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ERISA Doctor in the House--The Duty to Disclose Physician Incentives to Limit Health Care

Ryan Steven Johnson

Note

ERISA Doctor in the House? The Duty to Disclose Physician Incentives to Limit Health Care

*Ryan Steven Johnson**

Following his return from an overseas business trip, severe and recurring chest pains forced Patrick Shea to visit his long-time primary care physician.[1] During a series of visits, Mr. Shea discussed his family's lengthy history of heart disease with his physician and complained of chest pains, shortness of breath, muscle tingling, and dizziness.[2] Although these symptoms indicated potential heart problems, Mr. Shea's physician decided against referring Mr. Shea to a cardiologist.[3] Mr. Shea persisted in expressing concern over his continuing symptoms and even expressed his willingness to personally cover the costs of an examination by a cardiologist.[4] Despite Mr. Shea's offer, his physician persuaded him that he was too young to justify a visit to a cardiologist.[5] Within mere months, Mr. Shea died of heart failure.[6]

In order to receive medical benefits under the terms of his health insurance contract through Medica,[7] a health mainte-

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1. *See* Shea v. Esensten, 107 F.3d 625, 626 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 297 (1997). During this overseas trip, Mr. Shea was hospitalized for severe chest pains. *See id.*

2. *See id.*

3. *See id.*

4. *See id.* Under the terms of his health plan, Mr. Shea was insured for all necessary medical care, including cardiac care. *See id.* at 627.

5. *See id.* at 626. Mr. Shea was only forty years old at the time of these examinations. *See id.*

6. *See id.*

7. Mr. Shea's employer, Seagate Technologies, Inc., provided its employees with health care benefits through a contract with Medica. *See id.* Under this arrangement, Medica administered Seagate's employee health care plan.

nance organization (HMO),[8] Mr. Shea could not visit a cardiologist without first obtaining a referral from his primary care physician.[9] Unbeknownst to either Mr. Shea or his wife, Medica encouraged primary care physicians to minimize referrals to cardiologists and other specialty physicians through the use of financial incentives.[10] Following her husband's death, Mrs. Shea learned of Medica's financial incentive scheme and brought suit[11] on the belief that but for Medica's wrongful silence, her husband would have paid for the cardiologist himself, would have received necessary examinations and treatment, and would not have suffered a fatal heart attack at the young age of forty.[12] In federal court, Mrs. Shea asserted that "Medica's behind-the-scenes efforts to reduce covered referrals violated Medica's fiduciary duties under the Employee Retire-

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See id. Employer self-funded plans are regulated by the federal Employee Retirement Income Security Act (ERISA) and are largely immune from state regulation. *See* Eric Mills Holmes, *Solving the Insurance/Genetic Fair/Unfair Discrimination Dilemma in Light of the Human Genome Project*, 85 KY. L.J. 503, 594 (1997). For a complete discussion of ERISA, see *infra* Part II.

8. HMOs are managed care entities that are responsible for delivering, managing, and financing the health care services of their enrollees. *See* Allison Faber Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 207 n.2 (1997). HMOs contract directly with health care providers to provide cost-effective care to enrollees. *See id.* at 215. HMOs exist in a variety of forms including staff-models, group-models, independent practice associations (IPAs), and network-models. *See* Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 401 (1996). For a fuller discussion of other managed care entities, see *infra* note 15 and Part IA.

9. *See Shea*, 107 F.3d at 627. This cost-containment strategy is referred to as "gatekeeping." *See* Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?*, 83 GEO. L.J. 1821, 1823 (1995). Physician "gatekeepers" manage patient access to medical specialists and services by determining whether access is medically necessary, thus guarding the gates to expensive medical services. *See id.* at 1824.

10. *See Shea*, 107 F.3d at 627. Specifically, Medica offered physicians financial rewards if they did not exceed a designated number of referrals and docked a percentage of their fees if they exceeded this designated amount. *See id.*

11. Mrs. Shea initially brought a wrongful death action against Medica in Minnesota state court. *See id.* However, on Medica's motion, the case was removed to federal court based on ERISA's preemption provision, 29 U.S.C. § 1144 (1994). *See id.* ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee plan," including self-funded health plans. *Id.* at § 1144(a). For a discussion of ERISA's preemption jurisprudence, see *infra* note 61 and accompanying text.

12. *See Shea*, 107 F.3d at 627.

ment Income Security Act (ERISA),[13] claiming that under ERISA Medica had a duty to disclose its incentive program to its enrollees.[14]

The circumstances giving rise to Mr. Shea's tragedy are frighteningly common. Currently, over 120 million Americans are enrolled in managed care organizations (MCOs),[15] the majority of which increasingly rely on the use of financial incentives to influence physician medical decisionmaking.[16] Despite the ubiquity of financial incentive arrangements between MCOs and physicians[17] and the number of Americans enrolled in MCOs,[18] many MCO enrollees are unaware of the financial

13. 29 U.S.C. §§ 1001-1461 (1994).

14. *See Shea*, 107 F.3d at 627.

15. *See* Carol J. Simon et al., *The Impact of Managed Care on the Physician Marketplace*, *in* U.S. DEP'T HEALTH & HUMAN SERV., PUBLIC HEALTH REPORTS 222 (1997). The American Medical Association (AMA) defines managed care as "[t]he control of access to and limitation on physician and patient utilization of services by public or private payers or their agents through the use of prior and concurrent review for approval of or referral to service or site of service and financial incentives or penalties." John K. Iglehart, *Health Policy Report: The American Health Care System*, 326 NEW. ENG. J. MED. 962, 965 (1992). MCOs act as both insurers and health care providers, selling hybrid packages of insurance and delivery to employers and non-employer purchasers. *See* Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 443 (1997). MCOs exercise both direct and indirect control over medical treatment options, an area traditionally left to the clinical judgment of physicians. *See* Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J.L. & MED. 7, 25-28 (1996). MCOs encompass a number of entities including health maintenance organizations (HMOs), and preferred provider organizations (PPOs). *See* Furrow, *supra*, at 431. PPOs are panels of physicians that contract with insurers to provide medical services for insureds at reduced rates. *See* Kilcullen, *supra*, at 26.

16. *See* U.S. GAO, MEDICAID MANAGED CARE: MORE COMPETITION AND OVERSIGHT WOULD IMPROVE CALIFORNIA'S EXPANSION PLAN 33 (1995) (noting that "it has become increasingly common for HMOs to capitate physicians, or (more typically) physician groups, for all medical services—including inpatient hospital care"). The use of financial incentives is increasingly affecting physician practice. *See How Common Is Capitation?*, HEALTH DATA MGMT., August 1997, *available in* LEXIS, Health Library, Rxmega File. Moreover, "[a]mong practices with [HMO] contracts, nearly 20 percent of all revenues are capitated." Carol J. Simon & David W. Emmons, *Physician Earnings At Risk: An Examination Of Capitated Contracts*, HEALTH AFF., May/June 1997, at 120, 120.

17. *See* Simon & Emmons, *supra* note 16, at 120.

18. *See* Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, HEALTH AFF., May/June 1997, at 134, 134 (observing that American enrollment in HMOs rose from 36.5 million in 1990 to 58.2 million by 1995); Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan./Feb. 1997, at 125, 126 (noting that approximately

incentives MCOs employ to affect physicians' decisions to provide referrals to specialists, order diagnostic tests, or recommend certain treatments.[19] Unfortunately, as Patrick Shea's experience illustrates, such ignorance can produce devastating results.

