that plaintiffs are not entitled to extra−contractual damages as "other appropriate equitable relief." [142] This conclusion has in turn led to litigation to determine the scope of extra−contractual damages. [143] Plaintiffs clearly argue for a limited definition.

Accordingly, because courts are highly unwilling to award damages to individual beneficiaries on grounds that such damages are extra−contractual, holding doctors liable as ERISA fiduciaries at first glance may amount to nothing more than a Pyrrhic victory for plaintiffs. Plaintiffs might enjoy a court pronouncing the offending doctor liable for breach of fiduciary duty, but might see little or no monetary reward themselves for their efforts. [144] Significant time and expense would be expended to establish a breach of fiduciary duty, only for plaintiffs to be thwarted from recovery in the final instance.

However, plaintiffs might still pursue doctors for the benefit of the whole plan, and not solely for themselves. [145] This approach is at the crux of the bankruptcy issue. Plaintiffs who are willing to sue on behalf of the plan as a whole, and who have standing to do so, could recover from the physician for breach of fiduciary duty. Because the physician would be personally liable for the loss, [146] bankruptcy would be a legitimate concern. Large damage awards or multiple small awards would financially strain many physicians to the point of insolvency, and would leave them no alternative but bankruptcy.

b. *Preemption*

The inability to collect personal damages is exacerbated by the fact that plaintiffs may not have a state law cause of action against HMO doctors who act negligently because of ERISA's broad preemptive powers. Under 29 U.S.C. §

1144(a), ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)]." [147] Only those state laws which regulate insurance, banking, or securities are saved from ERISA's preemption clause. [148]

Courts have broadly construed section 1144's phrase "relate to." [149] This broad construction extends to tort and contract claims which relate to ERISA plans. [150] Moreover, it does not affect preemption analysis that plaintiffs will be left without a remedy if preemption is effected. [151] Courts consider it to be merely an unfortunate consequence of preemption that plaintiffs may be left with unredressable injuries. [152]

Accordingly, actions against HMO doctors for breach of fiduciary duty will "relate to" ERISA plans and will be preempted by federal law. Specifically, actions for negligent adminsitration or breach of contract will be preempted and removed to federal court where the defendants will be granted either dismissal or summary judgment. [153] Plaintiffs will be left with claims for breach of fiduciary duty on which they may never collect individually, but for which the plan might benefit. The preemption question would not affect the ability to collect on these claims though, and would still place doctors in danger of bankruptcy. [154]

Clearly, the damage question is one of the more difficult ones posed by this issue. There is little dispute that personal tort claims will be preempted and dismissed. However, there is still the possibility that claims for breach of fiduciary duty brought for the plan as a whole could succeed. If enough of these claims were successful, many physicians might be thrust into bankruptcy.

IV. Conclusions

There are several hurdles which must be overcome to establish that HMO doctors are ERISA fiduciaries. None of the three elements of the claim [155] are simple to prove, and each presents its own independent difficulties. Moreover, for the claim to succeed, ERISA must be carefully manipulated to squeeze the doctor's actions into ERISA's fiduciary scheme.

There is little doubt that present healthcare procedures give doctors incentives to act in a self−serving manner. It is also clear that these HMO practices often conflict with the statutory goals of ERISA. This suggests that Congress should revisit and revise ERISA to reflect current healthcare practices. Moreover, holding HMO doctors liable as ERISA fiduciaries creates the potential for damage awards which physicians could not bear. Many HMO doctors would be forced into bankruptcy by these awards. Many more physician partnerships could follow suit.

There is no clear answer to this problem. Plaintiffs have legitimate concerns; however, physician bankruptcy may not be the best response. In the end, the question of whether HMO doctors may be ERISA fiduciaries is best left for Congress to decide.

James P. Duffy, IV

FOOTNOTES:

[1] 154 F.3d 362 (7th Cir. 1998). Back To Text

[2] "Plan beneficiaries" will be interchangeably referred to as either "plan beneficiaries" or "participants" for the remainder of this note. Back To Text

[3] *See* 29 U.S.C. § 1109(a)(2) (1994) (establishing personal liability for plan fiduciaries); Mertens v. Bandrowski, 508 U.S. 248, 252 (1993) (stating that § 1109 assigns personal liability to fiduciaries who breach their duties); Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 139 (1985) (recognizing same). Back To Text

[4] *See* Dedrick v. Youngblood, 200 F.3d 744, 747 (11th Cir. 2000) (Fay, J., dissenting) (stating that malpractice insurance rates comprise major cost of practicing medicine today); Herdrich, 154 F.3d at 376 (recognizing "sky−rocketing malpractice insurance rates" which comprise 60 percent of some physician's overhead); Charles

Krauthammer, *Driving the Best Doctors Away: Physicians are Getting Hammered by Managed Care Micromanagement and Malpractice Insurance Premiums*, Wash. Post, Jan. 9, 1998, at A21 (recognizing high insurance premiums which doctors face). Back To Text

[5] *See* Herdrich, 154 F.3d at 367 (noting increased use of capitation, withhold, and bonus systems for minimizing healthcare administration costs); Ford v. Nylcare Health Plans of the Gulf Coast, Inc., 141 F.3d 243, 246 (5th Cir. 1998) (recognizing HMO withhold incentive plans); Capital Imaging Assocs. v. Mohawk Valley Med. Assocs., 996 F.2d 537, 539−40 (3d Cir. 1993) (noting that HMO operated under capitation system in order to lower costs); Kampmeier v. Sacred Heart Hosp., No. 95−7816, 1996 U.S. Dist. LEXIS 5739, at *7 n.4 (E.D. Pa. May 26, 1996) (noting that HMOs employ withhold and capitation incentive schemes to reduce costs). Back To Text

[6] See Herdrich v. Pegram, 154 F.3d 362, 369 (7th Cir. 1998); Brief of Petitioners at *2−*3, Herdrich v. Pegram, No. 98−1949, 1999 WL 1066835 (Nov. 19, 1999) (No. 98−1949). Back To Text

[7] *See* Herdrich, 154 F.3d at 365. Back To Text

[8] *See* id. Back To Text

[9] Cynthia Herdrich was entitled to coverage under the plan through her husband, who was employed by the State Farm Automobile Insurance Company, and who purchased the health insurance coverage from State Farm Helath Alliance Medical Plans, Inc. Brief of Respondent at *1, Herdrich v. Pegram, No. 98−1949, 1999 WL 1249419 (Dec. 20, 1999) (No. 98−1949); Brief of Petitioners at *7−*8, *Herdrich* (98−1949). Back To Text

[10] Brief of Petitioners at *7, *Herdrich* (No.98−1949); Brief of Respondent at *1, *Herdrich* (98−1949). Back To Text

[11] See Herdrich v. Pegram, 154 F.3d 362, 365 n.1 (7th Cir. 1998). Back To Text

[12] Brief of Respondent at *4, *Herdrich* (98−1949). Back To Text

[13] *See Herdrich* at 365 n.1. Back To Text

[14] *See* id. Back To Text

[15] *See* id; Brief for Respondent at *4, *Herdrich* (98−1949); Brief of Petitioners at *7−*8, *Herdrich* (98−1949) (stating, however, that Herdrich's appendix ruptured in March 1992). Back To Text

[16] Brief for Respondent at *4, *Herdrich* (98−1949). Back To Text

[17] *See* Herdrich v. Pegram, 154 F.3d 362, 365 (7th Cir. 1998); Brief for Respondent at *4−*5, *Herdrich* (98−1949); Brief of Petitioners at *8, *Herdrich* (98−1949). Back To Text

[18] *See* Herdrich, 154 F.3d at 366, Brief for Respondent at *5, *Herdrich* (98−1949), Brief of Petitioners at *8, *Herdrich*(98−1949). Back To Text

[19] *See* Herdrich, 154 F.3d at 366 n.2; Brief for Respondent at *5, *Herdrich* (98−1949); Brief of Petitioners at *8, *Herdrich* (98−1949). Back To Text

[20] *See* id.; Brief for Respondent at *5, *Herdrich* (98−1949); Brief of Petitioners at *8, *Herdrich* (98−1949). Back To Text

[21] *See* Herdrich, 154 F.3d at 366; Brief for Respondent at *5, *Herdrich* (98−1949); Brief of Petitioners at *8, *Herdrich* (98−1949). Back To Text

[22] The district court concluded in an unreported opinion that the defendants were entitled to summary judgment on Count IV "to the extent [she] relies on § 502(a)(3)(B) [of ERISA] as a basis for monetary relief, as opposed to equitable relief." Herdrich, 154 F.3d at 366. Back To Text

