1998

Requiring Managed Care to Disclose the Use of Financial Incentives: *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997)

Paul Heimann

*University of Nebraska College of Law*

Follow this and additional works at: [http://digitalcommons.unl.edu/nlr](http://digitalcommons.unl.edu/nlr)

Recommended Citation


Available at: [http://digitalcommons.unl.edu/nlr/vol77/iss3/5](http://digitalcommons.unl.edu/nlr/vol77/iss3/5)
Note*

Requiring Managed Care to Disclose the Use of Financial Incentives: *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997)

TABLE OF CONTENTS

I. Introduction ............................................. 588
II. Background .............................................. 591
III. Analysis of *Shea v. Esensten* .......................... 593
   A. Managed Care Organizations Traditionally Have Not Been Held Accountable for Cost-Containment Mechanisms .................................... 593
   B. The Role of ERISA in Claims That Attack Physician Incentives in Managed Care ............................. 597
   C. Fiduciary Duty to Disclose Physician Incentives Under ERISA ........................................ 604
   D. Remedy for Breach of Fiduciary Duty to Disclose Under ERISA ........................................ 610
IV. Conclusion .............................................. 615

I. INTRODUCTION

The American health care system is in the midst of a transformation from a traditional fee-for-service system to a managed care system. Under the traditional fee-for-service system, physicians were insulated from the cost of care they administered to their patients because the patient's insurer simply paid the bill that the physician submitted to them. Due to the rising costs of health care, however, policymakers and employers created managed care as an alternative...
to the traditional fee-for-service arrangement. Unlike the traditional fee-for-service system, managed care organizations (MCOs) both deliver and finance health care for their enrollees. Enrollees pay premiums, and in return, are entitled to receive a complete menu of medical services from the physicians in the MCO. Because the premiums are fixed, an MCO's ability to turn a profit is dependent on its ability to reduce the amount of care that it administers under its plan.

MCO's put much of the burden of reducing unneeded, expensive care on the physicians under their plan through the use of financial incentives. Primary care physicians serve as "gatekeepers" who decide whether a patient requires expensive care, such as referral to specialists, laboratory tests, or in-patient hospital stays. Most financial incentives discourage the use of expensive treatment by holding the physicians financially responsible for expensive care.4 Such arrangements sharply contrast traditional fee-for-service arrangements, where it is in the physician's financial best interests to provide more care because they will be compensated by the insurer for whatever care they administer.

The main criticism of financial incentive arrangements is that they create a conflict of interest between the physician's duty to provide treatment to his/her patient and the physician's financial well-being.5

4. Usually, such incentives are in the form of capitation or bonus/withhold compensation arrangements. In the typical capitation arrangement, a physician receives an actuarially determined amount per patient which takes into account the risk factors in the physician's patient pool. If the physician's costs exceed the capitated amount, the costs of care will come out of the physician's own pocket. Theoretically, the capitated amount reflects the physician's patient pool, so that if any one patient's costs exceed the capitated amount, such costs would be offset by patients whose care does not exceed the capitated amount.

In the bonus/withhold compensation arrangement, a certain percentage of the doctor's salary is withheld. The withheld amount is then used by the MCO as a bonus for physicians under the plan who control referrals to specialists, hospital stays, or other costly care. The less expensive services that a physician provides to his/her patients, the more bonus money the physician receives. See Michelle M. Kwon, Move Over Marcus Welby, M.D. and Make Way For Managed Care: The Implications of Capitation, Gag Clauses, and Economic Credentialing, 28 Tex. Tech. L. Rev. 829, 838-39 (1997).

However, because there is a clear legislative intent to allow the use of such incentives to reduce the costs of care, courts have, for the most part, been unwilling to consider claims that attack financial incentives. In addition, the Employee Retirement Income Security Act of 1974 (ERISA) acts as a shield that insulates MCOs from claims for compensatory and punitive damages in state courts.

Claims against MCOs for harm that results from their use of financial incentives face an especially hostile judicial and legislative environment. The Eighth Circuit decision in *Shea v. Esensten*, illustrates just how hostile the environment is. In *Shea*, a widow brought an action in state court for the wrongful death of her husband. She alleged that her husband's Health Maintenance Organization was fraudulent in its nondisclosure and misrepresentation about its physician incentive programs, and this limited her husband's ability to make an informed choice about life-saving health care. In its decision, the Eighth Circuit Court of Appeals found that ERISA preempted Mrs. Shea's state law claim, and that the Health Maintenance Organization had a fiduciary duty under ERISA to disclose its financial incentive structure. The court, however, failed to address the fact that under ERISA Mrs. Shea would not be able to receive punitive or compensatory damages for the death of her husband.

The holding in *Shea* that MCOs have a fiduciary duty to disclose their use of physician incentives under ERISA does not overcome the judicial reluctance to consider claims which attack physician incentives. *Shea* instead held that there is a fiduciary duty to disclose such incentives. The court appeared only to address the hidden nature of such incentives and did not discuss the conflict such incentives create between the physician's duty to care for his/her patient and the physician's own financial interests. Therefore, plaintiffs who allege that physician incentives are the cause of injuries or malpractice will continue to face a judicial environment that is hostile to their claims.

In addition, the holding in *Shea* maintains an ERISA preemption structure which continues to insulate MCOs from compensatory and punitive damages. Under ERISA, plaintiffs who allege that their MCO's financial incentive arrangements caused their injury will only be able to collect equitable damages. The court failed to address that under ERISA, a plaintiff like Mrs. Shea will not be able to collect any damages for the breach of the fiduciary duty to disclose financial incentive arrangements to reduce care.

---

6. See id. at 1833.
8. See discussion infra Part III.B.
10. See id. at 627.
11. See id.
This Note first presents the factual background and procedural history of Shea. Next, this Note analyzes the judicial and legislative reluctance to hold MCOs accountable for the results of their use of financial incentives. This Note then examines: 1) the impact of ERISA preemption on cases like Shea that attack the use of financial incentives to reduce care; 2) the court's solution to the "problem" presented in Shea, holding that there is a fiduciary duty to disclose such incentives under ERISA; and 3) the fact that despite the court's holding, Mrs. Shea cannot receive compensatory damages for the death of her husband. This Note concludes by finding that despite the court's interest in protecting patients from the "hidden nature" of financial incentives, the holding does little to address the larger problems which are implicit in such arrangements.

II. BACKGROUND

Shea v. Esensten12 began as a wrongful death action in Minnesota state court. The plaintiff's husband was an employee of Seagate Technologies, Inc. Seagate provided health care benefits to its employees by contracting with a Health Maintenance Organization (HMO) known as Medica. Medica required Seagate employees to select a primary care physician from its preferred provider list. Mr. Shea selected his family doctor, who happened to be on the list.13

After being hospitalized with severe chest pains during an overseas business trip, Mr. Shea visited his family doctor. During these visits, Mr. Shea informed his physician that he was suffering from chest pains, shortness of breath, muscle tingling, and dizziness. Mr. Shea, who was forty years old at the time, also revealed that his family had an extensive history of heart disease.14 Despite all the warning signs, Mr. Shea's doctor insisted that a referral to a cardiologist was unnecessary. When his condition did not improve, Mr. Shea offered to pay for the cost of the specialist out of his own pocket. Mr. Shea's doctor, however, persuaded him that he was too young and did not have enough symptoms to justify a visit to a cardiologist. A few months later, Mr. Shea died of heart failure.15

Unknown to Mr. Shea, Medica provided financial incentives to its physicians to not refer their patients to specialists. Specifically, physicians under the plan were docked a portion of their pay if they referred too many of their patients to specialists, and were rewarded bonus pay for making fewer referrals.16 In Mrs. Shea's wrongful death action against Medica, she alleged that if her husband had

13. See id. at 627.
14. See id. at 626.
15. See id.
16. See id. at 627.
known that his physician had a financial incentive not to refer him to a specialist, he would have disregarded his physician's advice, and he would have sought the opinion of a cardiologist at his own expense.  