In February 1997, the Eighth Circuit delivered a landmark decision, holding that ERISA imposes an affirmative duty[20] on plan fiduciaries to disclose the existence and nature of financial incentives imposed on physicians to affect their medical decisionmaking.[21] According to the court, "[h]ealth care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if it 'knows that silence might be harmful.'"[22] Although arriving at the correct result, the *Shea* court's five-page opinion fails to provide courts or commentators with significant guidance.[23]

This Note argues that ERISA requires MCOs and physicians to disclose the existence and nature of financial incentives designed to influence physician decisionmaking.[24] Part I

75% of American workers receive their health insurance through an MCO); Simon et al., *supra* note 15, at 222 (noting that American enrollment in managed care organizations rose from 10 million in 1982 to over 120 million in 1995).

19. *See HMO Homepage* (visited Feb. 17, 1998) <http://www.hmopage.org/mechanics.html>; *cf.* Stephen L. Isaacs, *Consumers' Information Needs: Results of a National Survey*, HEALTH AFF., Winter 1996, at 31, 33-34 (finding that most Americans do not understand how managed care operates).

20. I use the concept of an affirmative disclosure duty to denote a free-standing obligation to disclose, a duty that is not dependent on the conduct of either ERISA fiduciaries or beneficiaries.

21. *See* Shea v. Esensten, 107 F.3d 625, 629 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 297 (1997). Only two federal courts have directly addressed the issue of whether ERISA requires MCOs to disclose financial incentives designed to influence physician decisionmaking. *Compare Shea*, 107 F.3d at 629 (holding that an HMO was required to disclose its physician incentive scheme to enrollees), *with* Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748, 755 (S.D.N.Y. 1997) (holding that ERISA does not require HMOs to disclose their physician incentive arrangements to plan enrollees).

22. *Shea*, 107 F.3d at 629 (quoting Bixler v. Central Penn. Teamsters Health & Welfare Plan, 12 F.3d 1292, 1300 (3d Cir. 1993)).

23. *See id.* at 625-29.

24. Several scholars have addressed the issue of whether ERISA imposes an affirmative duty to disclose on plan fiduciaries. *See, e.g.*, Edward E. Bintz, *Fiduciary Responsibility Under ERISA: Is There Ever a Fiduciary Duty to Disclose?*, 54 U. PITT. L. REV. 979, 1015-17 (1993) (arguing for a fiduciary duty to disclose in instances that would clearly advance ERISA's principal goal of protecting the interests of plan beneficiaries); Bryan L. Clobes, *In the Wake of* Varity Corp. v. Howe*: An Affirmative Fiduciary Duty to Disclose Under ERISA*, 9 DEPAUL BUS. L.J. 221, 223 (1997) (concluding that ERISA imposes

examines the history of the managed care industry and the cost-control mechanisms it employs. Part II outlines ERISA's fiduciary jurisprudence and details its express disclosure requirements. Part III argues that by exercising discretionary control over the administration of an ERISA plan, MCOs and physicians assume ERISA fiduciary status and are thus governed by its fiduciary obligations.[25] Part III further argues that ERISA's fiduciary jurisprudence requires MCOs and physicians to disclose physician incentive schemes to MCO enrollees.

I. THE MANAGED CARE INDUSTRY

A. THE RISE OF MANAGED CARE

Until recently, insurance companies reimbursed physicians for medical care primarily on a fee-for-service basis.[26] The fee-for-service system traditionally provided patients with complete freedom to select physicians, provided physicians with complete freedom to select the cost and method of medical treatment for their patients, and vested insurance companies with complete responsibility for health care expenses they were powerless to control.[27] By insulating physicians and patients from health care costs, this system failed to provide either group with any incentive to minimize costly and unnecessary care,[28] a system blamed for the skyrocketing health care costs of the last several decades.[29]

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an affirmative duty to disclose on plan fiduciaries where the fiduciary knows that silence might be harmful to the beneficiary). Scholars have also addressed the issue of whether physicians should be required to disclose such information to their patients under a doctrine of informed consent. *See* McGraw, *supra* note 9, at 1847 (concluding that ethical principles and legal precedents indicate that physicians have a duty to disclose MCO physician reimbursement schemes to their patients).

25. For a general discussion of fiduciary liability under ERISA in the era of managed care, see Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189 (1997) (discussing the circumstances in which plan sponsors, insurers, third-party administrators, individual corporate officers, gatekeepers, utilization reviewers, and other health entities assume ERISA fiduciary status).

26. *See* Latham, *supra* note 8, at 400. Under a fee-for-service system, physicians are retroactively reimbursed by the insurer for the services they provide to patients. *See id.*

27. *See* Walsh, *supra* note 8, at 213.

28. *See id.* Under this system, "the more a physician did, the more the physician got paid." Henry T. Greely, *Direct Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53, 56 (1996).

29. *See* McGraw, *supra* note 9, at 1822. Despite the dominance of the

Politicians, private insurance companies, and employers latched onto the concept of managed care as a way to regulate medical expenditures and curtail rising costs.[30] As opposed to the traditional fee-for-service system, managed care employs an assortment of cost-containment mechanisms that encourage physicians to incorporate economic considerations into their medical decisionmaking.[31] To achieve this objective, MCOs tie physicians' compensation to specified rates of diagnostic tests, referral counts to specialists, and use of other costly medical treatments.[32] Physicians are encouraged to minimize their use of these medical services through the use of bonuses,[33] capitation payment schemes,[34] and withhold arrangements.[35] For example,

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managed care industry, medical costs are predicted to continue to rise during next several years. *See* Catherine Potts, *3%... 5%... 10%...Hike! Potential Increases for Managed Care*, 71 HOSP. & HEALTH NETWORKS 62 (1997) (estimating that health care costs could grow at nearly double the rate of inflation over the course of the next five years).

30. *See* Walsh, *supra* note 8, at 210.

31. *See id.* at 215.

32. *See* Marsha Gold et al., *Behind the Curve: A Critical Assessment of How Little Is Known About Arrangements Between Managed Care Plans and Physicians*, 52 MED. CARE RES. & REV. 307, 324-35 (1995) (reviewing the various payment approaches used by MCOs).

33. Bonuses reward physicians for cost-effectiveness, a criterion not solely premised on staying within an MCO's parameters of medical service. *See* Latham, *supra* note 8, at 403 (discussing the nature and variety of physician bonus formulae under managed care).

34. Federal regulations define "capitation" as "a set dollar payment per patient per unit of time (usually per month) that an organization pays a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided." 42 CFR § 417.479(c) (1997). A recent article described the nature of capitation schemes:

> Capitation breaks the link between higher utilization and higher physician reimbursements .... Physicians assume responsibility for the costs of the treatments they provide and may also be responsible for the costs of referrals, laboratory tests, and hospital services. In this manner, insurers shift the cost of treatment and much of the traditional insurance risk directly to physician practices and directly or indirectly to physicians themselves.

Simon & Emmons, *supra* note 16, at 120. At least one study suggests that capitation has been proven to be an effective method of controlling costs of medical care. *See, e.g.*, Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 86 (1989).

35. In a withhold arrangement, a percentage of each physician's capitated payment or negotiated fee is withheld and deposited in a risk pool. *See* Latham, *supra* note 8, at 404. Risk pool funds are used to pay for referral services and other services exceeding budget expectations. *See id.* At the end of an accounting period, the funds remaining in the risk pool are distributed

under capitation arrangements, if an MCO's suggested parameters of care are exceeded, the excess costs are borne by physicians.[36] Conversely, under capitation, physicians keep any savings generated from providing cost efficient health care.[37]

B. THE PRACTICE OF MANAGED CARE

Managed care has resulted in at least a one-time lowering of health care costs[38] and significantly affected the practice of medicine.[39] According to one study, HMO plans have used an average of twenty-two percent fewer tests, procedures, and other expensive treatments than fee-for-service insurance companies.[40] A different study found that by linking physician compensation to referral count as a means of reducing unnecessary referrals, MCO reimbursement schemes deter both unnecessary and necessary referrals to specialty physicians.[41] Although the effects of MCO physician incentive schemes on patient mortality and morbidity are currently uncertain,[42] empirical data indicate that patients in MCOs that use such systems are often treated differently than their fee-for-service counterparts.[43]

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among participating physicians. *See id.* If the funds have been depleted due to an excessive number of referrals or other services, the physicians share the loss. *See* Walsh, *supra* note 8, at 219. Some plans impose further risk on physicians by holding them responsible for any costs above those covered by the withhold fund. *See* Latham, *supra* note 8, at 404.