[23] See Herdrich v. Pegram, 154 F.3d 362, 366 (7th Cir. 1998); Brief for Respondent at *6−*7, *Herdrich* (98−1949); Brief of Petitioners at *8, *Herdrich* (98−1949). Back To Text

[24] *See* Herdrich, 154 F.3d at 366; Brief for Respondent at *7, *Herdrich* (98−1949); Brief of Petitioners at *8, *Herdrich* (98−1949). Back To Text

[25] Fed. R. Civ. P. 12(b)(6) (dismissing complaints for "failure to state a claim upon which relief may be granted"). Back To Text

[26] *See* Herdrich, 154 F.3d at 366; Brief for Respondent at *10, *Herdrich* (98−1949). Back To Text

[27] *See* Herdrich, 154 F.3d at 365. Back To Text

[28] *See* Herdrich v. Pegram, 154 F.3d 362, 365 (7th Cir. 1998). Back To Text

[29] *See* Herdrich, 154 F.3d at 369. Back To Text

[30] *See* id. at 365. Back To Text

[31] *See generally* California v. Sutter Health Sys., No. C99−03803 MMC, 2000 U.S. Dist. LEXIS 424, at *10 (N.D. Cal. Jan. 5, 2000) (relating strength and expansive coverage of managed care); HTI Health Servs. v. Quorum Health Group, 960 F. Supp. 1104, 1108 (S.D. Miss. 1997) (recognizing that HMOs have reorganized health care industry since 1990's); FTC v. University Health, Inc., No. CVI91−052, 1991 U.S. Dist. LEXIS 19299, at *29 (S.D. Ga. April 11, 1991) (relating increased prevalence of managed care**)**. Back To Text

[32] *See generally* Herdrich, 154 F.3d at 375−76 (recognizing existence of HMO created financial incentives at doctor/patient level); *see also* Herdrich, 154 F.3d at 367 (noting HMOs have increased use of capitation, withhold and bonus systems at costs to physician/patient level); Ford v. Nylcare Health Plans of the Gulf Coast, Inc., 141 F.3d 243, 246 (5th Cir. 1998) (recognizing HMO withhold incentive plans designed to contain costs at physician/patient level). Back To Text

[33] *See* Herdrich v. Pegram, 154 F.3d 362, 376 (7th Cir. 1998) (stating that 60% of HMOs employ capitation systems and that several others employ withhold and bonus programs); Ford, 141 F.3d at 246 (recognizing HMO withhold incentive plan requiring referrals only to participating HMO physicians); Capital Imaging Assocs. v. Mohawk Valley Med. Assocs. 996 F.2d 537, 539−40 (3d Cir. 1993) (noting that HMO operated under capitation system which gave doctors incentives to lower costs); Kampmeier v. Sacred Heart Hosp., No. 95−7816, 1996 U.S. Dist. LEXIS 5739, at *7 n.4 (E.D. Pa. May 26, 1996) (noting that HMOs employ withhold and capitation incentive schemes to reduce costs). Back To Text

[34] *See* Herdrich, 154 F.3d at 376 (describing how capitation system pays doctors flat fee per patient and not on fee for service basis); Capital Imaging Assocs., 996 F.2d at 539−40 (relating that capitation system is fixed monthly per patient price paid to HMO physicians); *Kampmeier*, 1996 U.S. Dist. LEXIS 5739, at *7 n.4 (noting that capitation system encourages doctors to under−treat patients because doctors are prepaid flat rate per patient regardless of services provided). Back To Text

[35] *See* Herdrich, 154 F.3d at 376 (relating that Cigna and Aetna employ withhold systems, whereby percentage of doctor's monthly fee is withheld and only reimbursed if doctor maintains low referral rates); *Kampmeier*, 1996 U.S. Dist. LEXIS 5739, at *7 (explaining that withhold system enables HMOs to retain percentage of doctors'income which is reimbursed only if treatment, outside referral, and hospitalization goals are reached); Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 692 F. Supp. 52, 60 (D.R.I. 1988) (relating that HMO withheld

20% of physicians' fees until year end as incentive to physicians to minimize health care costs). Back To Text

[36] *See* Herdrich, 154 F.3d at 376 (noting that U.S. Healthcare pays physicians bonuses for low referral rate); Moore v. Blue Cross and Blue Shield of the Nat. Capital Area, 70 F. Supp.2d 9, 34 (D.D.C. 1999) (relating that plan required written referral from primary care physician for other coverage); Shea v. Esensten, 107 F.3d 625, 627−28 (8th Cir. 1997) (recognizing that primary care physician was motivated by minimum referral reward program). Back To Text

[37] *See* Herdrich, 154 F.3d at 376 (recognizing U.S. Healthcare's physicians bonus plan for low number of referrals); Shea, 107 F.3d at 627−28 (observing that primary care physician dissuaded deceased from visiting cardiologist in order to preserve doctor's minimum referral reward); Moore, 70 F.Supp.2d 9, 34 (D.D.C. 1999) (relating plan requirement that written referral from primary care physician be obtained for other coverage). Back To Text

[38] *See* Herdrich v. Pegram,154 F.3d 362, 365 n.1 (7th Cir. 1998) (recognizing that doctor operating under incentive scheme delayed testing to comply with plan requirements); Shea, 107 F.3d at 627−28 (observing that primary care physician dissuaded deceased from visiting cardiologist in order to preserve doctor's minimum referral reward); *see also Kampmeier*, 1996 U.S. Dist. LEXIS 5739**,** at *1−*2 (noting that baby suffered injuries in childbirth after HMO denied mother needed ultrasound because of testing policy). Back To Text

[39] *See* Herdrich, 154 F.3d at 373 (stating that "[o]ur decision does not stand for the proposition that the existence of incentives *automatically* gives rise to a breach of fiduciary duty"); *see also* Ehlmann v. Kaiser Found. Health Plan of Tex., No. 98−11020, 2000 U.S. App. LEXIS 27, at * 4 (5th Cir. Jan. 4, 2000) (acquiescing implicitly to physician compensation schemes); Weiss v. CIGNA Healthcare, Inc., 972 F. Supp. 748, 753−55 (S.D.N.Y. 1997) (implying that HMO physician incentive schemes are inherently permissible); Shea, 107 F.3d at 629 (disfavoring incentive schemes but permitting them upon disclosure). Back To Text

[40] *See Ehlmann*, 2000 U.S. App. LEXIS 27, at *4 (holding that ERISA imposes no duty to disclose physician compensation schemes); Weiss, 972 F. Supp. at 753−55 (holding that no affirmative duty exists to disclose financial compensation scheme absent direct inquiry). *But see* Shea, 107 F.3d at 629 (giving HMO affirmative duty to disclose information concerning financial incentive scheme). Back To Text

[41] *See* Herdrich, 154 F.3d at 372−73 (accepting that doctor's self−interested action resulted in plaintiff's injuries); Shea v. Esensten, 107 F.3d 625, 626−27 (8th Cir. 1997) (recognizing plaintiff's damages after receiving unethical medical advice); *see also* Schmid v. Kaiser Found. Health Plan of the Northwest, 963 F. Supp. 942, 943 (D. Or. 1997) (noting plaintiff's allegation that defendant HMO doctors breached their duty of good faith by putting HMO's financial concerns ahead of patient's medical needs). Back To Text

[42] *See* Herdrich, 154 F.3d at 372−73 (accepting that doctor postponed test to preserve rewards, which resulted in plaintiff's injuries); Shea, 107 F.3d at 626−27 (recognizing plaintiff's damages after physician advised against referral in order to preserve minimum referral award). Because physicians operating under a capitation scheme are paid a fixed monthly rate for patients, their capitation profits are preserved by providing care which costs less than the fixed amounts received from the HMOs for the patient. *See* Capital Imaging Assocs., v. Mohawk Valley Med. Assocs., 996 F.2d 537, 539−40 (3d Cir. 1993) (relating that capitation system is fixed monthly per patient price paid to HMO physicians); Kampmeier v. Sacred Heart Hosp., No. 95−7816, 1996 U.S. Dist. LEXIS 5739, at *7 n.4 (E.D. Pa. May 2, 1996) (noting that capitation system encourages doctors to under−treat patients because doctors are prepaid flat rate per patient regardless of services provided). Accordingly, capitation systems furnish an inherent financial incentive to doctors to provide as little care as possible. The same is true with minimum referral awards and withhold bonuses. *See generally* Herdrich, 154 F.3d at 376 (noting Cigna's and Aetna's withhold systems whereby percentage of doctor's monthly fee is withheld and reimbursed only if doctor maintains low referral rates). Back To Text