Medica removed Mrs. Shea's claim to federal court, contending that Mrs. Shea's claims were preempted by ERISA. After her motion to remand was denied, Mrs. Shea amended her complaint to allege that Medica's "behind-the-scenes" efforts to use financial incentives to reduce referrals to specialists violated Medica's fiduciary duties under ERISA. The district court dismissed Mrs. Shea's amended complaint for failure to state a claim, finding that the HMO was not required to disclose its physician compensation arrangements because such arrangements are not "material facts affecting the beneficiary's interests."  

The Eighth Circuit reversed the district court's dismissal of Mrs. Shea's case. The court found that: 1) the district court correctly held Mrs. Shea's original state law claim was preempted by ERISA; 2) under ERISA, there is an affirmative duty to disclose material information "which could adversely affect a plan member's interests;" and 3) financial incentives to reduce care are indeed material facts which required disclosure under ERISA's fiduciary provisions.  

The court's finding that Mrs. Shea's state law claims were preempted by ERISA was clearly in keeping with past case law. Such claims are preempted by ERISA because the outcome of such a case would clearly affect how the health plan would be administered. The preemption of Mrs. Shea's state law claims was in line with Congress's intent to ensure the "nationally uniform administration of employee benefit plans."  

The finding that there is an "affirmative" duty to disclose material information, however, represents an extension of an ERISA-qualified plan administrator's fiduciary duties. While the court cited several cases that strongly suggest that there is such a duty, none of the

17. See id.  
18. See id. at 627.  
19. See id. at 627 (citing 29 U.S.C. §§ 1002(21), 1104(a)(1)).  
20. Id. at 627.  
21. Id. at 628.  
22. See id.  
23. See discussion infra Part III.B.  
decisions clearly held there is an "affirmative" duty to disclose under ERISA. Indeed, while these cases hold that a fiduciary under ERISA has a duty not to "lie to" or mislead its beneficiaries, the question of whether there is an "affirmative" duty to disclose remained unanswered. However, the tendency of the courts to rely on the common law of trusts indicates that ERISA fiduciaries do indeed have a fiduciary duty to disclose material information.28

Most significantly, the court's holding that financial incentives to physicians which discourage referrals to specialists are "material facts requiring disclosure," represents the first decision that has expressed genuine concern that such arrangements may compromise patients' interests. Most previous decisions that attack financial incentive arrangements were dismissed because of the clear legislative intent allowing such arrangements to reduce the cost of health care. However, Shea does not hold that such arrangements are in and of themselves illegal, and thus, does not directly conflict with legislative intent. Instead, the court addressed its concerns with the hidden nature of physician incentives by declaring that there is a fiduciary duty to disclose such incentives so that patients can decide whether or not to trust their physician's judgment. A claim alleging that there is a fiduciary duty to disclose represents a new approach to the concerns surrounding the use of financial incentives which reduce care.

III. ANALYSIS OF SHEA V. ESENSTEN

In Shea, the Eighth Circuit attempted to address the hidden nature of financial incentives. Yet, requiring disclosure does not appear to overcome the most significant problem that such arrangements create: financial incentives put physicians in the precarious position of having to choose between their patients' well-being and their own financial well-being.

A. Managed Care Organizations Traditionally Have Not Been Held Accountable for Cost-Containment Mechanisms

MCOs attempt to control the cost of health care by creating financial incentives, such as salary bonus or holdback systems, to reduce

27. In Varity Corp. v. Howe, 516 U.S. 489 (1996), the Court determined that a fiduciary has a duty not to mislead plan members, but noted that because the defendant's actions were intentional, it did not have to decide the issue of whether a fiduciary is under the obligation to affirmatively disclose material facts.
28. See id. at 496-97, 502-03.
29. See id.
30. See discussion infra Part III.A.
patients' utilization of expensive health care services, such as hospitalization, referral to specialists, and diagnostic testing. However, along with the reduced costs of care that result from such incentives comes the fear that incentives will interfere with the provider-patient relationship and corrupt the medical judgment of the provider, ultimately damaging his/her patient's interests. In *Shea*, these fears were realized when the plaintiff's husband died shortly after his physician refused to refer him to a specialist.

The Eighth Circuit was addressing such concerns when it held that MCOs have a fiduciary duty to disclose such incentives. Although no court before *Shea* had examined whether financial incentives used by MCOs must be disclosed, an examination of the case law indicates that courts have generally refused to find MCOs liable for financial incentives that cause physicians to under-treat their patients. This is because such holdings would be in direct conflict with the legislative intent to allow MCOs to reduce the costs of health care.

The California cases of *Wickline v. California* and *Wilson v. Blue Cross* were potential precedent setting decisions for finding MCOs liable for cost containment mechanisms that interfere with a physician's medical judgment. In *Wickline*, the plaintiff alleged that Medi-Cal, California's Medicaid HMO system, implemented a faulty utilization review procedure that caused her to be discharged four days earlier than was recommended by her physician. She alleged that this delay led to the amputation of her leg. The court found that neither the plaintiff's treating physician nor Medi-Cal fell below the legally applicable standard of care. However, the court did state that "third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms..." Nonetheless, the court noted that the physician "cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour."

In *Wilson*, the court sought to clarify the meaning of the dicta in *Wickline*. In *Wilson*, the plaintiffs alleged that their son's suicide was a result of the defendant's utilization review procedures which were followed when their son was released from a psychiatric ward, despite

---

32. See supra note 4.
34. 239 Cal. Rptr. 810 (Ct. App. 1986).
37. See *id*.
38. See *id* at 819-20.
39. *Id* at 819.
40. *Id*.
the treating physician's opinion that the release was premature.\textsuperscript{41} In denying the defendant's motion for summary judgment, the court stated the defendant could be found liable if its utilization review techniques were a substantial factor in the harm caused to the plaintiffs.\textsuperscript{42} As applied to the facts in \textit{Shea}, the defendant would be found liable if Medica's financial incentives to not refer the plaintiff's husband to a specialist was a substantial factor in his death.

The holdings in \textit{Wickline} and \textit{Wilson} set a precedent for examining MCOs' utilization review policies. This precedent could have been used to examine the financial incentives that were used in \textit{Shea} because both utilization review and financial incentives to reduce care are similar in their role as cost-containment mechanisms.\textsuperscript{43} Yet despite the guidance of \textit{Wickline} and \textit{Wilson}, there are few reported cases involving allegations that financial incentives have led to a patient's injury.\textsuperscript{44} The only successful case which seems to follow the precedent is the unreported case of \textit{Bush v. Dake}.\textsuperscript{45} In \textit{Bush}, the plaintiff alleged that the financial incentives\textsuperscript{46} used by the HMO deterred her physician from giving her a timely pap smear, which in turn delayed the detection of her cervical cancer.\textsuperscript{47} The plaintiff contended the HMO's policies provided physicians with financial disincentives to properly treat, refer, and hospitalize patients.\textsuperscript{48} The court found that there was "a genuine issue of material fact presented as to whether [the HMO] in and of itself proximately contributed to the malpractice."\textsuperscript{49} This holding indicates that courts are willing to examine whether the design of specific financial incentives themselves result in liability, but not whether all financial incentives should re-

\begin{itemize}
\item \textsuperscript{41} See Wilson v. Blue Cross, 271 Cal. Rptr. 876, 881-882 (Ct. App. 1990).
\item \textsuperscript{42} Specifically the court held that the test for joint liability for tortious conduct provides:
\begin{quote}
The actors' negligent conduct is a legal cause of harm to another if (a) his conduct is a substantial factor in bringing about the harm, and, (b) there is no rule of law relieving the actor from liability because of the manner in which his negligence has resulted in the harm.
\end{quote}
\textit{Id.} at 883 (quoting \textsc{Restatement (Second) of Torts} § 431 (1965)).
\item \textsuperscript{44} See id.
\item \textsuperscript{46} The HMO would set aside a certain amount of money each year for the network physicians. The money would be depleted with each referral to a specialist or the hospitalization of a patient made during the year. At the end of the year, the remaining money would be divided among the HMO and the network physicians. \textit{See id.} at 720.
\item \textsuperscript{47} See \textit{id.} at 720-21.
\item \textsuperscript{48} See \textit{id.} at 721.
\item \textsuperscript{49} Id.
sult in liability. The case was settled on appeal, and it has no precedential value since it is unpublished.