36. *See* Simon & Emmons, *supra* note 16, at 120.

37. *See* Greely, *supra* note 28, at 90.

38. *See* Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 252 (1997). It is not clear that these savings will endure. *See id.*

39. *See* Furrow, *supra* note 15, at 435-36 (discussing empirical studies that have found a link between managed care and underutilized medical services). For a recent review of the empirical literature comparing performance of managed care and fee-for-service systems, see Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., Sept./Oct. 1997, at 7, 7.

40. *See* Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1515 (1994).

41. *See* Furrow, *supra* note 15, at 436.

42. *See* 57 Fed. Reg. 59,024 (1992) (to be codified at 42 C.F.R. pts. 417, 434 (1998)) (proposed Dec. 14, 1992) (noting that neither the Department of Health and Human Services nor any member of the research community has identified "a link between the quality of care provided under the Medicare and Medicaid programs and the structure of physician incentive plans").

43. *See supra* notes 39-41 and accompanying text (discussing empirical data).

C. THE DOMINANCE OF MANAGED CARE

The last two decades have witnessed an explosive growth in the managed care industry.[44] Between 1970 and 1990, enrollment in HMOs grew by more than tenfold, from 3.6 million to more than thirty-five million enrollees.[45] As of 1996, an estimated sixty million Americans were enrolled in HMOs.[46] Moreover, from 1995 to 1997, the percentage of American workers who receive their health care through an MCO increased from fifty-one percent to seventy-three percent.[47] As of 1997, approximately sixty percent of physicians were involved in contractual relations with HMOs and commonly derived a significant percentage of their financial compensation from these relationships.[48] Over ninety percent of physician groups are expected to be treating patients under a capitated agreement within the next year.[49]

Although the rise of managed care has significantly affected the delivery of health care in America, the majority of Americans remain unaware of the existence of financial incentives designed to alter their physicians' decisionmaking processes.[50] Similarly, many persons are unaware of the gatekeeping systems employed by MCOs to restrict access to specialist physicians.[51] One reason for this ignorance is that MCOs generally do not have any legal obligation to disclose such information.[52]

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44. *See supra* note 18 (discussing growth in MCO enrollment).

45. *See* McGraw, *supra* note 9, at 1823.

46. *See* Robert Pear, *Laws Won't Let H.M.O.'s Tell Doctors What to Say*, N.Y. TIMES, Sept. 17, 1996, at A12.

47. *See* Jensen, *supra* note 18, at 126.

48. *See How Common Is Capitation?*, HEALTH DATA MGMT., August 1997, *available in* LEXIS, Health Library, Rxmega File. Moreover, "[a]mong practices with [HMO] contracts, nearly 20 percent of all revenues are capitated." Simon & Emmons, *supra* note 16, at 120.

49. *See How Common Is Capitation?*, *supra* note 48.

50. *See* McGraw, *supra* note 9, at 1824 (discussing empirical studies comparing the managed care and fee-for-service systems); David Mechanic et al., *Choosing Among Health Insurance Options: A Study of New Employees*, 27 INQUIRY 18 (1990); Arti Kaur Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 IND. L.J. 1015, 1017 (1997).

51. *See* Isaacs, *supra* note 19, at 33-34 (listing percentages of people who are uninformed about the various aspects of MCOs). *See supra* note 9 (explaining the gatekeeping system).

52. *See* Rai, *supra* note 50, at 1017.

D. EXISTING LEGAL PROTECTIONS

Aware of the potential for abuse in a system designed to affect physicians' medical decisionmaking,[53] federal officials have designed and implemented a number of regulations to protect Medicare and Medicaid HMO enrollees from potential harm.[54] These regulations prohibit HMOs from offering physicians financial incentives to limit medically necessary services[55] and require HMOs to disclose information concerning physician incentive plans to any Medicare beneficiary who requests such information.[56] Unfortunately, these regulations protect only Medicare and Medicaid recipients.

The dangers posed by contracts between MCOs and physicians have also prompted states to enact laws designed to regulate the conduct of MCOs.[57] For example, states have enacted laws requiring health plans to disclose information concerning financial incentive arrangements to plan participants.[58] In the majority of states, however, MCOs have no legal obligation to disclose such information to MCO enrollees.[59] Moreover, even in those states that require disclosure, employer self-funded health plans[60] are insulated from state laws regulating

53. According to the AMA, one of the primary dangers posed by managed care is that "physicians have an incentive to cut corners in their patient care, by temporizing too long, eschewing extra diagnostic tests, or refraining from an expensive referral." Council on Ethical and Judicial Affairs, AMA, *Ethical Issues in Managed Care*, 273 JAMA 330, 333 (1995). The obvious concern is that patients may not receive the medical care they need in a system in which physicians may sacrifice their patients' best interests for private economic gain.

54. *See* 42 C.F.R. § 417.479 (1997).

55. *See id.* § 417.479(d).

56. *See id.* § 417.479(h)(3)(i).

57. *See, e.g.*, GA. CODE ANN. § 33-20 A-6 (Supp. 1997) (prohibiting managed care plans from using "a financial incentive program that directly compensates a health care provider for ordering or providing less than medically necessary and appropriate care to his or her patients").

58. *See, e.g.*, ME. REV. STAT. ANN. tit. 24-A § 4302 (West Supp. 1997) (requiring health plans to provide a "general description of the methods used to compensate providers, including capitation and methods in which providers receive compensation based on referrals, utilization, or cost criteria").

59. Only a handful of states currently require the disclosure of physician incentive arrangements to MCO enrollees. *See, e.g.*, ARIZ. REV. STAT. § 20-2323 (1997); CAL. HEALTH & SAFETY CODE § 1367.10 (West 1997); LA. REV. STAT. ANN. § 40:2232 (West Supp. 1998); ME. REV. STAT. ANN. tit. 24-A § 4302 (West Supp. 1997); MD. CODE ANN., INSURANCE § 15-121 (1997).

60. Self-funded health care plans are "established or maintained by an employer . . . for the purpose of providing for its participants or their benefici-

insurance by ERISA's preemption provision.[61] A state is thereby prevented from regulating self-funded health care plans or enunciating comprehensive health care policies to safeguard all of its citizens. Moreover, ERISA frequently bars persons enrolled in self-funded health plans from bringing state tort law or statutory claims against MCOs.[62] Notably, most Americans obtain their health insurance through employer self-funded health care plans.[63] The combination of ERISA's preemption provision and the absence of a federal analogue to many state law claims leaves many plaintiffs with-

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aries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits . . . ." 29 U.S.C. § 1002(1)(A) (1994).

61. 29 U.S.C. §§ 1144(a)-(b) (1994). ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." *Id.* § 1144(a). Although Congress expressly exempted state laws governing insurance from the scope of ERISA's preemption clause, laws that purport to regulate insurance as applied to a self-funded health care plan remain subject to ERISA preemption. *See id.* § 1144(b)(2)(B) (providing that no self-insured pension or benefits plan "shall be deemed to be an insurance company or other insurer" by any state insurance law). This provision is known as the "deemer clause." *See* Edward Alburo Morrissey, *Legislative Reform, Deem and Deemer: ERISA Preemption Under the Deemer Clause as Applied to Employer Health Care Plans with Stop-Loss Insurance*, 23 J. LEGIS. 307, 309 (1997).