[43] *See* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 356−57 (3d Cir. 1995) (allowing complaints about provision of benefits to proceed in federal court, but recognizing that complaints about the quality of benefits provided are matters of state purview); *Kampmeier*, U.S. Dist. LEXIS 5739, at *3−*5 (recognizing same). The difficulty in this area is that the line between claims about the quality of benefits delivered and the amount of benefits provided is often unclear. *See* Dukes, 57 F.3d at 358 (noting difficulty of discerning between complaints about quality of benefits and quantity

of benefits). In close cases, courts may well decide that the claims relate to ERISA plans and are preempted. Nonetheless, some recognize the distinction and permit claims of pure malpractice to proceed. *See* Herdrich v. Pegram, 154 F.3d 362, 365 (7th Cir. 1998) (permitting recovery on medical malpractice claim). Back To Text

[44] *See generally* 29 U.S.C. § 1144(a) (1994) (directing that ERISA preempts any claims relating to ERISA plans); Unum Life Ins. Co. of Am. v. Ward, 119 S. Ct. 1380, 1384 (1999) (recognizing that ERISA preempts claims relating to ERISA plans); Shaw v. Delta Airlines, Inc., 463 U.S. 85, 91 (1983) (reiterating that ERISA preempts claims relating to ERISA plans). Back To Text

[45] *See* Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003, 1008 (9th Cir. 1998) (preempting wrongful death claim), cert. denied, 120 S. Ct. 170 (1999); Spain v. Aetna Life Ins. Co., 11 F.3d 129, 132 (9th Cir. 1993) (preempting claim for wrongful death); *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 57 (1987) (preempting state−law tort and contract claims for improper denial of plan benefits). Back To Text

[46] *See* Bast, 150 F.3d at 1010 (concluding that state laws are preempted by ERISA even if plaintiff is left wholly without remedy); Cannon v. Group Health Serv., 77 F.3d 1270, 1272 (10th Cir. 1996) (rejecting state law wrongful death claim on grounds of preemption even though plaintiff left without remedy); Tolton v. Am. Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) (recognizing that lack of effective remedy under ERISA does not mitigate preemption); Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1333 (5th Cir. 1992) (noting that statutory gap in remedies is necessary by−product of preemption). Back To Text

[47] *See* Herdrich, 154 F.3d at 373 (holding that mere existence of incentive schemes is insufficient to give rise to breach of fiduciary duty); *see also* Ehlman v. Kaiser Found. Health Plan of Tex., 198 F.3d 552, 554 (5th Cir. 2000) (suggesting that because HMOs are not obligated to disclose existence of compensation scheme, mere existence would be insufficient to support claim for breach of fiduciary duty). *But see* Shea v. Esensten, 107 F.3d 625, 629 (8th Cir. 1997) (suggesting that plaintiffs are injured by incentive plans where ignorant of them). Back To Text

[48] *See* Herdrich v. Pegram, 154 F.3d 362, 365 (7th Cir. 1998) (noting that plaintiff's mixed state and federal claims were removed from state to federal court); Crum v. Health Alliance−Midwest, Inc., 47 F. Supp.2d 1013, 1015 (D. Ill. 1999) (relating that plaintiff filed claims in state court and defendant removed and made motion to dismiss); Eversole v. Metro. Life Ins. Co., 500 F. Supp. 1162, 1163−64 (D. Cal. 1980) (stating that defendant removed plaintiff's tort and contract claims to federal court and filed motion to dismiss). Back To Text

[49] *See* Herdrich, 154 F.3d at 365 (reversing district court's grant of defendants' motion to dismiss plaintiff's ERISA claims); Crum, 47 F. Supp.2d at 1015 (discussing defendant's motion to dismiss following removal); Eversole, 500 F. Supp. at 1163−64 (recognizing defendant's motion to dismiss following successful removal motion). Back To Text

[50] *See also* Crum, 47 F. Supp.2d at 1015 (relating that defendant removed plaintiff's state law claims to federal court); Eversole, 500 F. Supp. at 1163−64 (explaining how defendant successfully removed plaintiff's tort and contract claims to federal court). *See generally* Pryzbowski v. U.S. Healthcare, Inc., 64 F. Supp.2d 361, 366−68 (D.N.J. 1999) (discussing manner in which courts decide if patient claims against doctors and HMOs are preempted by ERISA). Back To Text

[51] *See* Herdrich, 154 F.3d at 365 (noting defendants' removal of state law claims which related to ERISA plan); *see also* Crum, 47 F. Supp.2d at 1015 (removing plaintiff's state law claims to federal court because they related to ERISA); Eversole, 500 F. Supp. at 1163−64 (doing same). Back To Text

[52] *See* Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003, 1008 (9th Cir. 1998) (denying relief for wrongful death claim), cert. denied, 120 S. Ct. 170 (1999); Spain v. Aetna Life Ins. Co., 11 F.3d 129, 132 (9th Cir. 1993) (rejecting wrongful death claim preempted under ERISA); *see also* Tolton v. Am. Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) (recognizing that lack of effective remedy under ERISA does not mitigate preemption); Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1333 (5th Cir. 1992) (noting that statutory gap in remedies is necessary by−product of preemption). Back To Text

[53] *See* Bast, 150 F.3d at 1005 (affirming grant of summary judgment for defendants on preempted state−law tort claims) Tolton, 48 F.3d at 939 (affirming same); Turner v. Fallon Community Health Plan Inc., 953 F. Supp. 419, 425 (D. Mass. 1997) (granting summary judgment to defendants on preempted state−law tort claims), aff'd, 127 F.3d 196 (1st Cir. 1997), cert. denied, 523 U.S. 1072 (1998). Back To Text

[54] *See generally* U.P.A. § 15 (1999) (holding partners jointly and severally liable for wrongful acts of partners); R.U.P.A. § 306(a) (1999) (establishing same); Henkels & Mccoy, Inc. v. Adochio, 138 F.3d 491, 500 (3d Cir. 1998) (recognizing that partners may be held jointly and severally liable for debts). Back To Text

[55] ERISA exempts plans established or maintained by either the federal or state governments or by any agency or instrumentality thereof. *See* Bast, 150 F.3d at 1006 (relating that ERISA exempts from coverage government sponsored plans); *see also* 29 U.S.C. § 1002(32) (defining governmental plan as one established by the United States government and maintained for its employees); 29 U.S.C. § 1003(b)(1) (dictating that ERISA does not apply to governmental plans). Back To Text

[56] *See* Varity Corp. v. Howe, 516 U.S. 489, 496 (1996) (stating that "ERISA protects employee pensions and other benefits by providing insurance . . . ."); Mertens v. Hewitt Assocs., 508 U.S. 248, 251 (1993) (observing that ERISA is "a 'comprehensive and reticulate statute . . .' [aimed at] the Nation's private employee benefit system" (quoting Nachman Corp. v. Pension Benefit Guaranty Corp., 446 U.S. 359, 361 (1980)); Libbey−Owens−Ford Co. v. Blue Cross and Blue Shield Mut. of Ohio, 982 F.2d 1031, 1034 (6th Cir. 1993) (stating that ERISA governs employer created employee benefit plans where employer or industry engages in or affects inter−state commerce). Back To Text

[57] *See* 29 U.S.C. § 1001(a) (1994) (declaring ERISA's policy and stating that its purpose is to protect "financial soundness" of employee benefit plans); Varity Corp., 516 U.S. at 496 (relating that ERISA protects employee benefit and pension plans); Nachman Corp., 446 U.S. at 361−62 (quoting ERISA's declaration of policy to secure anticipated benefits for employees). Back To Text

[58] 29 U.S.C. § 1002(1) (1994); *see also* District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 127 (1992) (quoting requirements for welfare plan under ERISA); Herdrich v. Pegram, 154 F.3d 362, 369 (7th Cir. 1998) (relating same). Back To Text

[59] *See* 29 U.S.C. § 1102 (1994) (listing requirements for establishing ERISA plan); Mertens, 508 U.S. at 251 (noting that persons may be named by the plan as ERISA fiduciaries); *see also* Curtiss−Wright Corp. v. Schoonejongen, 514 U.S. 73, 83 (1995) (noting that written instrument establishing and governing plan is "core functional requirement"); Nachman Corp., 446 U.S. 361 at n.1 (noting that plan administrators are saddled with fiduciary responsibilities). Back To Text