Courts have generally refused to follow the precedent established in *Wickline* and *Wilson* by considering financial incentives as causative agents of adverse medical outcomes.\(^5\) Legislative policy assumes that such arrangements are a valuable approach for controlling health care costs.\(^5\) The original HMO statute actually encourages the use of financial incentives to reduce costs.\(^5\) Because they are a central part of managed care and legislatures approve of such efforts to reduce costs, courts have consistently refused to question the validity of such incentives.\(^5\) Instead, courts only examine whether or not the proper standard of care was met with respect to a particular patient, and regard the fact that the treating physician could receive a financial benefit as irrelevant.\(^5\)

This conclusion is clearly illustrated in *Pulvers v. Kaiser Foundation Health Plan.*\(^5\) In *Pulvers*, a plan member sued the plan and a participating physician for failure to refer a patient for a biopsy, which the patient alleged would have led to a timely diagnosis of a condition

\(^{50}\) Recently, however, the court in *Hendrich v. Pegraim*, 154 F.2d 362 (7th Cir. 1998), held on a motion for summary judgment "that [physician] incentives can rise to the level of a breach of fiduciary duty under ERISA where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e. where physicians delay administering proper care to plan beneficiaries for the sole purpose of increasing their bonuses)." *Id.* at 373.

\(^{51}\) See Furrow, *supra* note 33, at 467 & n.206 (noting that Medicare and Medicaid beneficiaries are allowed to enroll in HMOs at public expense); see also McClellan *v. Health Maintenance Org.*., 604 A.2d 1053, 1057 n.6 (Pa. Super. Ct. 1992)("The fundamental prerogative and duty of considering and establishing social policy, including, of course, the regulation of health care providers, is vested solely in the legislature."); Rex O'Neal, *Note, Safe Harbor for Health Care Cost Containment*, 43 STAN. L. REV. 399, 400-401 (1991)(noting that no court has found an insurer liable for its efforts to reduce costs because implementing cost containment mechanisms is in "society's economic interests.").

\(^{52}\) See 42 U.S.C. § 300e (1994). The HMO statute provides that HMOs shall "assume full financial risk on a prospective basis for the provision of basic health services, except that [an HMO] may . . . make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals through the institutions." 42 U.S.C. § 300e(c)(2)(D) (1994).


\(^{54}\) See *Madsen v. Park Nicollet Med. Center*, 419 N.W.2d 511, 515 (Minn. Ct. App. 1988)(excluding evidence of financial incentives in a medical malpractice action against an HMO because such evidence would be "only marginally relevant, and potentially very prejudicial"), *rev'd on other grounds*, 431 N.W.2d 855 (Minn. 1988); Sweede v. Cigna Healthplan, No. Civ.A.87C-SE-171-1-CV, 1989 WL 12608, at *6 (Del. Super. Ct. Feb. 2, 1989)(holding that any connection between the HMO financial arrangement and the non-referral decision was too remote to be of any probative value).

\(^{55}\) 160 Cal. Rptr. 392 (Ct. App. 1979).
known as Bowen's disease. The plaintiff alleged that the financial incentives in the plan, which compensated physicians for providing less care, led the plaintiff and his wife to fraudulently believe that they would receive the "best quality" of care and treatment. The court squarely rejected the plaintiff's arguments because the Health Maintenance Act of 1973 specifically requires the use of incentive plans as a means to control health care costs. The court noted that even though the plan encouraged its members to reduce costs through the use of financial incentives, such incentives do not prevent individual physicians from meeting the required standard of care.

Thus, plaintiffs like Mrs. Shea, who find themselves harmed by the use of financial incentives, face a judiciary that has been unwilling to allow any claims that would interfere with the use of financial incentives to lower the cost of health care. However, in Shea, Mrs. Shea did not allege the use of the financial incentives was the cause of her husband's death. Rather, she alleged the nondisclosure of the financial incentives caused her husband's death. Mrs. Shea's attack on Medica's physician incentives represented an issue that had not been addressed by the courts. Namely, whether financial incentives, although legal, must nonetheless be disclosed to the beneficiaries of managed care plans. Unlike claims that allege the use of financial incentives caused the plaintiff's harm, claims which allege nondisclosure arguably do not directly contradict the legislative intent to allow incentives which reduce the cost of health care.

B. The Role of ERISA in Claims that Attack Physician Incentives in Managed Care

In Shea, the Eighth Circuit Court of Appeals upheld the district court's finding that Mrs. Shea's state law wrongful death action was preempted by ERISA. The preemption of Mrs. Shea's claim results in a recovery that is limited to the remedies available under ERISA. Therefore, ERISA creates additional hurdles for plaintiffs like Mrs. Shea who bring claims against MCOs because recovery is limited to equitable damages.

Congress enacted ERISA to protect participants in employee benefit plans, including employee health plans administered by MCOs, by imposing regulatory control on employee benefit programs. Specifically, ERISA seeks to protect employees by requiring reporting and disclosure of plan provisions, and establishing standards for minimum

56. See id. at 394.
57. See id.
vesting, financial responsibility, and fiduciary duties. In addition, ERISA's enforcement provisions and sweeping preemption clauses serve to "eliminate[e] the threat of conflicting or inconsistent state and local regulation of employee benefit plans." This result is squarely in line with the congressional intent to create a national uniform system for the administration of employee benefits. Because up to seventy-five percent of all managed care plans are ERISA qualified, ERISA will continue to play a major role in litigation involving MCOs.

ERISA's civil enforcement provisions and preemption provisions have the combined effect of cutting off remedies for patients who are injured as a result of an MCO's cost-containment mechanisms. This is because courts have consistently held that ERISA displaces direct tort claims against MCOs that administer ERISA qualified health plans. Once MCOs remove such claims to federal court, recovery is limited to equitable damages.

ERISA preemption is particularly important to MCOs because it limits damages to those which are allowed under ERISA's civil enforcement provisions. Damages under ERISA are limited to the recovery of benefits, the enforcement of rights, or the clarifications of future

61. See 29 U.S.C. § 1132 (1994) (civil enforcement provision of ERISA). Under ERISA's civil enforcement provision, an employee benefit plan participant or beneficiary can bring a civil action in federal or state court 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." Id. § 1132(a)(1)(b).
62. See 29 U.S.C. § 1144(a) (1994) (the express preemption clause of ERISA). The preemption clause provides that ERISA's provisions "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Id.
65. See Furrow, supra note 33, at 494.
66. See Kuhl v. Lincoln Nat'l Health Plan, Inc., 999 F.2d 298 (8th Cir. 1993); Corcoran v. United Health Care Inc., 865 F.2d 1321 (6th Cir. 1992)(holding that ERISA preempts actions based on wrongful denial of benefits even though no adequate remedy could be provided).
benefits under the plan.\textsuperscript{68} Claims that seek punitive or compensatory damages are not available under ERISA's civil enforcement provisions.\textsuperscript{69} Plaintiffs whose claims are preempted by ERISA will find that damages normally available in state court will not be available under ERISA. Preemption allows ERISA-qualified MCOs to enact stringent cost-containment mechanisms, such as utilization review and financial incentives, with little exposure to compensatory or punitive damages for the results of such incentives.\textsuperscript{70}

In light of this structure, most MCOs will fall within the protection of ERISA unless they take no part in the administration of the plan. Typically, like the defendant in \textit{Shea}, it is the MCO that administers the employee health benefit plan through benefit determinations and cost-containment mechanisms. To the extent that claims against such an MCO "relate to" the administration of the employee benefit plan, the managed care plan will be insulated from compensatory and punitive damage claims.\textsuperscript{71} It is in the employer's and the MCO's best interests to allow the MCO to administer benefits under the employee health plan. The MCO can reduce its costs by insulating itself from compensatory and punitive damages, which in turn, may lower the employer's costs in providing health care to its employees.