With regard to claims against MCOs, courts have begun to distinguish between claims based on plan administration, which are preempted by ERISA, and plan quality, which are not. *See* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 358 (3d Cir. 1995); Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995). At least one case suggests that state actions premised on fraudulent disclosure or nondisclosure concern plan administration. *See* Shea v. Esensten, 107 F.3d 625, 627 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 297 (1997) (finding that widow's wrongful death claim premised on fraudulent nondisclosure was preempted by ERISA). According to the court, allowing state law to impose disclosure obligations on plan administrators would frustrate national uniformity by forcing administrators to tailor their disclosure obligations "to meet each state's unique requirements." *Id.* For a more complete discussion of ERISA's broad preemption, see Walter E. Schuler, Note, *The ERISA Pre-emption Narrows: Analysis of* New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company *and Its Impact on State Regulation of Health Care*, 40 ST. LOUIS U. L.J. 783, 784 (1996) (noting that ERISA has been called "the most sweeping federal preemption statute ever enacted by Congress").

62. *See, e.g., Shea*, 107 F.3d at 627; Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748, 751 (S.D.N.Y. 1997) (finding plaintiff's claim for breach of an implied warranty of good faith and fair dealing to be preempted by the terms of ERISA).

63. Karen Ann Jensen, Comment, *Genetic Privacy in Washington State: Policy Considerations and a Model Genetic Privacy Act*, 21 SEATTLE U. L. REV. 357, 372 (1997).

out an adequate legal remedy.[64] Their only recourse is to sue under ERISA.

II. ERISA AND THE DUTY TO DISCLOSE

ERISA governs the operation of self-funded employee benefits plans in a manner designed to protect employees, retirees, and their beneficiaries.[65] In accordance with the goal of shielding plan participants and beneficiaries from potential harm,[66] ERISA's broad regulatory scheme expressly requires the disclosure of certain information[67] to plan enrollees and imposes fiduciary standards[68] on persons involved in both plan management and administration.[69]

A. EXPRESS DISCLOSURE REQUIREMENTS

As a means of empowering plan beneficiaries to enforce their rights under an ERISA benefits plan,[70] Congress imposed several specific disclosure requirements on ERISA plan admin-

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64. Following removal to federal court, plaintiffs frequently find their state claims dismissed. *See* Brooks Richardson, Comment, *Health Care: ERISA Preemption and HMO Liability—A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 OKLA. L. REV. 677, 692 (1996). Moreover, even if such claims are recharacterized as ERISA claims, plaintiffs are limited to the equitable remedies provided by ERISA section 502: lost benefits, injunctions, restitution, and other equitable remedies. *See* Farrell, *supra* note 38, at 285. ERISA does not authorize recovery for compensatory relief or punitive damages. *See id.*

65. *See* 29 U.S.C. § 1001(b) (1994). According to its text, ERISA was designed:

> [to] protect... participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

Id.

66. *See id.*

67. *See id.* § 1024(b)(1).

68. ERISA fiduciaries must "discharge [their] duties with respect to a plan *solely* in the interest of the participants and beneficiaries." *Id.* § 1104(a)(1) (emphasis added). The duty to act solely in the interests of plan participants and beneficiaries is based on the common law duty of loyalty imposed on trustees. *See* Berlin v. Michigan Bell Tel. Co., 858 F.2d 1154, 1162 (6th Cir. 1988); Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir. 1982).

69. *See* 29 U.S.C. § 1024(b)(1) (1994).

70. *See id.* § 1001(b).

istrators.[71] Under ERISA's terms, plan administrators are required to provide a summary plan description (SPD) to each participant in the plan. The SPD's technical disclosure requirements include the plan's name, the type of employee benefit plan, a description of circumstances that may result in ineligibility, and the plan's eligibility rules for participation and benefits.[72] ERISA emphasizes the importance of presenting the information in a manner that maximizes the likelihood of beneficiary comprehension.[73]

B. FIDUCIARIES AND THEIR DISCLOSURE OBLIGATIONS

Under ERISA's terms, a person is a fiduciary "to the extent" that she "exercises *any* discretionary authority or discretionary control respecting management," or "has *any* discretionary . . . responsibility in the administration" of the plan.[74] ERISA defines fiduciary status in functional terms[75] and limits the scope of a person's fiduciary duty to conduct and decisions relevant to the management or administration of the plan.[76] Lower courts have indicated that Congress intended ERISA's definition of fiduciary to be broadly construed.[77] Through their discretionary administration of health care plans, MCOs assume fiduciary status under ERISA.[78]

In *Corcoran v. United HealthCare, Inc.*,[79] the Fifth Circuit held that utilization review by a utilization review organization

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71. *See id.* § 1021. ERISA defines a "plan administrator" as the person named in the written instrument. *See id.* § 1002(16)(A)(i). If the written instrument does not name such a person, the plan sponsor becomes the default "plan administrator." *See id.* § 1002(16)(A)(ii). In the absence of a named administrator, and if a plan sponsor cannot be identified, ERISA authorizes the Secretary of Labor to designate an administrator by regulation. *See id.* § 1002(16)(A)(iii).

72. *See id.* § 1022.

73. *See id.* § 1022(a)(i) (requiring that the language in the plans be "calculated to be understood by the average plan participant").

74. *See id.* §§ 1002(21)(A)(i), (iii) (emphasis added).

75. *See* Mertens v. Hewitt Assoc., 508 U.S. 248, 262 (1993) (noting that ERISA "defines 'fiduciary' not in terms of formal trusteeship, but in *functional* terms of control and authority over the plan . . . thus expanding the universe of persons subject to fiduciary duties").

76. *See* 29 U.S.C. § 1002(21)(A)(iii) (1994).

77. *See* Cantor, *supra* note 25, at 191.

78. *See* O'Reilly v. Ceuleers, 912 F.2d 1383, 1386 (11th Cir. 1990); Morales v. Health Plus, Inc., 954 F. Supp. 464, 468 (D.P.R. 1997); Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748, 751 (S.D.N.Y. 1997).

79. 965 F.2d 1321 (5th Cir. 1992). In *Corcoran*, Mrs. Corcoran, a longtime employee of the South Central Bell Telephone Company (Bell), filed a

(URO)[80] constituted administration of an ERISA benefits plan.[81] The court reasoned that although URO decisions are often medical in nature, these decisions take place "in the context of making a determination about the availability of benefits under the plan."[82] By determining whether plan enrollees were eligible for treatment covered by the plan, the URO ultimately determined whether they were entitled to employee benefits and thus exercised discretionary control in plan administration.[83]

C. CONGRESSIONAL DELEGATION AND THE COMMON LAW OF TRUSTS

Congress invoked the common law of trusts to help define the appropriate duties of ERISA fiduciaries.[84] Rather than

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medical malpractice claim against Blue Cross & Blue Shield, an MCO that administered Bell's self-funded health benefits plan, and United Healthcare, a utilization review firm that monitored the self-funded plan. *See id.* at 1322-24. In 1989, Mrs. Corcoran became pregnant. *See id.* at 1322. Towards the end of her pregnancy, Mrs. Corcoran's obstetrician ordered her hospitalized for the purpose of constant monitoring of the fetus. *See id.* at 1322-23. United determined that hospitalization was not necessary and recommended ten hours per day of home nursing care. *See id.* at 1324. Despite United's determination, Mrs. Corcoran entered the hospital, but because of United's failure to approve the hospitalization, she was discharged within ten days. *See id.* Less than two weeks later, the fetus went into distress and died. *See id.*

80. UROs use boards of hired physicians and nurses to review each insured patient's records to determine if prescribed treatments are medically necessary. *See* Walsh, *supra* note 8, at 216. If the board concludes that treatment is not medically necessary, that treatment is not covered by the health plan. *See id.* Under Bell's plan, United was required to pre-approve certain medical decisions. *See Corcoran*, 965 F.2d at 1323. If a plan participant ignored United's determination that a certain treatment was unnecessary and received such treatment, the plan participant would be penalized by having her benefits reduced by twenty percent for the remainder of the calendar year. *See id.*

81. *See Corcoran*, 965 F.2d at 1331.