[60] *See* Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996) (declaring that ERISA neither requires employers to establish employee benefits plans nor commands what benefits to provide); Curtiss−Wright Corp., 514 U.S. at 78 (relating that ERISA does not create statutory entitlement to employer funded benefit programs); Shaw v. Delta Airlines, 463 U.S. 85, 91 (1983) (stating that "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits"); Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees, 740 F.2d 454, 456 (6th Cir. 1984) (asserting that employers have no duty to provide pension plans and may decide what benefits to confer should pension plans be furnished). Back To Text

[61] *See* Mertens v. Hewitt Assocs., 508 U.S. 248, 251(1993) (observing that persons other than named fiduciaries can assume fiduciary status); Sprague v. Gen. Motors Corp., 133 F.3d 388, 404 (6th Cir. 1998) (stating that "'[F]iduciary duties under ERISA attach not just to particular persons, but to particular persons performing particular functions'") (quoting Hozier v. Midwest Fastners, Inc., 908 F.2d 1155, 1158 (3d Cir. 1990)), cert. denied, 524 U.S. 923 (1998); Libbey−Owens−Ford Co., 982 F.2d at 1035 (recognizing that person other than named fiduciary may be held to fiduciary standards). Back To Text

[62] This definition of fiduciary is inapposite in this discussion because doctors generally do not render any investment advice to ERISA plans. *See generally* Dasler v. E.F. Hutton & Co., 694 F. Supp. 624, 632 (D. Minn. 1988) (holding brokerage firm liable for breach of fiduciary duty after churning funds of profit sharing plan). Back To Text

[63] 29 U.S.C. § 1002(21)(a); Sprague, 133 F.3d at 404 (quoting text of 29 U.S.C. § 1002(21)(a)); Eversole v. Metro. Life Ins. Co., 500 F. Supp. 1162, 1165 (C.D. Cal. 1980) (quoting same). Back To Text

[64] *See* 29 U.S.C. § 1104(a) (1994) (defining prudent man standard of care); Varity Corp. v. Howe, 516 U.S. 489, 497 (1996) (noting that ERISA imposes prudent man standard of care on plan fiduciary); Donovan v. Bierwirth, 680 F.2d 263, 264 (2d Cir. 1982) (quoting § 1104's prudent man standard of care). Back To Text

[65] 29 U.S.C. § 1104; Sprague, 133 F.3d at 404 (quoting § 1104's requirement that ERISA fiduciary act "'solely in the interest of the participants and beneficiaries' and 'for the exclusive purpose' of 'providing benefits to participants and their beneficiaries'" (quoting 29 U.S.C. § 1104)); Donovan, 680 F.2d at 264 (quoting language of § 1104). Back To Text

[66] 29 U.S.C. § 1004(a). See Sprague v. General Motors Corp., 133 F.3d 388, 404 (6th Cir. 1998) (recognizing that ERISA fiduciary must act for benefit of plan participants and beneficiaries), cert. denied, 524 U.S. 923 (1998); Donovan, 680 F.2d at 264 (noting same). Back To Text

[67] *See* 29 U.S.C. § 1106 (1994) (enumerating several prohibited transactions, such as: "(A) sale or exchange, or leasing, of any property between the plan and a party in interest; (B) lending of money or other extension of credit between the plan and a party in interest; (C) furnishing of goods, services, or facilities between the plan and a party in interest; . . . (E) acquisition, on behalf of the plan, of any employer security or employer real property . . ."); Lockheed Corp. v. Spink, 517 U.S. 882, 888 (1996) (noting that ERISA fiduciary breaches duty if he engages in transactions forbidden by 29 U.S.C. § 1106); Donovan, 680 F.2d at 264 (enumerating transactions prohibited by 29 U.S.C. § 1106); *see also* Geweke Ford v. St. Joseph's Omni Preferred Care, Inc., 130 F.3d 1355, 1360−61 (9th Cir. 1997) (recognizing that parties in interest may also violate 29 U.S.C. § 1106). Back To Text

[68] 29 U.S.C. § 1109 (1994). See Mertens v. Bandrowski, 508 U.S. 248, 252 (1993) (stating that § 1109 assigns personal liability to fiduciaries who breach their duties and enumerates "remedies available against them"); *see also* Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997) (recognizing that plan participants may assert claim for breach of fiduciary duty); Anoka Orthopedic Assocs. v. Cooley, 773 F. Supp. 158, 165 (D. Minn. 1991) (noting that aggrieved beneficiary may assert cause of action for breach of fiduciary duty on behalf of plan). Back To Text

[69] 29 U.S.C. § 1132 (1994); *see* Varity Corp v. Howe., 516 U.S. 489, 507−08 (1995) (quoting language of § 1132); Mertens, 508 U.S. at 252 (1993) (relating that § 1132 permits beneficiaries, participants, fiduciaries, or Secretary of Labor to bring civil action to enforce § 1109). Back To Text

[70] *See* Corcoran v. United Healthcare, Inc., 956 F.2d 1321, 1335 (5th Cir. 1992) (rejecting plaintiff's claim for extra−contractual or punitive damages as other appropriate equitable relief); *see also* Mertens, 508 U.S. at 253 (noting that other equitable relief may not include money damages). *See generally* Bast v. Prudential Life Ins. Co. of Am., 150 F.3d 1003, 1009 (9th Cir. 1998) (noting that extracontractual, compensatory and punitive damages are not available under ERISA), cert. denied, 120 S. Ct. 170 (1999). Back To Text

[71] *See* Herdrich v. Pergram, 154 F.3d 362, 369 (7th Cir. 1998) (enumerating three requirements for properly stating claim for breach of fiduciary duty under ERISA); *see also* 29 U.S.C. § 1109 (assigning liability to fiduciaries for breach of their duty and enumerating remedies available for such breach); id. § 1132(a) (permitting action by beneficiary against fiduciary for violation of § 1109); id. § 1004(a) (establishing prudent man standard of care for plan fiduciaries). Back To Text

[72] 29 U.S.C. § 1002(21)(a). See Sprague v. Gen. Motors Corp., 133 F.3d 338, 404 (6th Cir. 1998) (quoting text of 29 U.S.C. § 1002(21)(a)), cert. denied, 524 U.S. 923 (1998); Eversole v. Metro. Life Ins. Co., 500 F. Supp. 1162, 1165 (C.D. Cal. 1980) (doing same). Back To Text

[73] *See generally* Sprague, 133 F.3d at 405 (recognizing that corporation acted as fiduciary because it administered plan when explaining retirement program to early retirees); Godfrey v. Bell South Telecomm., Inc., 89 F.3d 755, 758 (11th Cir. 1996) (noting that defendant company self−administered plan, making it ERISA fiduciary); Donovan v. Bierwirth, 680 F.2d 263, 276 (2d Cir. 1982) (relating that Grumman's officers and affiliates acted as trustees of pension fund, which gave them fiduciary status). Back To Text

[74] Insurers and physician groups are saddled with fiduciary status when they are given power to administer claims. *See* Herdrich, 154 F.3d at 370 (recognizing that physician group's ability to decide disputed and non−routine claims gave them discretionary control); Libbey−Owens−Ford Co. v. Blue Cross and Blue Shield Mut. of Ohio, 982 F.2d 1031, 1035 (6th Cir. 1993) (concluding that insurance company's ability to administer claims gave it discretionary authority, thereby saddling it with fiduciary status). Moreover, employers have been held to act as fiduciaries when given discretion in treatment decisions. *See* Place v. Abbott Labs., Inc., 938 F. Supp. 1373, 1378 (N.D. Ill. 1996) (concluding that employer was plan fiduciary because "the decision was up to . . . Abbott as to how to proceed" with treatment). HMO doctors tailoring treatment plans are given discretionary authority to determine how plan treatment benefits are administered, because cost incentive programs force them to weigh the need for care against its cost to them personally. *See generally* Ehlmann v. Kaiser Found. Health Plan of Tex., No. 98−11020, 2000 U.S. App. LEXIS 27, at *2 n.2 (5th Cir. Jan. 2, 2000) (noting allegations of HMO doctor bonus/incentive and withhold programs designed to reward doctors for reduced treatment costs); Maltz v. Aetna Health Plans of N.Y., 114 F.3d 9, 10 (2d Cir. 1997) (stating that in 1995, Aetna changed method of doctor compensation to capitation system to participating doctors'chagrin); Shea v. Esensten, 107 F.3d 625, 627 (8th Cir. 1997) (relating that plaintiff's HMO constructed treatment scheme which "created financial incentives [for doctors] that were designed to minimize referrals"). Accordingly, HMO doctors exercise discretionary authority in the formulation of treatment plans, which makes them ERISA fiduciaries. Back To Text