Three ERISA sections deal specifically with preemption. The express preemption clause dictates that any state law is preempted if it relates to any employee benefit plan.\textsuperscript{72} The "savings clause"\textsuperscript{73} excludes from preemption state laws regulating insurance and banking, while the "deemer clause"\textsuperscript{74} provides that an employee benefit plan

\textsuperscript{68} See 29 U.S.C. § 1132 (a)(1)(B) (1994); see also 29 U.S.C. § 1109 (1994)(stating that a fiduciary under ERISA "shall be subject to such other equitable or remedial relief as the court may deem appropriate").

\textsuperscript{69} Courts have consistently held that compensatory damages are not available as appropriate equitable relief under ERISA's civil enforcement provision. See McLeod v. Oregon Lithoprint Inc., 102 F.3d 376, 378 n.2 (9th Cir. 1996), cert. denied, 117 S. Ct. 1823 (1997)(noting that "[a]ll of the circuits which have considered the issue [of whether compensatory damages are available under ERISA] have held that compensatory damages are not available as 'appropriate equitable relief' under [ERISA]'"; see also Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 139-44 (1985)(holding that an ERISA-covered employee could not recover compensatory or punitive damages for financial losses which occurred when the plan mishandled the processing of the employee's claim for disability benefits).

\textsuperscript{70} Managed Care Organizations will still face exposure to claims from beneficiaries whose plans are not covered by ERISA. ERISA does not cover government or church employee benefit plans or plans maintained for the sole purpose of complying with workers' compensation, unemployment compensation, or disability insurance laws. See 29 U.S.C. § 1003(b)(1994).


\textsuperscript{72} See 29 U.S.C. § 1144(a) (1994).

\textsuperscript{73} Id. § 1144(b)(2)(A) (1994).

\textsuperscript{74} Id. § 1144(b)(2)(B) (1994).
shall not be deemed an insurance company or insurer for savings clause purposes.

In light of ERISA's preemption provisions, the United States Supreme Court established that "the language of ERISA's preemption clause sweeps broadly, embracing common law causes of action if they have a connection with or a reference to an ERISA plan."75 Laws that have a "connection with or a reference to such a plan" are deemed to relate to the plan for ERISA preemption purposes.76 Under this analysis, a state law will be preempted under ERISA even if its effect on the plan is incidental to the administration of the plan. ERISA's broad preemption provision has been narrowed by recent cases such as Dukes v. U.S. Healthcare, Inc.77 In Dukes, the Third Circuit created a new rationale for finding that ERISA does not preempt state law claims. The court created a distinction between plan created rights of care and the right to quality care, and found that ERISA would preempt claims for benefits under the plan, but would not preempt actions that challenge the quality of care.78 The court based its holding on the fact that ERISA "simply says nothing about the quality of benefits received."79 Under this new rationale, claims that attack an MCO for the administration of benefits will be preempted, while claims that attack the quality of those benefits will not.

The Supreme Court has also indicated there may be limits to ERISA preemption.80 In Shaw v. Delta Air Lines, Inc.81 the Court stated that state law will not be preempted if "its affect on employee benefit plans [is] too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to the plan'."82 In New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,83 the Supreme Court held that state laws aimed at advancing general state goals, such as assuring the quality of care, may avoid preemption if they do not specifically target or disproportionally burden employee benefit plans.84

The influence of decisions that narrow the scope of ERISA preemption is reflected by the fact many courts refuse to preempt claims against MCOs for the vicarious liability of their physicians, while con-

77. 57 F.3d 350 (3rd Cir. 1995).
78. See id. at 357.
79. Id.
81. Id.
82. Id. at 100 n.21.
84. See id; see also Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825 (1988).
tinuing to preempt claims that allege "direct" negligence in the MCO's administration of benefits. Thus, Mrs. Shea's state law action for wrongful death would not have been preempted had she brought an action for malpractice against the physician for negligence, contending Medica was vicariously liable. However, she brought the claim against Medica only. Therefore, her claim for fraudulent nondisclosure of physician incentives was preempted because the court determined that it "related to" the administration of benefits under the plan.

In *Shea*, the court relied on the reasoning in *Kuhl v. Lincoln National Health Plan, Inc.* for its determination that Mrs. Shea's claim was preempted under ERISA. In *Kuhl*, the plaintiffs alleged that a delay in approval for a surgical procedure resulted in the death of their family member. The court held that claims of misconduct against the administrator of an employee health plan for its financial incentives fit within ERISA's preemption provision. The impact that

85. See *Pacificare, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995). In *Pacificare*, the court held that ERISA did not preempt a claim that the HMO was vicariously liable for alleged medical malpractice of one of its physicians because the claim did not involve administration or quantity of benefits promised by the plan. However, the court held that the claim which alleged fraudulent administration of an employee benefit plan was preempted because it clearly related to the administration of the plan. See also *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3rd Cir. 1995) (allowing vicarious liability claims against MCO for medical malpractice to proceed in state court); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 187 (E.D. Pa. 1994) (holding that while ERISA preempts plaintiff's direct negligence claim against MCO, vicarious liability claim for negligent treatment by plan's physician was not preempted); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983, 988-89 (E.D. Pa. 1990) (holding that medical malpractice type claims brought against HMO under the "ostensible agent theory" are not preempted by ERISA). But see *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1493-94 (7th Cir. 1996) (suggesting in dictum that ERISA's policy of protecting employers' plans from having to comply with differing state regulations should preclude vicarious liability of all kinds); *Corcoran v. U.S. Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (holding that ERISA preempts actions based on wrongful denial of benefits even though no adequate remedy could be provided); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993) (holding that ERISA preempted patient's state tort claim that HMO was vicariously liable for alleged medical malpractice of one of its providers where vicarious liability claim related to the plan); *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61, 63-65 (D. Conn. 1990) (holding that negligent supervision claim against HMO on the theory of vicarious liability was preempted by ERISA).

86. See *Shea v. Esensten*, 107 F.3d 625, 627-28 (8th Cir. 1997), cert. denied, 118 S. Ct. 297 (1997) (citing *Anderson v. Humana, Inc.*, 24 F.3d 889, 891 (7th Cir. 1994) (holding plan participants' attacks on HMO incentive structure were both preempted and removable)); see also *Rodriguez v. Pacificare, Inc.*, 980 F.2d 1014, 1016-17 (5th Cir. 1993) (holding state law claims based on HMO's refusal to provide referral letter were properly preempted and removed).

87. 999 F.2d 298 (8th Cir. 1993).

88. See id. at 302-03.
ERISA's preemption structure has on plaintiffs who bring actions against MCOs is clearly illustrated in the court's holding. Following the reasoning of Kuhl, the court in Shea stated:

The outcome of Mrs. Shea's lawsuit would clearly affect how [the defendant's] ERISA-regulated benefit plan is administered, and if similar cases are brought in state courts across the country, ERISA plan administrators will inevitably be forced to tailor their plan disclosures to meet each state's unique requirements. This result would be at odds with Congress's intent to ensure "the nationally uniform administration of employee benefit plans." 