82. *Id.* According to the court:

> By its very nature, a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary, faced with the knowledge of specifically what the plan will and will not pay for, will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits.

Id. at 1332.

83. *See id.* at 1331.

84. *See* Varity Corp. v. Howe, 116 S. Ct 1065, 1070 (1996); S. REP. NO. 127, at 29 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4865 (declaring that

providing an exhaustive and explicit enumeration of all fiduciary powers and duties, Congress expected courts to supplement ERISA's express provisions by developing a "federal common law of rights and obligations."[85] Precedent makes clear that so long as courts do not revise ERISA's text,[86] courts are authorized to develop a federal common law to supplement ERISA when necessary to effectuate its purposes.[87]

The "duty to disclose material information is the core of a fiduciary's responsibility" under the common law of trusts.[88] Trustees must neither mislead nor deceive plan beneficiaries.[89] Moreover, a beneficiary's request triggers the duty for fiduciaries to disclose "complete and accurate information material to the beneficiary's circumstance,"[90] including information that "comprises elements about which the beneficiary has not specifically inquired."[91] Failure to faithfully discharge these broad

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ERISA's "fiduciary responsibility section, in essence, codifies and makes applicable to [ERISA] fiduciaries certain principles developed in the evolution of the common law of trusts").

85. *Varity*, 116 S. Ct. at 1070 (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110-11 (1989)).

86. *See* Mertens v. Hewitt Associates, 508 U.S. 248, 252-60 (1993). According to the Supreme Court:

> [T]he law of trusts will often inform, but will not necessarily determine the outcome of an effort to interpret ERISA's fiduciary duties. In some instances, trust law will offer only a starting point, after which courts must go on to ask whether, or to what extent, the language of the statute, its structure, or its purposes require departing from the common-law trust requirements.

Varity, 116 S. Ct. at 1070.

87. *See* Singer v. Black & Decker Corp., 964 F.2d 1449, 1452 (4th Cir. 1992).

88. Eddy v. Colonial Life Ins. Co., 919 F.2d 747, 750 (D.C. Cir. 1990).

89. *See Varity*, 116 S. Ct. at 1074; Pocchia v. Nynex Corp., 81 F.3d 275, 278-79 (2d Cir. 1996); Wilson v. Southwestern Bell Tel. Co., 55 F.3d 399, 405 (8th Cir. 1995); Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund, 12 F.3d 1292, 1300 (3d Cir. 1993) (holding that once a beneficiary has requested information from an ERISA fiduciary who is aware of the beneficiary's status and circumstances, the fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstances); Drennan v. General Motors Corp., 977 F.2d 246, 251 (6th Cir. 1992); Eddy v. Colonial Life Ins. Co. of Am., 919 F.2d 747 (D.C. Cir. 1990); Peoria Union Stock Yards Co. Retirement Plan v. Pennsylvania Mut. Life Ins. Co., 698 F.2d 320, 326 (7th Cir. 1983).

90. *Bixler*, 12 F.3d at 1300.

91. *Id.* Importantly, "while the beneficiary may, at times, bear a burden of informing the fiduciary of her material circumstances, the fiduciary's obligations will not be excused merely because she failed to comprehend or ask about a technical aspect of the plan." *Id.*

disclosure obligations constitutes a breach of the fiduciary's duty towards the beneficiary.[92]

Although the common law of trusts imposes broad disclosure requirements on trustees, an affirmative duty does not typically exist for trustees to disclose material facts to their beneficiaries absent a direct inquiry.[93] The common law does recognize, however, an affirmative duty when the trustee possesses superior knowledge of certain information that the beneficiary needs to know to protect her interests.[94] According to the Second Restatement of Trusts, "[the trustee] is under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection in dealing with a third person with respect to his interest."[95]

D. JUDICIAL PERSPECTIVES CONCERNING AN AFFIRMATIVE DUTY TO DISCLOSE PHYSICIAN INCENTIVES UNDER ERISA

The first two courts to consider whether ERISA requires MCOs to disclose the existence of their physician incentive schemes to their enrollees have reached contrary conclusions.[96] In *Shea v. Esensten*, the Eighth Circuit held that an MCO's financial incentive scheme for reducing referrals was a material fact, and thus the MCO had a duty under ERISA to affirmatively disclose such information to its enrollees.[97] The court concluded that in the absence of such information, a patient cannot reasonably be expected to protect her own interests.[98]

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92. *See id.*

93. *See* RESTATEMENT (SECOND) OF TRUSTS § 173 cmt. d (1959).

94. *See id.*; *see also Eddy*, 919 F.2d at 747 (holding that once an employee informed his group health insurer that his employer was terminating his insurance policy, insurer had a duty under ERISA to provide complete and accurate material information about his status and conversion option).

95. RESTATEMENT (SECOND) OF TRUSTS § 173 cmt. c (1959).

96. *Compare* Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997) (holding that Medica, an MCO, was a fiduciary under ERISA and was therefore required to disclose its financial incentive scheme to its members), *with* Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748 (S.D.N.Y. 1997) (holding that the fiduciary duties imposed by ERISA go no further than forbidding fiduciaries from intentionally misleading or deceiving beneficiaries).

97. *See Shea*, 107 F.3d at 628-29.

98. *See id.*

A mere five months later, in *Weiss v. Cigna Healthcare, Inc.*,[99] New York's Southern District Court refused to join the Eighth Circuit, holding instead that ERISA's disclosure requirements did not go beyond the "obligation to neither deceive nor mislead plan participants or beneficiaries about material facts; i.e., not to lie to them."[100] Thus, according to the *Weiss* court, in the absence of misleading or deceptive conduct by the fiduciary, failure to speak does not constitute a breach of ERISA's fiduciary obligations.[101] Future decisions must resolve this jurisprudential divide.

III. ERISA REQUIRES MCOS AND PHYSICIANS TO DISCLOSE PHYSICIAN INCENTIVE SCHEMES TO PATIENTS

Future courts should join the Eighth Circuit and recognize that ERISA imposes on MCOs an affirmative duty to disclose the existence and nature of its physician incentive arrangements to plan enrollees. Furthermore, future courts should go beyond the *Shea* decision, should recognize physicians as ERISA fiduciaries, and should hold that ERISA obliges physicians to disclose the existence of financial incentive arrangements that present potential conflicts of interest.

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99. 972 F. Supp. at 748. The plaintiff in *Weiss* alleged that the defendant breached its general fiduciary obligation under ERISA by failing to affirmatively disclose the existence and nature of its compensation of physicians. *See id.* at 753.

100. *Id.* at 754. Although the *Weiss* court recognized that Supreme Court precedent authorized courts to go beyond the "bounds of express statutory requirements," it refused to interpret ERISA's general fiduciary language to supplement disclosure obligations expressly detailed in another part of the statute. *Id.* The court noted that the general fiduciary obligations set forth in ERISA's section 404 do not refer to the disclosure of information to plan participants, and thus, the court concluded "it would be 'inappropriate to infer an unlimited disclosure obligation on the basis of general provisions that say nothing' about such duties." *Id.* (quoting Board of Trustees of the CWA/ITU, 107 F.3d 139, 147 (2d Cir. 1997)). In determining the scope of ERISA's fiduciary duties, other courts have pursued a similar interpretative strategy. *See, e.g.*, Faircloth v. Lundy Packing Co., 91 F.3d 648, 657 (4th Cir. 1996) (holding that because the specific disclosure obligations in ERISA sections 101 to 111 do not mention physician incentives, it would be inappropriate for courts to interpret section 404's general fiduciary obligations to require the disclosure of such information).