[75] *See* Maltz, 114 F.3d at 10 (observing that Aetna communicated intention to terminate doctors not acquiescing to new capitation payment system); *see also* Weiss v. CIGNA Healthcare, Inc., 972 F. Supp. 748, 751 (S.D.N.Y. 1991) (denying defendant HMO's motion for summary judgment on plaintiff's claim that HMO: (1) engaged in "'undisclosed policy' of preventing its physicians from 'advising patients of treatment options which are not compensable by the HMO;'" and (2) would reprimand or terminate violators). Back To Text

[76] *See* Herdrich v. Pegram, 154 F.3d 362, 365 n.1 (7th Cir. 1998) (relating that doctor postponed diagnostic test to avoid cost to both plan and doctor herself of sending patient to outside facility); *see also* Shea, 107 F.3d at 627−28 (recounting that doctor decided not to refer patient to specialist to save plan money and to protect own bonus); *Ehlmann*, 2000 U.S. App. LEXIS 27, at *4 (holding ERISA imposes no fiduciary duty of disclosure of physician compensation schemes). Back To Text

[77] *See* 29 U.S.C. § 1002(21)(a) (directing that discretionary authority to manage or dispense plan assets is hallmark of ERISA fiduciary status); *see also* Sprague, 133 F.3d at 405 (recognizing that company which decided how to distribute plan benefits acted as fiduciary); Donovan v. Bierwirth, 680 F.2d 263, 276 (2d Cir. 1982) (relating that corporate officers and affiliates who decided how pension funds were dispensed were ERISA fiduciaries). Back To Text

[78] *See* Herdrich, 154 F.3d at 370 (reasoning that HMO's "exclusive right to decide all disputed and non−routine claims" made it ERISA fiduciary); Harris Trust and Savs. Bank v. Provident Life and Accident Ins. Co., 57 F.3d 608, 613 (7th Cir. 1995) (relating same); Libbey−Owens−Ford Co., 982 F.2d at 1035 (finding that insurance company was ERISA fiduciary because it had authority to grant or deny plan beneficiary claims). Back To Text

[79] *See* Herdrich, 154 F.3d at 370 (holding HMO to be ERISA fiduciary because of its right to discretionarily decide claims appeals); Harris Trust and Savs. Bank, 57 F.3d at 613 (recognizing same); Libbey−Owens−Ford Co., 982 F.2d at 1035 (saddling insurance company with fiduciary status because of authority to grant or deny plan beneficiary claims). Back To Text

[80] *See* Lee v. Blue Cross/Blue Shield of Ala. 10 F.3d 1547, 1549 (11th Cir. 1994) (relating that HMO initially granted plaintiff's claim for surgery because it was "medically necessary and payable under the contract," but later refused

coverage of related procedures); Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1322−23 (5th Cir. 1992) (observing that defendant HMO in wrongful death action: (1) denied plaintiff's doctor's request for pre−certified hospital stay before plaintiff's delivery despite medical history of fetus distress; and (2) determined instead that home nursing was sufficient course of action); Person v. Physicians Health Plan, Inc., 20 F. Supp.2d 918, 920 (E.D. Va. 1998) (relating that: (1) deceased's appeal for medical treatment was denied on grounds that procedure was not medically necessary, and (2) that claims administrator later reversed own denial of benefits three days after patient perished from heart failure); Waddell v. Kaiser Found. Health Plan of Tex., 877 S.W.2d 341, 344 (Tex. Ct. App. 1994) (noting that insurer terminated in−patient benefits on grounds of eligibility); *see also* Crum v. Health Alliance−Midwest, Inc., 47 F. Supp.2d 1013, 1015−16 (C.D. Ill. 1999) (recapping how: (1) HMO's advisory nurse denied approval for emergency room visit for deceased despite wife's repeated requests, (2) instead advised deceased to drink milk for upset stomach, and (3) that deceased perished from heart failure in wife's car en route to emergency room). Back To Text

[81] *See* Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 136−37 (1985) (relating that plaintiff's benefits claim was determined by plan administrator after submitting reports from physicians); Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 183−85 (1st Cir. 1998) (stating that plaintiff's benefits termination appeal was denied by insurer, and noting that insurer merely followed physician's and therapist's recommendations to deny total disability claim); Waddell, 877 S.W.2d at 344 (noting that insurer informed patient's primary care physician that HMO had denied further in−patient care under plan). Back To Text

[82] *See* Herdrich v. Pegram, 154 F.3d 362, 365 n.1 (7th Cir. 1998) (noting that plaintiff's doctor required her to wait eight days before performing necessary diagnostic test after discovering "six by eight centimeter inflamed mass in Herdrich's abdomen," which resulted in ruptured appendix); Shea v. Esensten, 107 F.3d 625, 626−27 (8th Cir. 1997) (observing that plaintiff's husband died of heart failure after primary care physician dissuaded deceased from visiting cardiologist in order to preserve doctor's rewards for minimizing referrals); Pryzbowski v. U.S. Healthcare, Inc., 64 F. Supp.2d 361, 365−66 (D.N.J. 1999) (relating that surgeon would not perform needed surgery until patient consulted with specific physicians which HMO was remiss to approve). Back To Text

[83] *See* Herdrich, 154 F.3d at 365 n.1 (noting that doctor placed patient in dire straights to preserve minimal referral bonus); Shea, 107 F.3d at 626−27 (concluding that physician dissuaded deceased from visiting cardiologist in order to preserve minimal referral reward); *see also* Pryzbowski, 64 F. Supp.2d at 365−66 (D.N.J. 1999) (relating that HMO was reluctant to approve referral which surgeon required before performing needed surgery). Back To Text

[84] *Compare* Corcoran, 965 F.2d at 1322−23 (observing HMO's questionable decision to deny hospital benefits based on cost/benefit determination), *and* Waddell, 877 S.W.2d at 344 (terminating in−patient benefits on grounds of eligibility), *with* Herdrich, 154 F.3d at 365 n.1 (requiring waiting period in excess of one week for diagnostic test to preserve minimal referral bonus), *and* Shea, 107 F.3d at 626−27 (discouraging referral with fatal results to preserve minimal referral reward). *See generally* supra note 41 (noting deleterious effects of compensation schemes). Back To Text

[85] *See* 29 U.S.C. § 1002(21)(a) (directing that discretionary authority or discretionary responsibility to administer plan benefits makes ERISA fiduciary); Herdrich, 154 F.3d at 370 (concluding that discretionary authority gave rise to fiduciary duty); Harris Trust and Sav. Bank v. Provident Life and Accident Ins. Co., 57 F.3d 608, 613 (7th Cir. 1995) (recognizing that discretionary authority made company fiduciary). Back To Text

[86] *See* Herdrich, 154 F.3d at 366 (seeking relief for suspect medical decision); Shea, 107 F.3d at 626−27 (suing for damages after receiving unethical medical advice); *see also* Schmid v. Kaiser Found. Health Plan of the Northwest, 963 F. Supp. 942, 943 (D. Or. 1997) (noting plaintiffs'allegation that defendant HMO doctors breached their duty of good faith by putting HMO's financial concerns ahead of patient's medical needs). Back To Text

[87] *See* Herdrich v. Pegram, 154 F.3d 362, 365 n.1 (7th Cir. 1998) (implying that patient never challenged doctor's decision to postpone diagnostic test); Shea v. Esensten, 107 F.3d 625, 626−27 (8th Cir. 1997) (recognizing that patient questioned doctor's decision to reject referral to specialist, but also noting that no claims appeal was filed in response); *see also* Crum v. Health Alliance−Midwest, Inc., 47 F. Supp.2d 1013, 1015−16 (C.D. Ill. 1999) (noting that patient

unsuccessfully petitioned HMO's advising nurse for permission to visit emergency room). Back To Text

[88] Once a patient has been injured by a physician's decision not to make a test available sooner or to grant referral to a specialist, no appellate procedure can reverse the specific denial of benefits which caused the harm in question. *See* Herdrich, 154 F.3d at 365 n.1 (noting that patient's appendix ruptured while complying with doctor's decision to postpone diagnostic test); Shea, 107 F.3d at 626−27 (relating that patient's heart attack occurred because patient followed doctor's advice that specialist opinion was unnecessary); *see also* Schmid, 963 F. Supp. at 943 (alleging that defendant HMO doctors ignored medical needs because of financial concerns). Back To Text