The issue of whether actions against MCOs for fraudulent nondisclosure of their incentive structures are preempted under ERISA was considered in Lancaster v. Kaiser Foundation Health Plan, Inc. In Lancaster, the plaintiff brought vicarious liability claims against an HMO for its physician's negligence, along with claims alleging fraudulent nondisclosure of its physician incentive program. The court

---

89. Mr. Kuhl was a member of Lincoln National Health Plan, a network model HMO plan. Under the provisions of the plan, Lincoln National was not required to pay for services outside of the HMO's service area. Mr. Kuhl was scheduled to undergo surgery which could not be performed in the Kansas City area, because Kansas City area hospitals did not have the proper equipment. Mr. Kuhl's physicians recommended that the surgery be conducted in St. Louis, which was outside of the HMO's service area. Prior to the scheduled surgery, Lincoln National contacted Mr. Kuhl and informed him the plan would not pay for the surgery because it would take place outside of the HMO's service benefit area. Lincoln National then sought the second opinion of a physician who determined that the surgery was indeed necessary. On July 20, 1989, based on the second opinion, Lincoln National informed Mr. Kuhl that he would be allowed to proceed with the surgery in St. Louis. However, due to the delay, the surgery had to be rescheduled for late September of 1989. Prior to surgery in September, the surgeons determined that surgery was no longer a viable option. Instead, Mr. Kuhl was placed on a heart transplant waiting list, and died before a donor could be located. Mr. Kuhl's family brought medical malpractice, tortious interference, and breach of contract claims against Lincoln National in state court based on the decision not to pre-certify Mr. Kuhl's surgery. Lincoln National removed the case to federal court pursuant to ERISA. The federal court granted Lincoln National's motion for summary judgment determining that the plaintiffs' claims were preempted pursuant to ERISA because the claims "related" to the administration of the health plan. On appeal, the Eighth Circuit affirmed. The court specifically rejected the plaintiffs' argument that Lincoln National assumed the role of Mr. Kuhl's physician and made negligent decisions concerning his care for his heart condition by "canceling" the surgery. Instead, the court held that Lincoln National's decision not to pre-certify payment for the first scheduled surgery in St. Louis "related" directly to its obligation to administer benefits on behalf of Mr. Kuhl's employer, and therefore, was preempted by ERISA. Since damages under ERISA are limited to the recovery of benefits, the enforcement of rights, or clarification of future benefits under the plan, the plaintiffs were left without a remedy. See id. at 304-05.


92. See id. at 1140-41.
found that the vicarious liability claims against the health plan were not preempted because they did not "sufficiently implicate the underlying objectives of the ERISA statute." However, the court did find that the claim against the plan for concealing a system of physician incentives was preempted because such claims "at their core, assert that [the plaintiff] was denied benefits by the administrative decision to establish and implement the [physician] [i]ncentive [p]rogram" and therefore, the claims related to the administration of the plan.

Judicial interpretation of ERISA's preemption and civil enforcement provisions has created a hostile environment for plaintiffs who attempt to sue MCOs for state law actions, such as fraudulent nondisclosure or negligence. These claims will be preempted to the extent that they "relate to" the administration of the employee benefit plan, which in turn, leaves the plaintiff without a remedy because compensatory and punitive damages are not available under ERISA's civil enforcement provisions. On the other hand, if a similar plaintiff claims an HMO is vicariously liable for the negligence of its physician, the vicarious liability claim will not be preempted. Such claims may encourage MCOs to reduce malpractice by restructuring their cost-containment mechanisms so they will not encourage physician malpractice. The more likely result, however, is that MCOs will attempt to minimize their relationship with those who provide care under their plan in order to reduce their exposure to vicarious liability claims. Shea did not involve a claim against Medica for vicarious liability, and the court in turn found Mrs. Shea claim preempted by ERISA. Because claims that attack physician incentives inevitably "relate to" the plan, they are essentially seen by the courts as a denial of benefits and will likely continue to be preempted.

Even if plaintiffs' claims are not preempted by ERISA, claims against MCOs for the operation of physician incentive plans will still face a hostile environment in state court. Courts have generally refused to hold MCOs liable for the use of physician incentives. Typically, courts have refused to accept such claims because legislative policy dictates that they are a legitimate instrument for reducing the costs of health care. The hostile environment has forced plaintiffs like Mrs. Shea to find new strategies to hold MCOs accountable for the results of physician incentives.

In Shea, the district court's finding that Mrs. Shea's tort claims were preempted by ERISA effectively dismissed her state law tort claims. Under ERISA, Mrs. Shea could not collect any compensatory

93. Id. at 1150.
94. Id.
95. See supra note 70.
96. See supra Part III.A.
97. See id.
or punitive damages for the death of her husband because ERISA's
civil enforcement provisions do not allow such claims. Because pre-
emption left Mrs. Shea without a claim, she was forced to amend her
complaint "to assert Medica's behind-the-scenes efforts to reduce cov-
ered referrals violated Medica's fiduciary duties under ERISA." 98

C. Fiduciary Duty to Disclose Physician Incentives Under
ERISA

After the district court found that ERISA preempted Mrs. Shea's
claim for wrongful death, she amended her claim to assert that
Medica's behind-the-scenes financial incentives to reduce referrals to
specialists violated Medica's fiduciary duties under ERISA. 99 "Con-
gress intended the definition of 'fiduciary' under ERISA to be broadly
construed." 100 Under ERISA, "a person is a fiduciary with respect to a
plan to the extent (i) he exercises any discretionary authority or dis-
cretionary control respecting management of such plan or exercises
any authority or control respecting management or disposition of its
assets, . . . or (iii) he has any discretionary authority or discretionary
responsibility in the administration of such plan." 101

This definition of fiduciary implies that "there need not be an ex-
press delegation of fiduciary duty in the [health] [plan instrument it-
self for persons performing duties of a fiduciary nature to be
considered fiduciaries." 102 Therefore, in the context of ERISA, a per-
son is a fiduciary to the extent his/her activities under the plan bring
him/her within the scope of that definition. 103 Under this analysis,
Medica was a fiduciary to the extent that it exercised discretionary
control respecting the management of Mr. Shea's health plan.

In Shea, it was not disputed that Medica was a fiduciary with re-
spect to Mr. Shea's health plan. It was disputed, however, whether
Medica had the responsibility as a fiduciary under ERISA to disclose
the financial incentives it used to discourage physicians from referring

98. Shea v. Esensten, 107 F.3d 625, 627 (8th Cir. 1997), cert. denied, 118 S. Ct. 297
(1997).
99. See id. The court also determined that Mrs. Shea had standing to pursue an
ERISA remedy. Because Mrs. Shea was not a current beneficiary of the plan (her
husband was dead and she was no longer a beneficiary under the plan), Medica
alleged that she lacked standing to pursue an ERISA remedy. The court held
that "if the fiduciary's alleged ERISA violation caused the former employee to
lose plan participant status, the former employee will nonetheless have standing
to challenge the fiduciary violation. . . . Any other result would reward Medica for
giving its preferred doctors an incentive to make more money by delivering
cheaper care to the detriment of patients like Mr. Shea. . . ." Id. at 628 (citations
omitted).
100. Donovan v. Mercer, 747 F.2d 304, 308 (5th Cir. 1984).
103. See Maniace v. Commerce Bank, N.A., 40 F.3d 264, 267-68 (8th Cir. 1994).
patients to specialists. Medica disputed the claim that the duty of loyalty required an ERISA fiduciary to affirmatively disclose material facts that could adversely affect a plan member's interests. Fiduciaries under ERISA have a stringent duty of absolute loyalty and a stringent duty to act in the best interests of plan participants and beneficiaries. The issue of whether this means a fiduciary must "affirmatively" disclose information which might adversely affect a plan beneficiary's interests, however, was not directly addressed by the courts prior to Shea.

In its finding that an ERISA fiduciary has an affirmative duty to disclose material facts, the court in Shea relied on its previous decision in Howe v. Varity Corp. and the Supreme Court's affirmation of that decision. In Varity, a group of active employees and a group of retirees sued their employer, Varity Corporation, for the benefits they would have received had they not been tricked by their employer's plan to rid the company of debt and unwanted employee benefits liabilities. The district court found that the employer had breached its fiduciary duty under ERISA to act solely in the interest of

105. See 29 U.S.C. § 1104(a)(1) (1994). The standard of care for ERISA fiduciaries is defined as follows:
   (i) A fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and —
   (A) for the exclusive purpose of:
   (I) providing benefits to participants and their beneficiaries; and
   (ii) defraying reasonable expenses of administering the plan;
   (B) 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 in the conduct of an enterprise of a like character and with like aims . . . .

Id.