101. *See Weiss*, 972 F. Supp. at 754.

A. MCOs and Physicians Are ERISA Fiduciaries to the Extent They Exercise Discretionary Authority or Control over the Management or Administration of an ERISA Plan

ERISA unconditionally imposes fiduciary status on any person who "exercises *any* discretionary authority or discretionary control" over the management or administration of an employee self-funded health benefits plan.[102] Literally read, if either MCOs or physicians exercise *any* control in plan administration or management, they qualify as ERISA fiduciaries.[103] In determining whether an MCO's or physician's conduct amounts to plan administration or management, Supreme Court precedent indicates that a functional analysis should guide the inquiry.[104]

1. MCOs Are ERISA Fiduciaries

Applying the Supreme Court's functional test[105] within the context of the managed care industry demonstrates that MCOs become ERISA fiduciaries when they employ physician incentive schemes to administer self-funded health plans. Managed care plans work with a limited budget.[106] To keep costs down, MCOs must allocate resources in a way that avoids expending scarce resources in a wasteful manner.[107] MCOs enlist physician support in their cost-containment project through the use of financial incentives.[108] By influencing physician decisionmaking, MCO guidelines affect whether plan members receive

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102. 29 U.S.C. § 1002(21)(A) (1994) (emphasis added).

103. *See* O'Reilly v. Ceuleers, 912 F.2d 1383, 1385 (11th Cir. 1990); Morales v. Health Plus, Inc., 954 F. Supp 464, 468-69 (D.P.R. 1997); *Weiss*, 972 F. Supp. at 751.

104. *See supra* note 75 and accompanying text (discussing the definition of fiduciary status).

105. *See* note 75 and accompanying text.

106. *See* Council on Ethical and Judicial Affairs, AMA, *supra* note 53, at 273 JAMA 330 (1995). Aside from the obvious lack of infinite funds, the need to guarantee the financial viability of the MCO and to curb healthcare expenditures so that insurance is affordable to employers set budgetary limits on MCOs.

107. *See id.* For-profit MCOs also seek to avoid unnecessary spending so that they can compete and report favorable information to their shareholders. *See id.*

108. *See supra* notes 31-37 and accompanying text (discussing financial incentives).

medical services covered by their health plans.[109] Empirical studies confirm that the use of financial incentives reduces some medical services,[110] and thus ultimately affects allocation of plan benefits to enrollees. Although financial incentives admittedly exert only indirect control on physician behavior, ERISA's language does not differentiate direct from indirect control, nor does it require ultimate and final control over such activities.[111] Through their use of such incentive systems, MCOs exercise discretionary control over the administration of ERISA plans.

2. Physicians Are ERISA Fiduciaries

While the law has generally refused to recognize physicians as fiduciaries with respect to ERISA health plans,[112] functional analysis indicates that under the appropriate circumstances physicians should be recognized as ERISA fiduciaries. Physician decisionmaking, although inherently medical in nature, constitutes benefits determination within the con-

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109. *See supra* note 41 and accompanying text (discussing one study that found that the use of financial incentives reduced both necessary and unnecessary referrals).

110. *See supra* note 41 and accompanying text (examining MCO reimbursement schemes).

111. *See supra* text accompanying note 74 (providing ERISA's definition of a "fiduciary").

112. *See* Cantor, *supra* note 25, at 208. Traditionally, state law medical malpractice claims against physicians have not been preempted by ERISA. *See id.* Consequently, persons injured as a result of a physician's failure to disclose remain free to bring malpractice suits against physicians, and, in some states, against MCOs under the theory of respondeat superior. *See* Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995) (holding that a medical malpractice claim against an MCO was not completely preempted by ERISA); Lupo v. Human Affairs Int'l, Inc., 28 F.3d 269 (2d Cir. 1994) (ruling that medical malpractice, breach of fiduciary duty, and intentional infliction of emotional distress claims were not preempted by ERISA); *see also supra* note 61 (discussing recent distinction between claims based on plan administration, which are preempted, and claims based on plan quality, which are not preempted).

Although the threat of malpractice lawsuits may curb abuses by both physicians and MCOs, the tort law system is an inadequate mechanism for protecting plan enrollees from harm in the era of managed care. Tort law only provides retrospective compensatory relief, a poor substitute for completely avoiding the injury with continued health and longevity. Mandated disclosure empowers plan enrollees by informing them of potential conflicts of interest and thus allows them to better protect their health from the dangers associated with the use of physician incentives. *See* McGraw, *supra* note 9, at 1843 (discussing the inadequacies of the tort law system with regard to physician incentives in managed care).

text of managed care.[113] The financial incentive arrangements employed by MCOs effectively delegate discretionary control to physicians to determine which plan members are entitled to medical benefits covered by their health plans. For example, under the gatekeeper system, if a physician does not provide a plan member with a referral to a specialist, the health plan will not cover the cost of that service.[114]

In addition to making these individualized determinations, physicians also control the allocation of health care benefits among plan members. Financial incentives increase physician awareness of resource scarcity, forcing the physician to consider resource allocation with respect to patient need.[115] As noted by the AMA:

> [T]he physician is required by rules and encouraged by incentives to be aware of the overall financial limitations of the managed care entity for which he or she works. The physician knows that there are other patients who have subscribed to the managed care plan and who are owed a certain level of health care. These competing concerns mean that a patient's further treatment depends not only on the physician's judgment about the legitimacy of that patient's present medical need but also on the relative weight of that need in comparison with the organization's need to serve all patients and control costs.[116]

Ultimately, by deciding which plan members receive referrals to specialists or receive other costly procedures covered in the health plan, physicians allocate benefits among plan members. Benefits determination constitutes plan administration and thus a fiduciary function under ERISA.[117] Consequently, to the extent that physicians exercise such discretionary control, physicians fit within ERISA's functional definition of fiduciary.

B. A DUTY TO DISCLOSE PHYSICIAN COMPENSATION ARRANGEMENTS

Functional analysis compels the conclusion that the financial incentive arrangements between MCOs and physicians impose ERISA fiduciary status on both groups.[118] The next in-

113. *Cf.* Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992) (holding that utilization review constituted benefits determination despite its inherent medical nature).

114. *See* McGraw, *supra* note 9, at 1823 (discussing the role of the "gatekeeper" physician).

115. *See* Council on Ethical and Judicial Affairs, AMA, *supra* note 53, at 330.

116. *Id.* at 332.

quiry is whether physicians and MCOs must affirmatively disclose physician incentive information to plan enrollees. Although ERISA's text does not explicitly answer this question, the common law of trusts, congressional intent, ERISA's purpose, and public policy all support imposing such an obligation on both MCOs and physicians.

1. ERISA's Incorporation of the Common Law of Trusts Requires Disclosure

The common law of trusts requires a trustee to disclose material facts affecting a beneficiary's interests when the trustee knows that the beneficiary is ignorant of such facts and that such knowledge is necessary to allow the beneficiary to protect her interests.[119] MCOs presumably know that many of their enrollees are unaware that their physicians benefit financially by minimizing patient access to specialty physicians, diagnostic testing procedures, and other costly services. The vast majority of MCO enrollees are unaware of the potentially hazardous fact that their physicians receive financial incentives to reduce their consumption of medical resources.[120] Historically, MCOs have maintained this ignorance through nondisclosure and the use of "gag clauses"[121] that prohibit physicians from discussing their financial incentive arrangements with patients.[122] Absent the belief that enrollees are unaware of their MCOs' physician incentive schemes, the purpose of these gag clauses becomes difficult to discern.