[89] *See* 29 U.S.C. § 1104(a)(1)(A)(ii) (enumerating that "defraying reasonable expenses of administering the plan" is one of ERISA fiduciary's duties); Cent. States, S.E. & S.W. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 570 n.10 (1985) (noting ERISA's cost containment purpose); *see also* Herdrich, 154 F.3d at 383 n.1 (Flaum, J., dissenting) (recognizing that goal of managed care plans is "to deliver health care more cost−effectively"). Back To Text

[90] *See* Park Ave. Radiology Assocs. v. Methodist Health Sys., No. 98−5668, 1999 U.S. App. LEXIS 29986, at *16 (6th Cir. Nov. 10, 1999) (recognizing that HMOs are intended to address cost of providing healthcare); U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 591 (1st Cir. 1993) (recognizing that HMOs serve to control health care costs); Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 635 F. Supp. 1287, 1299 (D. Kan. 1986) (recognizing use of HMOs as means of controlling costs). Back To Text

[91] *See* Birmingham v. Sogen−Swiss Int'l Corp. Retirement Plan, 718 F.2d 515, 523 (2d Cir. 1983) (permitting certain conflicts of interest in named plan fiduciary in order to avoid hamstringing said fiduciary); Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir. 1982) (recognizing that pension plan trustee could take action which had residual benefits for himself and interested party as long as decisions were made "with an eye single to the interests of the participants and beneficiaries"). Back To Text

[92] *See* 29 U.S.C. § 1108(c)(3) (1994) (permitting sponsoring corporation to appoint officers as plan trustees); Curtiss−Wright Corp. v. Schoonejohgen, 514 U.S. 73, 75 (1995) (recognizing that plan benefit coverage was determined by employer officers and committees); Birmingham, 718 F.2d at 523 (permitting officers of sponsoring company to act as plan trustees); Donovan, 680 F.2d at 271 (allowing same); *see also* John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank, 510 U.S. 86, 89 (1993) (relating that fiduciary status usually attaches through management of plan assets). Back To Text

[93] *See* Donovan, 680 F.2d at 468 (permitting employers to have minor conflicts in effort to propagate ERISA plans); *see also* 29 U.S.C. § 1004(a) (enumerating cost effective plan administration as fiduciary duty). *See generally* Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996) (declaring that ERISA neither requires employers to establish employee benefits plans nor commands what benefits must be provided); Curtiss−Wright Corp., 514 U.S. at 78 (relating that ERISA does not create statutory entitlement to employer funded benefit programs). Back To Text

[94] *See* Herdrich v. Pegram, 154 F.3d 362, 373 (7th Cir. 1998) (concluding that conflicts of interest result in breaches of fiduciary duty where fiduciary trust between beneficiaries and fiduciaries is abrogated); *see also* 29 U.S.C. § 1104(a)(1) (dictating that fiduciaries breach their duties of care when they act to benefit their own interests); Donovan, 680 F.2d at 271 (recognizing that although fiduciaries may have some conflicts of interest, they still must always act "with an eye single to the interests of the participants and beneficiaries"). Back To Text

[95] Exposing doctors to liability for breach of fiduciary duty may create policy issues concerning the practice of medicine. For instance, it is plausible to assume that less doctors would be willing to work for HMOs which treated ERISA plan members. This is not an actual ERISA issue, however, and is nonetheless beyond the scope of this paper. Back To Text

[96] *See* 29 U.S.C. § 1109(a) (establishing personal liability for ERISA fiduciaries who breach their duties); Mertens v. Bandrowski, 508 U.S. 248, 252 (1993) (stating that § 1109 assigns personal liability to fiduciaries who breach their duties); Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 139 (1985) (recognizing same). Back To Text

[97] *See* 29 U.S.C. § 1104(a) (requiring plan fiduciaries to "discharge their duties . . . solely in the interest of the participants and beneficiaries"); Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997) (noting that ERISA requires plan fiduciary to discharge duties for beneficiary's sole benefit); Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir. 1982) (requiring plan fiduciaries to act "with an eye single to the interest of . . . participants and beneficiaries"). Back To Text

[98] However, increased liability for HMO doctors could indirectly affect an employer's willingness to create health benefit plans. If increased exposure for doctors increased the cost of HMO coverage, employers might be less willing to create plans. This would eventually become a problem for the HMOs to solve. Employers still exist whether or not they provide health benefit plans. HMOs do not last long if they price themselves out of the benefit plan market. Accordingly, HMOs would eventually discern a means of combating any increased costs resulting from increased physician liability. Back To Text

[99] 516 U.S. 489 (1995). Back To Text

[100] *See* id. at 498. Back To Text

[101] *See* id. at 503. Back To Text

[102] *See* id. at 499. Back To Text

[103] Id. at 493 (relating company's intention to create new subsidiary designed to fail to which parent would transfers obligations, such as outstanding employee benefits, so that company could avoid liability for these obligations). Back To Text

[104] *See* Varity Corp. v. Howe, 516 U.S. 489, 493−94 (1995). Back To Text

[105] *See* id. at 501. Back To Text

[106] *See* Herdrich v. Pegram 154 F.3d 362, 365 n.1 (7th Cir. 1998) (noting that plaintiff's doctor required her to wait eight days before performing necessary diagnostic test after discovering "six by eight centimeter inflamed mass in Herdrich's abdomen," resulting in ruptured appendix); Shea v. Esensten, 107 F.3d 625, 626−27 (8th Cir. 1997) (observing that plaintiff's husband died of heart failure after primary care doctor dissuaded deceased from visiting cardiologist in order to preserve doctor's rewards for minimizing referrals); *see also* Crum v. Health Alliance−Midwest, Inc., 47 F. Supp.2d 1013, 1015−16 (C.D. Ill. 1999) (recapping how: (1) HMO's advisory nurse denied approval for emergency room visit for deceased despite wife's repeated requests, (2) instead advised deceased to drink milk for upset stomach, and (3) that deceased perished from heart failure in wife's car en route to emergency room). Back To Text

[107] *See generally Herdrich*, 154 at 365−66 (suggesting that defendant doctor postponed necessary diagnostic test to preserve personal benefits); Shea, 107 F.3d at 626−27 (recognizing that doctor dissuaded deceased from visiting cardiologist to preserve referral award); Crum, 47 F. Supp.2d at 1015−16 (relating that HMO nurse rejected emergency room approval to patient's demise because of referral policy). Back To Text

[108] *See* Herdrich, 154 F.3d at 365−66 (noting that patient did not question decision to wait eight days for necessary diagnostic test); Shea, 107 F.3d at 626−27 (recognizing that patient questioned doctor about visiting cardiologist but still accepted assurances that it was not necessary); *see also* Crum, 47 F. Supp.2d at 1015−16 (recounting that deceased's wife questioned nurse's judgment to deny emergency approval, but waited hours before taking husband anyway). Back To Text

[109] *See* Ehlmann v. Kaiser Found. Health Plan of Tex., No. 98−11020, 2000 U.S. App. LEXIS 27, at *4 (5th Cir. Jan. 4, 2000) (holding ERISA imposes no fiduciary duty of disclosure of physician compensation schemes); Weiss v. CIGNA Healthcare, Inc., 972 F. Supp. 748, 753−55 (S.D.N.Y. 1997) (holding that no affirmative duty exists for HMO or doctor to disclose financial compensation scheme absent direct inquiry). *But see* Shea, 107 F.3d at 629 (holding that

HMO had affirmative duty to disclose to participant information concerning financial incentive scheme). Back To Text

[110] *See* Herdrich, 154 F.3d at 369 (concluding that plan doctor could be ERISA fiduciary where medical judgement may have been tainted by desire for cost−efficiency based bonus); *see also* Ehlmann, 198 F.3d 552, 554−55 (recognizing patient ignorance of HMO cost reduction incentive plan). Back To Text

[111] *See* Varity Corp. v. Howe, 516 U.S. 489, 502−03 (regarding communication about future benefits as sufficiently plan related to impose fiduciary duties). Back To Text

[112] *See* id. at 502; 29 U.S.C. § 1103(a) (1995) (expressing that plan funds are to be held in trust by fiduciary); Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989) (noting Congressional intent to include law of trusts in ERISA fiduciary standards); Cent. S.E. & S.W. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 570 (1984) (explaining that Congress incorporated law of trusts into ERISA fiduciary standards). Back To Text

[113] Varity Corp., 516 U.S. at 502. Back To Text

[114] Id. Back To Text

[115] *See* id. at 502 (stating that discussing important plan purpose was plan−related activity). Back To Text