108. In Varity, Varity Corporation and its subsidiary, Massey Ferguson, developed "Project Sunshine," a plan to rid themselves of debt and employee benefits liability by shifting the liability under its health plan to a new subsidiary, Massey Combines. To accomplish the shift, Massey transferred 4,000 of the retirees from the Varity self-insured health plan to the new Massey Combines health plan. Then, through meetings and written materials, it persuaded 1,500 active employees to accept employment and health plan coverage from Massey Combines. Throughout "Project Sunshine," Varity conveyed the message to the active employees that Massey Combines was solid financially, and that their benefits would be identical to the benefits they had under the Varity plan. In reality, Massey Combines' odds for success were minimal, and "Project Sunshine" was nothing more than Varity's attempt to clear its financial statements of health plan liability and other debts. Despite the assurances that Massey Combines was financially sound, it was bankrupt from its inception, with a negative net worth exceeding $46 million. As a result, the company's active employees and retirees were without benefits which included medical coverage. See id. at 492-94.
plan participants and beneficiaries by deliberately deceiving the employees about the security of their benefits.\(^{109}\) The district court also held that the plaintiffs were entitled to equitable relief which included reinstatement of coverage under the plan and monetary damages.\(^{110}\)

In affirming the district court's decision, the Supreme Court specifically rejected Varity's argument that because it complied with ERISA's express disclosure requirements, there was no duty to disclose any additional information. The Court stated, "If the fiduciary duty applied to nothing more than activities already controlled by other specific legal duties, it would serve no purpose."\(^{111}\)

The Court relied on the common law of trusts in finding that Varity Corporation had a fiduciary duty to disclose under ERISA.\(^ {112}\) It noted that under the common law of trusts, "[i]lying is inconsistent with the duty of loyalty owed by all fiduciaries."\(^ {113}\) However, the Court specifically noted the breach in Varity was an affirmative breach because Varity Corporation lied to its employees. It stated that because Varity affirmatively misled the plaintiffs, "we need not reach the question whether ERISA fiduciaries have any fiduciary duty to disclose truthful information on their own initiative, or in response to employee inquiries."\(^ {114}\)

The decision in Varity strongly indicates that ERISA fiduciaries do in fact have an affirmative duty to disclose. Under the common law of trusts, the trustee has 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."\(^ {115}\) As applied to Shea, the fact that a physician has financial incentives not to refer his/her patient to a specialist would seem to be a material fact affecting a patient.\(^ {116}\)

The finding in Shea that there is an affirmative duty to disclose financial incentives to reduce care leaves many open questions about

\(^{109}\) See id. at 494.

\(^{110}\) See id. at 494-95.

\(^{111}\) Id. at 504.

\(^{112}\) See id. at 496 (citing Central States, S.E. & S.W. Areas Pension Fund v. Central Transp., Inc., 472 U.S. 559, 570 (1985)(noting that Congress invoked the common law of trusts to define the general scope of a fiduciary's duties under ERISA)).

\(^{113}\) Id. at 506 (quoting Peoria Union Stock Yards Co. Retirement Plan v. Penn Mut. Life Ins. Co., 698 F.2d 320, 326 (7th Cir. 1983)).

\(^{114}\) Id.


\(^{116}\) In Shea, the court relied heavily on its own finding in Howe v. Varity Corp., 36 F.3d 746, 754 (8th Cir. 1994), that "the duty of loyalty requires an ERISA fiduciary to communicate any material facts which could adversely affect a plan member's interests." Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997), cert. denied, 118 S. Ct. 297 (1997).
the scope of the fiduciary duty to disclose. It is not clear what other sorts of omissions could be found to be material facts that the fiduciary must disclose. For example, does the rule in *Shea* require an MCO to disclose the fact that it may pay its primary care physicians less than other MCOs? An MCO’s pay rates could reflect the quality of physicians it employs, and therefore, be material to the beneficiaries who wish to receive the highest quality of care. The same question arises with respect to an MCO’s procedures for screening its health care providers, the death rates for surgeries under the plan or under specific surgeons, and even to the rotation schedules of its providers.

One way of limiting the holding in *Shea* is to look at the specific problem that the court was addressing. In its holding, the court stated, “From the patient’s point of view, a financial incentive scheme put in place to influence a treating doctor’s referral practices when the patient needs specialized care is certainly a material piece of information. This kind of patient necessarily relies on the doctor’s advice about treatment options, and the patient must know whether the advice is influenced by self-serving financial considerations created by the health insurance provider.” This language indicates the court was specifically addressing the hidden nature of financial incentives and the fact that financial incentives to reduce care are not normally present in the provider/patient relationship.

Given the unique nature of the problem that the court was addressing, the holding in *Shea* could be limited to the disclosure of “unique” facts which are present in the context of managed care. Differing levels of skill and experience, death rates for surgery, and rotation schedules for physicians are all normally present in the provider/patient relationship outside of the context of managed care, and therefore, would probably not have to be disclosed under the rule formulated in *Shea*. The disclosure of financial incentives levels the playing field, and moves patients closer to the position that they would be in if they were not receiving care from an MCO.

Although the court in *Shea* found an affirmative duty to disclose financial incentives under ERISA, a district court recently reached the opposite conclusion in *Weiss v. CIGNA Healthcare, Inc.* In *Weiss*,

---


118. That is not to say that the rule makes managed care entirely similar to traditional fee-for-service arrangement. Patients under managed care will still be subject to other cost-containment measures such as utilization review, limited access to certain medications, and reduced hospital stays. However, these cost-containment measures differ significantly from “direct” financial incentives to reduce care because such procedures are disclosed in plan documents or are highly visible to patients, while financial incentives are not. *See McGraw, supra* note 5.

the plaintiffs\textsuperscript{120} alleged that the defendant violated ERISA by failing to disclose the nature of its financial arrangements with the physicians under the plan and sought declaratory and injunctive relief to disclose the terms of the arrangements. Unlike the holding in \textit{Shea}, the court in \textit{Weiss} refused to extend the fiduciary under ERISA to include the affirmative duty to disclose material information. The court noted the Supreme Court's holding in \textit{Varity} was limited to circumstances where the "fiduciary did not merely fail to disclose information, but in fact provided incorrect or misleading information."\textsuperscript{121} The court relied on the fact that no specific injury was alleged, because the contentions "that physicians will compromise their ethical responsibilities in response to financial incentives—while possibly a valid legislative concern—is too speculative to support a legal claim pursuant to ERISA."\textsuperscript{122}

The \textit{Weiss} court's conclusion that an MCO's use of physician incentives is a legislative, not a judicial issue, is supported by the fact that courts have been unwilling, even outside the context of ERISA, to consider actions against an MCO's use of physician incentives.\textsuperscript{123} Holding that an MCO must disclose its physician incentives, however, is distinguishable from actions which could force an MCO to discontinue the use of incentives. Disclosure does not force an MCO to discontinue or change its physician incentive structure; it merely requires the MCO to inform its customers that such incentives are in place. By holding that such incentives must be disclosed, \textit{Shea} did not contradict the legislative intent to allow such incentives which control the cost of health care. Rather, the court was addressing the fact that patients in managed care are unaware that such incentives are used, and therefore, are unable to make a fully informed decision about whether they can trust their physician's judgment, and if it is necessary, seek a second opinion.\textsuperscript{124} In this context, holding that an MCO must disclose its physician incentive structure arguably does not

\textsuperscript{120} The plaintiffs in \textit{Weiss} were participants in an employee welfare benefit plan, and the defendant, CIGNA Healthcare of New York, was an HMO retained by the plaintiff's employer to provide health care under the plan. See \textit{id}. at 748.

\textsuperscript{121} \textit{id}. at 754.

\textsuperscript{122} \textit{id}. at 755. Indeed, the court went as far as to state that "Weiss' contention that CIGNA's compensation package facially violates ERISA simply because it deprives her of her right to receive 'medical opinions and referrals unsullied by mixed motives' is tantamount to a claim that risk-sharing arrangements in managed care are inherently illegal, a position that is refuted by federal and New York Law." \textit{id}. at 753 (citation omitted). The court also noted that "[t]o the extent that the result here is inconsistent with the decision[.] of the Eighth Circuit Court of Appeals in \textit{Shea} v. \textit{Esensten}, . . . this Court respectfully declines to follow [that] decision[.]" \textit{id}. at 755 n.6 (citation omitted).