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117. *See* Varity Corp. v. Howe, 116 S. Ct. 1065, 1077 (1995) (noting that "a plan administrator engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits under the terms of the plan documents"); Libbey-Owens-Ford Co. v. Blue Cross and Blue Shield Mut., 982 F.2d 1031, 1035 (6th Cir. 1993) (concluding that "[w]hen an insurance company administers claims for [a plan] and has authority to grant or deny the claims, the company is an ERISA 'fiduciary'"); *Corcoran*, 965 F.2d at 1331 (holding that a URO that determined medical necessity ultimately made benefits determinations, and thus was an ERISA fiduciary); Cantor, *supra* note 25, at 206.

118. *See supra* Part III.A.

119. *See supra* notes 94-95 and accompanying text.

120. *See supra* note 19 and accompanying text.

121. Gag clauses are contractual provisions between MCOs and physicians that often proscribe physicians from communicating specified information to patients. *See* Jennifer L. D'Isidori, *Stop Gagging Physicians*, 7 HEALTH MATRIX 187, 194 (1997).

122. *See id.* These provisions often prohibit physicians from discussing their compensation agreements with a patient under the threat of having their contract terminated by the MCO. *See id.*

Patients generally trust and rely on their physicians' advice about medical treatment options.[123] In the absence of information concerning physician incentives to minimize medical services, some enrollees will undoubtedly follow treatment recommendations blindly, deprived of the opportunity to actively protect their health interests in an informed manner. If provided with such information, enrollees could choose to protect their health interests by rejecting their physicians' decisions and personally covering the expense of unauthorized treatment[124] or by using their MCOs' grievance mechanisms more aggressively. Enrollees could also sue for breach of fiduciary duty under ERISA if they believed that their physicians were improperly motivated by self-serving financial considerations.[125] The common law of trusts intended affirmative disclosure of information in precisely these types of circumstances: The plan fiduciary knows that the beneficiary is not in possession of information needed to protect her interests involving matters of life and death.[126]

2. Affirmative Disclosure Obligations Accord with ERISA's Text

Although ERISA's incorporation of the common law of trusts suggests that ERISA fiduciaries have an affirmative

123. *See* John G. Bradley et al., *Patient Preferences for Control in Medical Decision Making: A Scenario Based Approach*, 28 FAM. MED. 496, 496 (1996) ("Although preference for level of control in medical decisionmaking varied by scenario . . . patients most often preferred physicians to play the primary role in decision-making."); Lesley F. Degner & Jeffrey A. Sloan, *Decision Making During Serious Illness: What Role Do Patients Really Want to Play?*, 45 J. CLINICAL EPIDEMIOLOGY 941, 941 (1992); Jack Ende et al., *Measuring Patients' Desire for Autonomy: Decision-Making and Information-Seeking Preferences Among Medical Patients*, 4 J. GEN. INTERNAL MED. 23, 26-27 (1989) (finding that patients' desire to make autonomous decisions declined in relation to the severity of the illness); Robert F. Nease, *Patient Desire for Information and Decision Making in Health Care Decisions: The Autonomy Preference Index and the Health Opinion Survey*, 10 J. GEN. INTERNAL MED. 593, 596 (1995) (finding that many patients have little desire to be involved in medical decisionmaking).

124. *See* Shea v. Esensten, 107 F.3d 625, 627 (8th Cir. 1997) (discussing plaintiff's allegation that but for ERISA fiduciary's wrongful silence, her husband would have opted to personally cover the costs of a cardiologist visit).

125. *See, e.g., id.* at 625.

126. *See id.* at 629 ("Health care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if it 'knows that silence might be harmful.'" (quoting Bixler v. Central Penn. Teamsters Health & Welfare Fund, 12 F.3d 1292, 1300 (3d Cir. 1993))); *see also supra* note 94 and accompanying text (discussing the common law of trusts).

duty to disclose physician incentives, Supreme Court precedent commands courts to respect ERISA's text when incorporating the common law of trusts to supplement its express provisions.[127] Textual analysis is somewhat complicated by the fact that ERISA has arguably two separate areas that govern disclosure, sections 101 to 111[128] and section 404.[129] None of these sections specifically addresses whether plan fiduciaries must inform MCO enrollees of physician incentive schemes.[130]

The Supreme Court has observed that, when statutory provisions are in arguable conflict, the more specific section makes the more general section inapplicable.[131] Although courts have interpreted section 404's general fiduciary duty of loyalty to govern fiduciaries' communications with their beneficiaries,[132] this section does not specifically govern disclosure at all.[133] Sections 101 to 111 do specifically address disclosure and enumerate several disclosure requirements.[134] However, these sections also fail to address the disclosure of financial incen-

127. *See supra* note 86 and accompanying text (explaining the importance of textual interpretation).

128. 29 U.S.C. §§ 1021-1031 (1994).

129. *Id.* § 1104.

130. *See id.* § 1021.

131. *See* Clifford F. MacEvoy Co. v. United States, 322 U.S. 102, 107 (1944) ("However inclusive may be the general language of a statute, it 'will not be held to apply to a matter specifically dealt with in another part of the same enactment . . . . Specific terms prevail over the general in the same . . . statute which otherwise might be controlling.'") (quoting Ginsberg & Sons v. Popkin, 285 U.S. 204, 208 (1932)). For an excellent discussion on the use of maxims of statutory interpretation, see WILLIAM N. ESKRIDGE & PHILIP P. FRICKEY, CASES AND MATERIALS ON LEGISLATION: STATUTES AND THE CREATION OF PUBLIC POLICY 633-715 (2d ed. 1995).

132. *See* Varity Corp. v. Howe, 116 S. Ct. 1065, 1074-75 (1995) (interpreting the common law of trusts to require ERISA fiduciaries to speak truthfully to plan beneficiaries); Shea v. Esensten, 107 F.3d 625, 628-29 (8th Cir. 1997) (holding that ERISA's fiduciary duty of loyalty requires MCO fiduciaries to disclose physician incentive schemes to their enrollees); Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund, 12 F.3d 1292, 1300 (3d Cir. 1993) (holding that ERISA's fiduciary duty requires plan fiduciaries to convey complete and accurate information in response to a beneficiary's request); Eddy v. Colonial Life Ins. Co., 919 F.2d 747, 752 (D.C. Cir. 1990) (ruling that ERISA fiduciary's knowledge of beneficiary's circumstances required fiduciary to disclose complete and accurate material information to plan beneficiary).

133. *See* 29 U.S.C. § 1104 (1994) (discussing general fiduciary responsibilities of prudence and loyalty).

134. *See id.* §§ 1021-1031 (enumerating ERISA plan administrator's disclosure obligations).

tives.[135] In accordance with the "specific trumps the general" canon, the specific disclosure requirements of sections 101 to 111 have been interpreted as an exhaustive list of disclosure requirements that prevent courts from supplementing the listed disclosure duties through expansive interpretations of section 404.[136] According to courts that have adopted this interpretive strategy, by enacting sections 101 to 111, did all it intended to do in the disclosure area.[137]

Nevertheless, the "specific trumps the general" canon of statutory interpretation is poorly suited to the inquiry of whether ERISA requires MCOs and physicians to disclose physician incentive arrangements to plan enrollees.[138] The Supreme Court has noted that "[t]o apply a canon properly one must understand its rationale."[139] The "specific trumps the general" canon is a "warning against applying a general provision when doing so would undermine limitations created by a more specific provision"[140] and thus frustrate congressional intentions. This canon is merely a "rule of thumb,"[141] however, and should not apply if there is evidence of contrary legislative intent or policy.[142] Given the fact that disclosure is the "core of a fiduciary's responsibilit[ies]" under the common law of trusts,[143] ERISA's incorporation of trust law indicates that Congress did not intend ERISA's specifically enumerated disclosure obligations to be an exhaustive list.