[116] Varity Corp. v. Howe, 516 U.S. 489, 503 (1995). Back To Text

[117] *See* id. Back To Text

[118] Id. Back To Text

[119] *See* id. Back To Text

[120] *See* id. Back To Text

[121] *See* 29 U.S.C. § 1109 (establishing personal liability for fiduciaries who breach their duties); Mertens v. Bandrowski, 508 U.S. 248, 252 (1993) (stating that § 1109 assigns liability to fiduciaries who breach their duties and enumerating "remedies available against them"); *see also* Shea v.Esensten, 107 F.3d 625, 628 (8th Cir. 1997) (recognizing that plan beneficiaries may enforce fiduciary duties); Anoka Orthopedic Assocs., P.A. v. Cooley, 773 F. Supp. 158, 165 (D. Minn. 1991) (noting that aggrieved beneficiary may assert cause of action for breach of fiduciary duty). Back To Text

[122] *See* 29 U.S.C. § 1104(a)(1) (requiring ERISA fiduciaries to act solely for beneficiaries and plan participants); Sprague v. Gen. Motors Corp., 133 F.3d 388, 404 (6th Cir. 1998) (recognizing that ERISA fiduciary must act "solely in the interest of the participants and beneficiaries'and 'for the exclusive purpose' of 'providing benefits to participants and their beneficiaries'" (quoting 29 U.S.C. § 1104(a)(1)), *cert. denied*, 524 U.S. 923 (1999); Donovan v. Bierwirth, 680 F.2d 263, 264 (2d Cir. 1982) (quoting same language of § 1104); *see also* Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 184 (1st Cir. 1998) (directing that deferential standard of review of district court's findings may not be warranted where fiduciary had conflict of interests). Back To Text

[123] Donovan, 680 F.2d at 271. *See* 29 U.S.C. § 1104(a)(1) (requiring total fiduciary loyalty); Herdrich v. Pegram, 154 F.3d 362, 371 (7th Cir. 1998) (stating that ERISA fiduciary breaches duty when acting in its own interest). Back To Text

[124] *See* Herdrich, 154 F.3d at 365−66 (relating how doctor delayed test administration to minimize outside referrals); Shea, 107 F.3d at 626−27 (observing that plaintiff's husband died of heart failure after primary care physician dissuaded deceased from visiting cardiologist in order to preserve doctor's rewards for minimizing referrals); Crum v. Health Alliance Midwest, Inc., 47 F. Supp.2d 1013, 1016 (C.D. Ill. 1999) (recognizing that beneficiary died after

repeated denials for emergency room referral). Back To Text

[125] *See* 29 U.S.C. § 1104(a)(1) (requiring total fiduciary loyalty); John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank, 510 U.S. 86, 95 (1993) (stating that fiduciary must act for sole interest of beneficiaries and participants); *see also* New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) (focusing on plain meaning of statute unless otherwise necessary); U.S. v. Ron Pair Enter., 489 U.S. 235, 489 U.S. 235, 241 (1989) (directing that plain meaning of statute must be followed where clear); U.S. v. Choice, No. 99−1607, 2000 U.S. App. LEXIS 732, at *9 (6th Cir. Jan. 20, 2000) (instructing that plain meaning of statute be followed where unambiguous). Back To Text

[126] *See* Barnhart v. Unum Life Ins. Co. of Am., 179 F.3d 583, 587 (8th Cir. 1999) (recognizing that ERISA contemplates fiduciaries who are not entirely neutral); Besten v. Delta Am. Reins. Co., No. 98−6225, 1999 U.S. App. LEXIS 34489, at *12 (6th Cir. Dec. 22, 1999) (declaring ERISA permits fiduciaries to assume conflicting roles, and that "for a conflict of interest to be properly weighed in determining whether a benefit determination was arbitrary or capricious, there must be, at a minimum, an allegation that the conflict tainted the fiduciary's benefit determination, and some evidence supporting such allegation"); *see also* Carr v. Gates Health Care Plan, 195 F.3d 292, 296 (7th Cir. 1999) (requiring specific evidence of actual bias or significant conflict of interest for standard of review to change). Back To Text

[127] *See* Herdrich, 154 F.3d at 373 (stating that existence of incentive plan does not give rise to per se breach of fiduciary duty); *see also* Ehlmann v. Kaiser Found. Health Plan of Tex., No. 98−11020, 2000 U.S. App. LEXIS 27, at *4 (5th Cir. Jan. 4, 2000) (rejecting claim that ERISA imposes fiduciary duty to disclose physician compensation schemes); Weiss v. CIGNA Healthcare, Inc., 972 F. Supp. 748, 753−55 (S.D.N.Y. 1997) (denying that affirmative duty exists for HMO or doctor to disclose financial compensation scheme absent direct inquiry). *But see* Shea v. Esensten, 107 F.3d 625, 629 (8th Cir. 1997) (requiring disclosure financial incentive scheme). Back To Text

[128] *See* Herdrich v. Pegram, 154 F.3d 362, 373 (7th Cir. 1998) (noting that incentive plan could evidence breach of fiduciary duty). *See generally* Fed. R. Evid. 401 (defining relevant evidence as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence"). Back To Text

[129] *See* Fed. R. Civ. P. 12(b)(6) (permitting dismissal for failure to state a claim upon which relief may be granted); *see also* Irish Lesbian and Gay Organization v. Giuliani, 143 F.3d 638, 644 (2d Cir. 1998) (relating that court must accept as true all allegations stated in complaint, and must draw all reasonable inferences in favor of non−moving party when evaluating Rule 12(b)(6) motions); Bernheim v. Litt, 79 F.3d 318, 321 (2d Cir. 1996) (directing that complaints may not be dismissed under Rule 12(b)(6) unless it "appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief") (quoting Allen v. West Point−Pepperell, Inc., 945 F.2d 40, 44 (2d Cir. 1991)). Back To Text

[130] *See generally* Fed. R. Civ. P. 56 (permitting party to move for summary judgment on the pleadings with or without supporting affidavits); Vital v. Interfaith Med. Ctr., 168 F.3d 615, 620 (2d Cir. 1999) (stating that court must '"resolve all ambiguities and draw all reasonable inferences against the moving party'" when considering motion for summary judgment) (quoting Skubel v. Fuoroli, 113 F.3d 330, 334 (2d Cir. 1997)); Irish Lesbian and Gay Org., 143 F.3d at 644 (directing court considering 12(b)(6) motion to: (1) accept as true all allegations stated in complaint, and (2) draw all reasonable inferences in favor of non−moving party). Back To Text

[131] *See* 29 U.S.C. § 1109 (assigning liability to fiduciaries for breach of their duty and enumerating remedies available for such breach); id. § 1132(a) (permitting action by beneficiary against fiduciary for violation of § 1109); Herdrich, 154 F.3d at 369 (enumerating that third requirement for prevailing on claims for breach of fiduciary duty is proving cognizable loss). Back To Text

[132] *See* 29 U.S.C. § 1332(a) (permitting civil action by either participant, beneficiary, or fiduciary); Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 142 (1985) (stating that Congress intended "remedies that would protect the entire plan, rather than . . . the rights of an individual beneficiary"); Herdrich, 154 F.3d at 369 (recognizing that

ERISA's remedies are meant to accrue to whole plan and not individual); *see also* Corcoran v. United Healthcare, Inc., 956 F.2d 1321, 1335 (5th Cir. 1992) (rejecting plaintiff's claim for extra−contractual or punitive damages). Back To Text

[133] *See* 29 U.S.C. § 1109(a) (holding ERISA fiduciaries personally liable for their breaches); Mertens v. Bandrowski, 508 U.S. 248, 252 (1993) (stating that § 1109 assigns liability to fiduciaries who breach their duties) *see also* Massachusetts Mut. Life Ins. Co., 473 U.S. at 139 (quoting § 1109). Back To Text

[134] 29 U.S.C. § 1109(a); Mertens, 508 U.S. at 252 (relating that § 1109 assigns liability for breach of fiduciary duty); Massachusetts Mut. Life Ins. Co., 473 U.S. at 139 (quoting § 1109(a)). Back To Text

[135] 29 U.S.C. § 1132(a). See Mertens, 508 U.S. at 252 (discussing remedies available to plaintiffs under § 1132); Massachusetts Mut. Life Ins. Co., 473 U.S.140 (recognizing § 1132's rights of redress); Herdrich, 154 F.3d at 369 (recognizing beneficiary's right to bring civil action under § 1132(a) to enforce duties imposed under § 1109). Back To Text