\textsuperscript{123} \textit{See supra} Part III.A.

lessen the legislature's goal to contain health care costs through the use of such incentives.

Shea did not address the fact that physicians are also likely to be obligated to disclose the use of financial incentives under the doctrine of informed consent. In Moore v. Regents\(^{125}\) the California Supreme Court held that a physician is required to disclose the presence of a financial conflict of interest. In Moore, the plaintiff sued his physician who used his spleen cells to create a financially lucrative line of cells. The plaintiff alleged the physician failed to disclose his preexisting economic interest in the plaintiff's cells before he obtained consent for the medical procedure that removed the cells.\(^{126}\) The court held that under the doctrine of informed consent, the duty to disclose included personal economic interests that were unrelated to the patient's health because such interests "may affect the physician's professional judgment."\(^{127}\) While the decision did not directly address the financial arrangements used in managed care, the court's holding arguably suggests that under the doctrine of informed consent, financial incentives to reduce care could be considered interests that may affect a physician's medical judgment, and therefore, must be disclosed.

Despite the holding in Moore, it does not appear that physicians are willing to disclose financial incentives which reduce care. A recent report of the Council of Ethical and Judicial Affairs of the American Medical Association (AMA) stated that such "incentives are not inherently unethical, but they can be depending on their design and intensity."\(^{128}\) Instead of advocating disclosure of such incentives as part of the doctrine of informed consent, the AMA recommends that incentives to reduce care should be disclosed by the plan administrator on enrollment and annually thereafter.\(^{129}\) However, by requiring disclosure of the plan, the AMA is ignoring the same problems which the court in Shea failed to address: whether MCOs could disclose the language in a way that is unclear to the consumer.\(^{130}\) Many of the same problems surrounding the use of standard form contracts would exist because most consumers are unable to accurately assess the impact that financial incentives would have on their care. Even if the disclosure language is clear, most enrollees have little choice over what plan they select because it is part of their employee benefits package. Even if consumers do have a choice, they are unlikely to read the plan literature at all.\(^{131}\) Most importantly,

\(^{125}\) 783 P.2d 479 (Cal. 1990).
\(^{126}\) See id. at 482-83.
\(^{127}\) Id. at 483.
\(^{129}\) See id. at 335.
\(^{130}\) See McGraw, supra note 5, at 1839.
\(^{131}\) See id.
both the AMA and the court's holding in *Shea* ignore the fact that despite disclosure by the plan administrator, the fundamental conflict created by financial incentives will still exist. The physician will still be put in the precarious position of having to choose between the medical well-being of his/her patient and his/her own financial well-being.

In addition, plaintiffs who bring actions for failure to disclose financial incentives still face the difficult task of establishing that his/her harm was a result of the failure to disclose such arrangements. Plaintiffs have to establish that they would have taken affirmative steps to find other care. Due to the inherent power differential in the physician-patient relationship, most patients are unlikely to question their physician's judgment even in the face of a disclosure that their physician's income is dependent on reducing the cost of care which they administer.\(^{132}\) Because most medical malpractice actions do not result in verdicts for plaintiffs, disclosure by physicians seems to be an unlikely solution to the problems presented by managed care.\(^{133}\)

### D. Remedy for Breach of Fiduciary Duty to Disclose Under ERISA

*Shea* addressed the fact that patients in MCOs are unaware of physician incentives without disturbing the legislative intent of allowing such incentives to reduce costs. However, the court failed to address that under ERISA, Mrs. Shea probably does not have an adequate remedy for the death of her husband.\(^{134}\) Under ERISA section 409(a)\(^{135}\) and 502(a)\(^{136}\) remedies are expressly limited to equitable damages.

Prior to the *Varity* opinion, it appeared an individual could not sue for breach of fiduciary duty and obtain any appropriate relief under ERISA. In *Massachusetts Mutual Life Insurance Co. v. Russell*,\(^{137}\) the Supreme Court held that ERISA section 409 only authorized relief for the plan as a whole. Therefore, individuals suing an ERISA plan administrator for breach of fiduciary duty apparently could not seek "appropriate equitable relief" for themselves, and could only recover

---

132. See id. at 1844.
134. The court specifically declined to consider any remedy related issues. See id. at 629.
for the plan as a whole. In the holding in *Russell* led a number of courts to conclude an individual could not recover individual relief for breach of fiduciary duty under ERISA. In addition, in *Mertens v. Hewitt Associates* the Supreme Court held that the “appropriate equitable relief” available under section 502 (a)(3) of ERISA included only traditional equitable relief, such as injunctive relief and restitution, and did not include traditional “legal damages” that would allow compensatory or even punitive damages.

In *Varity Corp. v. Howe*, the Supreme Court reversed its tendency to interpret ERISA as providing only limited remedies. For the first time, the Court recognized that a plan participant may recover individual relief for a breach of fiduciary duty under ERISA. In *Varity*, this relief came in the form of reinstating employees to a plan that “but for” the employer’s breach of fiduciary duty, the employees would have never left. In *Varity*, the Court assumed that this was “appropriate equitable relief.” The Court noted, however, that “characterizing a denial of benefits as a breach of fiduciary duty does not necessarily change the standard a court should apply when reviewing the administrator’s decision to deny benefits.” Therefore, courts are likely to continue to limit the type of damages under ERISA to equitable damages only.

In light of the decision in *Varity*, a plaintiff’s ability to recover against an MCO for a breach of fiduciary duty depends on whether such damages can be properly characterized as “appropriate equitable

---


143. See *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993); see also Buckley Dement, Inc. v. Travelers Plan Adm’rs, 39 F.3d 784 (7th Cir. 1994)(no recovery for medical expenses that would have been recovered if plan administrator had not failed to process plaintiff’s claim within the time period covered by the plan).


145. The Court found that the language of section 502 (a)(3) is “broad enough to cover individual relief for breach of a fiduciary obligation.” *Id.* at 510. Therefore, section 409 which only allows relief for the plan as a whole, is not the exclusive means of remedying a breach of fiduciary duty. Section 502(a)(3) acts as a “catch-all” provision allowing appropriate equitable relief for injuries caused by violations of ERISA which might not otherwise be available. *See id.* at 512.

146. *Id.* at 515.

147. *Id.* at 514.
relief." If a plaintiff seeks damages that can be characterized as compensatory or punitive, they will be afforded no relief under ERISA.148

In Macleod v. Oregon Lithoprint, Inc.,149 the court determined compensatory damages were not appropriate equitable relief under ERISA. In Macleod, the plaintiff alleged the defendant breached his fiduciary duty under ERISA by failing to inform her in a timely manner that she had become eligible for coverage under a cancer insurance policy. The plaintiff sought a judgment for the amount of benefits she would have received had she elected coverage under the cancer policy. The court noted the plaintiff's claim "is in essence a negligence claim, for which she seeks to be made whole through an award of money damages equal in amount to the benefits that she would have been paid and compensation for her emotional distress" and the scope of relief available under ERISA is limited to equitable damages.150 The court distinguished its holding from the Supreme Court's holding in Varity by noting that the plaintiffs in Varity were seeking reinstatement into a plan not compensatory relief.151

As applied to the facts in Shea, it does not appear that any damages for the wrongful death of Mrs. Shea's husband could be properly characterized as "appropriate equitable relief" under ERISA. She could not reinstate her husband to the plan because he was already dead. Any monetary recovery that she could receive for Medica's breach of fiduciary duty to disclose its financial incentives can only be characterized as compensatory relief for the death of her husband. An action for breach of fiduciary duty under ERISA will afford Mrs. Shea no appropriate relief for the death of her husband. Therefore, even if she could show that Medica breached its fiduciary duty to disclose, Mrs. Shea's claim would ultimately be dismissed because she has no appropriate remedy under ERISA.