3. Congressional Intention Requires Imposing an Affirmative Duty to Disclose Physician Incentives on MCOs and Physicians Under ERISA

Given the relatively recent appearance of HMOs as major actors on the political stage, it is unlikely that Congress held any specific intentions concerning their status and obligations

135. *See id.* §§ 1021-1031, 1104.

136. *See* Faircloth v. Lundy Packing Co., 91 F.3d 648, 657 (4th Cir. 1996); Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748, 754 (S.D.N.Y. 1997).

137. *See, e.g., Weiss*, 972 F. Supp. at 754. According to the *Weiss* court, "Had Congress seen fit to require the affirmative disclosure of physician compensation arrangements, it could certainly have done so in ERISA §§ 101-111." *Id.*

138. *Cf.* Varity Corp. v. Howe, 116 S. Ct. 1065, 1077 (1996).

139. *Id.*

140. *Id.*

141. *See id.*

142. *Cf.* Bintz, *supra* note 24, at 988.

143. *See supra* note 88 and accompanying text.

when it enacted ERISA in 1974.[144] It is also unlikely that Congress considered the implications of capitated payment schemes in relation to ERISA disclosure obligations. Clearly, however, Congress intended to empower plan beneficiaries to protect their interests under benefit plans by providing them with information via express disclosure requirements and by imposing fiduciary obligations on persons who exercise discretion in the administration or management of ERISA plans.[145] In addition, ERISA's fiduciary jurisprudence rests on the acknowledgment that Congress intended courts to interpret ERISA's provisions with respect to the common law of trusts as a means of supplementing stated fiduciary obligations and protecting plan beneficiaries.[146] Recognizing an affirmative duty to disclose physician incentives furthers congressional intent in at least two ways: (i) it empowers plan beneficiaries with material information so that they can protect their own interests; and (ii) it incorporates disclosure obligations found within the common law of trusts.

4. ERISA's Purpose Supports Recognition of an Affirmative Disclosure Duty

Reasonable legislators would not have intended to leave plan beneficiaries in a worse situation than they would have been in ERISA's absence.[147] However, interpreting ERISA's fiduciary obligations to exclude the disclosure of financial incentive arrangements achieves exactly such a result. In the absence of ERISA and its preemption provisions, persons would be entitled to state protection from the dangers associated with the use of financial incentives.[148] Holding ERISA to exclude affirmative

144. Congress enacted the Health Maintenance Organization Act in 1973. *See* 42 U.S.C. § 300e (1994). Despite Congress authorizing the establishment of HMOs one year before enacting ERISA, HMOs did not become a dominant force in the health market until the following decade. *See supra* note 45 and accompanying text.

145. *See supra* notes 65-69 and accompanying text.

146. *See supra* notes 84-87 and accompanying text.

147. Under the purposive approach to statutory interpretation, courts assume reasonable persons pursuing reasonable goals reasonably. *See* Philip Frickey, *Statutory Interpretation as Practical Reasoning*, 42 STAN. L. REV. 321, 333 (1990) (discussing the purposive approach to statutory interpretation). Clearly, reasonable legislators would not intend to enact legislation designed to make citizens worse off than they would have been in the absence of such legislation.

148. *See supra* note 61 and accompanying text.

disclosure obligations produces an anomalous result—a statute premised on disclosure obligations potentially denies persons material information to which they could otherwise be legally entitled under state law.[149] Given ERISA's recognition of disclosure as a means of enrollee empowerment, courts should recognize that MCOs and physicians have a fiduciary duty under ERISA to disclose information concerning physician incentive schemes.

5. Public Policy Supports Disclosure

Studies indicate that the majority of MCO enrollees are not aware of the fact that their MCOs employ cost-containment mechanisms to influence physician decisionmaking, mechanisms that introduce potential conflicts of interest into their relationships with their physicians.[150] In the absence of such information, enrollees are deprived of important opportunities to question their physicians' objectivity, to personally cover treatments not covered by their health plans, and to use their MCOs' grievance systems more aggressively. Instead, such enrollees accept physicians' recommendations solely on faith, ignorant of the possible conflicts of interest that may result in improper medical decisions adverse to their long-term health.[151] Requiring MCOs and physicians to disclose physician incentive information to MCO enrollees empowers enrollees with an increased ability to protect their health interests from dangers created by their MCOs.[152]

The contextual dynamics of the patient-physician relationship also support recognizing a duty for MCOs physicians to disclose their compensation schemes to enrollees. Trust is the linchpin of the patient-physician relationship.[153] This relation-

149. *See supra* note 58 and accompanying text.

150. *See supra* note 19 and accompanying text.

151. *See supra* note 53 and accompanying text.

152. According to one commentator:

> With this knowledge, [an enrollee] might be more likely to take charge of her health care destiny and aggressively use the existing grievance procedures to get the desired treatment. The [MCO] would view this outcome as undesirable, but the enrollee would arguably view such an outcome as desirable: her knowledge about the compensation structures used in her health plan empowered her to take a more active role in decisions concerning her health care.

McGraw, *supra* note 9, at 1838-39.

153. *See* Council on Ethical and Judicial Affairs, AMA, *supra* note 53, at 331.

ship is founded on the belief that "physicians are dedicated first and foremost to serving the needs of their patients."[154] Empirical studies indicate that the vast majority of persons trust and follow their physicians' treatment recommendations.[155] Given the high degree of trust that persons place in their physicians, it is unreasonable to expect that many persons would independently question their physicians' objectivity and investigate contractual incentives to reduce care. Consequently, if neither physicians nor MCOs disclose physician incentive information to plan enrollees, many of them would presumably fail to educate themselves and gain access to material information affecting their health interests. The informational burden should not fall on enrollees, the parties least likely to suspect any conflict of interest and those most vulnerable to injury.

Opponents of an affirmative duty to disclose may argue that such an imposition would harm patient and physician dialogue by incorporating distrust and anxiety into this intimate relationship. However, imposing disclosure obligations on physicians may actually further the ideal of the patient and physician relationship by fostering candid dialogue. Although a recent survey indicates that many people would not trust their physicians if they knew that they had financial incentives to avoid certain treatments or testing procedures,[156] this study does not speak to the effect that physician candor and subsequent dialogue would have on the patient and physician relationship. Physicians that address the topic in a forthright manner would demonstrate their ability to speak truthfully to patients and evidence their respect for their patients' autonomy and right to know material information. Under these circumstances, many patients would presumably be willing to trust their physicians and enjoy an increased ability to protect their health care interests.

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154. *Id.* Since the time of Hippocrates, trust has been recognized as an essential element of this intimate relationship. *See Hippocratic Oath, reprinted in* JUDITH AREEN ET AL., LAW, SCIENCE & MEDICINE 230 (1996). In relevant part, the Hippocratic Oath states: "I will apply . . . measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. . . . Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice." *Id.*

155. *See supra* note 123.

156. *See HMO Homepage* (visited 2/17/1998) <http://www.hmopage.org/mechanics.html>.

CONCLUSION

Patrick Shea's tragic story illustrates the materiality of information concerning physician compensation agreements with MCOs. In order to protect and enforce their interests under an ERISA health benefit plan, enrollees must be informed of the existence and nature of financial incentives designed to affect their physicians' decisionmaking. Requiring MCOs and physicians to disclose such information furthers ERISA's primary purpose of protecting plan beneficiaries through disclosure. Furthermore, strong public policy arguments indicate that MCOs and physicians should disclose the existence and nature of physician incentives to MCO enrollees, thereby allowing them to actively protect their interests in the era of managed care.