[136] *See* 29 U.S.C. § 1132(a)(2) (permitting suits for "other equitable relief" under § 1109); Massachusetts Mut. Life Ins. Co., 473 U.S.140 (stating that § 1132 permits beneficiary to sue to enforce § 1109); Herdrich v. Pegram, 154 F.3d 362, 369 (7th Cir. 1998) (stating same). Back To Text

[137] Crum v. Health Alliance−Midwest, Inc., 47 F. Supp.2d 1013, 1017 (C.D. Ill. 1999). *See* Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 65−66 (1987) (stating that § 1132(a) is meant to constitute sole remedy for injury under ERISA); *see also* Mertens, 508 U.S. at 253 (asserting that causes of action not expressly included in ERISA should not be read in). Back To Text

[138] 29 U.S.C. § 1132(3)(B). Back To Text

[139] *See* Corcoran v. United Healthcare, Inc., 956 F.2d 1321, 1335 (5th Cir. 1992) (rejecting plaintiff's claim for extra−contractual or punitive damages as other appropriate equitable relief); *see also* Mertens v. Bandrowski, 508 U.S. 248, 253 (1993) (noting that other equitable relief may not include money damages), cert. denied, 120 S. Ct. 170 (1999). Back To Text

[140] *See* Massachusetts Mut. Life Ins. Co. v. Russel, 473 U.S. 134, 138 (1988) (granting certiorari to determine if compensatory or punitive damages permitted under ERISA); Corcoran, 956 F.2d at 1335 (debating propriety of awarding extra−contractual damages); *see also* Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003, 1010 (9th Cir. 1998) (discussing scope of "other appropriate equitable relief" and noting that it does not include money damages), cert. denied, 120 S. Ct. 170 (1999). Back To Text

[141] *See* Massachusetts Mut. Life Ins. Co., 473 U.S. at 140 (recognizing Congressional intent to have damage recoveries accrue to benefit of whole plan); Corcoran, 956 F.2d at 1335 (restating Court's conclusion that actions for damages were for entire plan and not single beneficiary). *See generally* Bast, 150 F.3d at 1009 (stating that ERISA forbids recovery of compensatory, punitive and extracontractual damages). Back To Text

[142] Nero v. Indus. Molding Corp., 167 F.3d 921, 931−32 (5th Cir. 1999) (denying claim for out−of−pocket expenses on grounds they constitute extra−contractual damages); Bast, 150 F.3d at 1009 (denying claim for extra−contractual damages under ERISA); Corcoran, 956 F.2d at 1335 (rejecting plaintiff's claim for extra−contractual or punitive damages as other appropriate equitable relief); Lee v. Burkhart, 991 F.2d 1004, 1005 (2d Cir. 1993) (confirming that extra−contractual damages may not be awarded under ERISA); *see also* Mertens, 508 U.S. at 253 (noting that other equitable relief may not include money damages); Fotta v. Trustees, 165 F.3d 209, 213 (3d Cir. 1998) (concluding that interest on wrongfully denied benefits not extra−contractual). *But see* George Lee Flint, Jr., Extracontractual Damages Mandated for Benefit Claims Actions, 36 Ariz. L. Rev. 611, 612 (1994) (arguing that Congress intended full range of damages for beneficiary plaintiffs, including extra−contractual damages). Back To Text

[143] *See* Nero, 167 F.3d at 931−32 (declaring out−of−pocket expenses to be extracontractual); Corcoran, 956 F.2d at 1335 (holding punitive damages to be extra−contractual). *See generally* Bast, 150 F.3d at 1009 (discussing scope of extracontractual damages). Back To Text

[144] *See* 29 U.S.C. § 1109(a) (making ERISA fiduciary personally liable for losses suffered because of fiduciary breach); Massachusetts Mut. Life Ins. Co., 473 U.S. at 139 (recognizing same); Custer v. Sweeney, 89 F.3d 1156, 1163 (4th Cir. 1996) (noting that ERISA fiduciary status imposes personal liability). Back To Text

[145] *See* 29 U.S.C. § 1109(a) (stating that fiduciary is personally liable to ERISA plan for breach of fiduciary duty); Massachusetts Mut. Life Ins. Co., 473 U.S. at 140 (recognizing Congressional intent to have damage recoveries accrue to benefit of whole plan); Corcoran v. United Healthcare, Inc., 956 F.2d 1321, 1335 (5th Cir. 1992) (restating Court's conclusion that actions for damages were for entire plan and not single beneficiary). Back To Text

[146] *See* 29 U.S.C. § 1109(a) (assigning fiduciary personal liability for breach of fiduciary duty); Custer, 89 F.3d at 1163 (recognizing that ERISA imposes personal liability on fiduciaries); Reich v. Lancaster, 55 F.3d 1034, 1045 (5th Cir. 1995) (stating that ERISA imposes personal liability on fiduciaries). Back To Text

[147] 29 U.S.C. § 1144(a) (1994). *See* Unum Life Ins. Co. of Am. v. Ward, 119 S. Ct. 1380, 1384 (1999) (quoting preemption language of § 1144(a)); Shaw v. Delta Airlines, Inc., 463 U.S. 85, 91 (1983) (restating ERISA's preemption language). Back To Text

[148] *See* 29 U.S.C. § 1144(b)(2)(A) (stating that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities"); Unum Life Ins. Co. of Am., 119 S. Ct. at 1384 (recognizing that state laws regulating insurance are not preempted); *see also* De Buono v. NYSA−ILA Med. and Clinical Servs. Fund, 520 U.S. 806, 813 (1997) (recognizing that starting presumption for Court is that Congress did not intend preemption). Back To Text

[149] *See* De Buono, 520 U.S. at 813 (recognizing that § 1144's literal text is "clearly expansive"); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45−46 (1987) (noting that "relate to" has been broadly interpreted to reflect Congressional intent to supercede state law in area of employee benefit plans); Shaw, 463 U.S. at 96−97 (counseling that preemptive reach is long, and stating that law relates to ERISA plan when it has "a connection with or reference to"employee benefit plan); Pryzbowski v. U.S. Healthcare, Inc., Medemerge, P.A., 64 F. Supp.2d 361, 366 (D.N.J. 1999) (noting that "relate to" is defined broadly). Back To Text

[150] *See* Pilot Life Ins. Co., 481 U.S. at 57 (preempting state common law contract and tort actions); Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003, 1007−08 (9th Cir. 1998) (reviewing cases in which state law contract and tort claims were deemed preempted), cert. denied, 120 S. Ct. 170 (1999); Spain v. Aetna Life Ins. Co., 11 F.3d 129, 132 (9th Cir. 1993) (preempting wrongful death action). Back To Text

[151] *See* Bast, 150 F.3d at 1010 (recognizing that ERISA preempts state law claims even if plaintiffs are left wholly without remedy); Cannon v. Group Health Serv., 77 F.3d 1270, 1272 (10th Cir. 1996) (preempting state law claim even though ERISA provided no remedy); Tolton v. Am. Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) (recognizing that preemption must occur even if ERISA provides no effective remedy); Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1333 (5th Cir. 1992) (noting that statutory gap in remedies is necessary by−product of preemption). Back To Text

[152] *See* Bast, 150 F.3d at 1010 (concluding that preemption must occur even if plaintiffs cannot otherwise recover); Cannon, 77 F.3d at 1272 (preempting plaintiff's wrongful death claim and leaving him without remedy); Tolton, 48 F.3d 937 at 943 (recognizing that lack of effective remedy under ERISA does not prohibit preemption); *see also* supra note 151 (discussing same). Back To Text

[153] *See* Herdrich v. Pegram, 154 F.3d 362, 366 (7th Cir. 1998) (removing state law cause of action to federal court and filing 12(b)(6) motion); Pryzbowski, 64 F. Supp.2d at 366 (moving for summary judgment or dismissal in alternative on grounds that negligence claim is preempted by ERISA). Back To Text

[154] Plaintiffs alleging breach of fiduciary duty under ERISA file federal claims over which the federal courts have jurisdiction. *See* Fed. R. Civ. P. § 1331 (giving federal courts jurisdiction over civil actions arising under the laws of the United States); *see also* 29 U.S.C. § 1144(a) (recognizing that ERISA preempts all state laws relating to employee benefit plans). Accordingly, preemption is inapposite to claims for breach of fiduciary duty brought under ERISA because they are federal claims over which federal courts have jurisdiction. Back To Text

[155] *See* Herdrich, 154 F.3d at 369 (enumerating three requirements for properly stating claim for breach of fiduciary duty under ERISA); *see also* supra note 71 (discussing same). Back To Text