Because it does not appear that compensation for the death of Mrs. Shea's husband can be characterized as "equitable" relief, MCOs will continue to be insulated from individual claims for compensatory and punitive damages in all cases where such claims are preempted by ERISA.152 However, the rule in Shea that MCOs have a fiduciary duty under ERISA to disclose their financial incentives is likely to be effective in cases where the plaintiffs seek only equitable relief. The rule in Shea allows beneficiaries of ERISA-qualified health plans to seek declaratory actions to force their health care providers to disclose their incentive structure to the beneficiaries under the plan.

148. See supra Part III.B.
149. 102 F.3d 376 (9th Cir. 1996).
150. Id. at 378.
151. See id. at 379.
152. See supra Part III.B.
In *Drolet v. Healthsource, Inc.*, a group of health plan beneficiaries brought a class action suit against the HMO alleging that various undisclosed financial incentives the HMO provided to its physicians breached the HMO's fiduciary duties under ERISA. In denying the HMO's motion to dismiss, the court stated that “Drolet's breach of fiduciary duty claims plainly involve the deprivation of her legally protected interest in receiving accurate information from the plan's fiduciaries.” The holding in *Drolet* represents the type of situation in which the holding in *Shea* will be most applicable.

Even though the court in *Shea* failed to address the remedy issues, the holding addressed the most significant problems involving an MCO's use of financial incentives to reduce care, which is the fact that patients are unaware of such incentives. The holding in *Shea* indicates there is a growing judicial concern that such incentives, although approved by Congress, must be disclosed to beneficiaries. As the *Shea* court stated, patients have a right to know whether the care they are receiving is “influenced by self-serving financial considerations created by the health insurance provider” in order to make a fully informed decision whether to trust their physicians' treatment recommendations.

Because Mrs. Shea does not have a remedy for her husband's death under ERISA, the court's holding in *Shea* is in essence a policy decision by the court. In holding that there is a fiduciary duty to disclose the use of financial incentives, the court has dictated that while such incentives are inherently legal, they nonetheless must be disclosed to beneficiaries under ERISA-qualified plans. As applied to plans which are not ERISA qualified, the holding in *Shea*, if followed, dictates that the use of financial incentives in such plans must also be disclosed. Because the fiduciary duty recognized in *Shea* has its foundations in the common law of trusts, the decision should be equally applicable to similar claims, whether or not such claims are preempted. The only difference is that in the cases which are not preempted, plaintiffs like Mrs. Shea will not be precluded from collecting compensatory or punitive damages for their claims for breach of fiduciary duty.

Yet, requiring MCOs to disclose their use of financial incentives will have a minimal effect on the most significant problem surrounding their use. Disclosure does nothing to prevent physicians from considering their own financial interests when treating their patients.

---

154. Id. at 759-60.
156. See supra Part III.B.
158. See supra Part III.D.
Rather, it puts the burden on the consumer to make a decision about whether or not such financial incentives are hindering the quality of care that he/she is receiving from his/her own physician. Health care consumers are usually involuntary consumers who cannot plan their purchases or assess alternatives carefully.\textsuperscript{159} Even if consumers are aware that a plan uses financial incentives which reduce care, they may not be able to properly assess the effect a plan is likely to have on the quality of care they receive.\textsuperscript{160} Most health care consumer knowledge is dependent upon the consumer's relationship with his/her own physician.\textsuperscript{161} In addition, even if a consumer of health care is informed that his/her physician's financial interests are potentially in conflict with his/her medical decisions, the cost of finding a second opinion may be too great because the money is likely to come out of the consumer's own pocket.\textsuperscript{162}

The only way to eliminate the conflict of interest problems which are created by the use of financial incentives is to ban their use or to reduce their strength.\textsuperscript{163} Congress has already restricted the use of such incentives in Medicare risk-contract programs, by not allowing specific incentive payments to individual physicians to reduce care to specific patients.\textsuperscript{164} Such regulations are in direct response to studies finding that pressures on physicians to reduce care was greatest when the incentives are based on the performance of an individual physician rather than a group of physicians.\textsuperscript{165} However, the regulations affecting non-Medicare risk contract programs are not nearly as effective.\textsuperscript{166} These regulations restrict direct incentives to reduce care and limit physicians' salary bonus/withhold payments to 25% of a physician's income, but do not apply to MCOs with more than 25,000 enrollees.\textsuperscript{167} Congress could strengthen these regulations by further limiting incentive payments as a percentage of physician income and by making all MCOs subject to such regulations, regardless of their enrollment numbers. Furthermore, Congress could require that financial incentives must be calculated according to the performance of a sizable group of physicians, rather than to individual physicians. Congress could also require that financial incentives be based on qual-

\textsuperscript{159} See Marc A. Rodwin, Medicine, Money, and Morals: Physicians' Conflicts of Interest 216 (1993).
\textsuperscript{160} See id. at 216-17.
\textsuperscript{161} See id. at 217.
\textsuperscript{162} See id. at 231-33.
\textsuperscript{163} See id.
\textsuperscript{164} See McGraw, supra note 5, at 1833.
\textsuperscript{165} See id. at 1835 (citing U.S. Gen. Accounting Office, GAO/HRD-89-29, Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (1988)).
\textsuperscript{166} See 42 C.F.R. § 417.479 (1997).
\textsuperscript{167} See id.
ity, rather than quantity, of care.\textsuperscript{168} Such regulations would address the most important issue surrounding the use of financial incentives by reducing the chance that physicians will take their financial well-being into account over their patients' medical well-being.

In light of the problems surrounding the disclosure of financial incentives, it appears that the court's holding in \textit{Shea} does little to address the most significant problem that financial incentives create. The holding in \textit{Shea} does not decrease the likelihood that a physician will take into account his/her own economic interests in making medical decisions. \textit{Shea} merely holds that patients should be warned that the plan uses such incentives. Given the inherent difficulties that consumers in the health care context have in assessing the effect that financial incentives will have on the quality of care, requiring disclosure does little to address the problems that financial incentives introduce into the provider-patient relationship.

\section*{IV. CONCLUSION}

The holding in \textit{Shea} represents the limitations of addressing concerns surrounding the use of financial incentives to reduce the costs of health care through the judiciary. The fact that Congress has expressly allowed the use of financial incentives to control the costs of care means that claims attacking their use generally will not be successful. In addition, ERISA preemption creates a mechanism which insulates MCOs from compensatory and punitive damages that would otherwise be available to plaintiffs. The court in \textit{Shea} went out of its way to hold that there is a fiduciary duty under ERISA to disclose the use of financial incentives by first expanding the existing law to find there is an affirmative duty to disclose such incentives and then by finding that Mrs. Shea had a claim for breach of fiduciary duty, despite the fact that such a claim probably will not afford her any remedy for the death of her husband.

Despite the fact that the court went out of its way to create a policy of financial incentives disclosure, such a policy will have a limited effect on the most significant problem surrounding financial incentive use. Even if such incentives are disclosed, the conflict between a physician's financial well-being and his/her patients' well-being will still exist. In addition, this problem is magnified by the fact that health care consumers are typically dependent on their physician as their main source of information in making decisions about the quality of their care. Therefore, the court's holding in \textit{Shea} represents only a limited solution to the problems which are created by the use of financial incentives. Only health care consumers who are capable of prop-

\begin{footnotesize}
\textsuperscript{168} See Council Report, supra note 128, at 335.
\end{footnotesize}
erly evaluating the significance of the disclosure of financial incentives will benefit.

The hurdles facing plaintiffs who attack financial incentives were created by the legislature. Legislative policy ensures that the use of financial incentives to lower the costs of care will not be attacked by the courts, and ensures that plaintiffs who sue ERISA-qualified plans will only be able to receive equitable damages. Because *Shea* represents the judicial limits of addressing the problems surrounding the use of financial incentives, these problems can only be further resolved through fundamental changes in legislative policy.

*Paul Heimann '99*