No. 98-1949

In the Supreme Court of the United States

LORI PEGRAM, M.D., ET AL., PETITIONERS

v.

CYNTHIA HERDRICH

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

Whether respondent, an enrollee in a health maintenance organization (HMO) offered through an employee welfare benefit plan, states a claim of breach of fiduciary duty under the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, by alleging that the HMO has established an incentive arrangement under which a bonus is paid to physicians who (1) provide medical care in a manner that minimizes diagnostic tests and referrals to non-HMO facilities and non-HMO physicians and (2) determine whether disputed and non-routine health insurance claims are covered under the plan.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF THE UNITED STATES

This case presents questions concerning the fiduciary status and duties under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, of a health maintenance organization (HMO) that provides medical care to members enrolled through an employee welfare benefit plan and that maintains incentives for HMO physicians to implement cost-containment measures. The Secretary of Labor has primary responsibility for enforcing and administering Title I of ERISA, including its fiduciary duty provisions. 29 U.S.C. 1002(13), 1136(b). Accordingly, the United States has a substantial interest in the case. The United States has participated in many other ERISA cases in this Court, including cases that have addressed the nature and scope of fiduciary duties under ERISA, such as *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882 (1996); *Varity Corp.* v. *Howe*, 516 U.S. 489 (1996); and *Mertens* v. *Hewitt Associates*, 508 U.S. 248 (1993).

STATEMENT

1. State Farm Insurance Company maintains a Group Medical Health Plan (the State Farm Plan) for its employees, under which eligible employees may choose a group medical insurance plan or, "as an alternative health care choice," a health maintenance organization (HMO). J.A. 101. Respondent Cynthia Herdrich is married to a State Farm employee who enrolled in an HMO, Carle Care HMO, offered under the State Farm Plan. Pet. App. 84a.

The Carle Care HMO is "a product of" petitioner Health Alliance Medical Plans (HAMP), a for-profit Illinois domestic stock insurance corporation. Pet. App. 84a, 93a. HAMP, in turn, is a wholly-owned subsidiary of petitioner Carle Clinic Association, an Illinois professional medical corporation owned by its physician shareholders. HAMP contracts with Carle Clinic to furnish the medical services provided by the HMO. *Id.* at 86a. The net effect of this arrangement is that the physicians who provide care through the HMO are also the owners of the HMO.

2. Respondent sought treatment for abdominal pain from petitioner Laurie Pegram, a Carle Clinic physician, who scheduled her for an ultrasound procedure eight days later at a distant hospital affiliated with the HMO. Pet. App. 2a n.1, 23a-24a. Respondent's appendix ruptured in the interim, resulting in peritonitis. *Id.* at 2a n.1. Respondent then brought a two-count complaint in Illinois state court alleging medical negligence by Pegram and seeking to hold Carle Clinic liable under the doctrine of respondeat superior. *Id.* at 3a, 66a.

Subsequently, respondent amended her state court complaint to add a claim (Count III) against Carle Clinic, alleging that it violated the Illinois Consumer Fraud and Deceptive Business Practices Act, 815 Ill. Comp. Stat. Ann. § 505/1 (West 1999), by failing to advise her of material facts

regarding the ownership of HAMP and by failing to inform her that the compensation of the HMO's physicians was increased to the extent they did not order diagnostic tests, did not utilize facilities not owned by Carle Clinic, and did not make emergency or consultation referrals. Pet. App. 3a & n.2. She also brought a claim against HAMP (Count IV) alleging that by implementing those cost-containment measures, HAMP breached its state-law duty of good faith and fair dealing. *Ibid.*

Petitioners removed the case to federal court, on the ground that Counts III and IV were completely preempted by ERISA. Pet. App. 2a, 3a. The district court thereupon ruled that both counts were preempted and granted summary judgment on Count IV, but it gave respondent leave to amend Count III. *Id.* at 80a.[1]

Respondent then amended Count III to assert the claim now at issue, *i.e.*, that HAMP and Carle Clinic breached fiduciary duties under ERISA.[2] Respondent alleged that petitioners had the exclusive right to decide all disputed and non-routine claims under "the Plan," which she defined as

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[1] The district court ruled that Count IV was preempted and could not properly be amended to state an ERISA claim because respondent sought extra-contractual damages that were not available under ERISA. Pet. App. 67a-68a, 70a-76a. The court also ruled that Count III "relate[d] to" an employee welfare benefit plan, 29 U.S.C. 1144(a), and thus was preempted because it sought to impose additional disclosure requirements on an ERISA plan administrator under state law in addition to those expressly enumerated in ERISA's comprehensive disclosure scheme. Pet. App. 76a-80a. As explained below, when respondent subsequently amended Count III to assert a fiduciary breach claim under ERISA, the amendment did not allege any failure to disclose information.

[2] Respondent also brought her fiduciary breach claim against Carle Health Insurance Management Co., Inc. (CHIMCO), a management entity, which like HAMP is alleged to be a wholly owned subsidiary of Carle Clinic. Pet. App. 84a. CHIMCO is not a petitioner in this Court.

the Carle Care HMO,[3] and exercised discretionary control of claims management, property management, and administration of "the Plan." Pet. App. 85a.

On the basis of those factual allegations, respondent asserted that petitioners breached fiduciary duties under Section 404 of ERISA, 29 U.S.C. 1104, because Carle Clinic physicians receive a year-end distribution paid out of "supplemental medical expense payments" that HAMP and CHIMCO pay to Carle Clinic based on contractual provisions requiring the physicians to minimize the use of diagnostic tests, of facilities not owned by Carle Clinic, and of referrals to "non-contracted" physicians. Pet. App. 85a-86a. Respondent also asserted that petitioners sought to fund the year-end payments by "administering disputed and non-routine health insurance claims," and determining, *e.g.*, "which claims are covered under the Plan and to what extent" and "what the applicable standard of care is." *Id.* at 86a. Respondent alleged that "the Plan" had been wrongfully deprived of amounts comprising the supplemental medical expense payments made by HAMP and CHIMCO to Carle Clinic and sought an order requiring reimbursement by Carle Clinic of the supplemental medical expense payments received from HAMP and CHIMCO as well as such other equitable relief as the court deemed just. *Id.* at 87a.

Petitioners moved to dismiss amended Count III under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted. The district court granted the motion on the ground that respondent had "fail[ed] to identify how any of the [petitioners] is involved as a fiduciary to the Plan." Pet. App. 63a (magistrate's report); see *id.* at 59a-60a (adopting magistrate's report). Respondent's state-law medical malpractice claims were

[3] As we explain below, pp. 9-11, *infra*, respondent's use of the term "plan" to refer to the HMO differs from the term's meaning under ERISA.

then tried to a jury, which rendered a $35,000 verdict in her favor. *Id.* at 6a, 81a-82a. After entry of final judgment, respondent appealed the dismissal of her ERISA fiduciary breach claim.

3. a. A divided panel of the court of appeals reversed. Pet. App. 1a-38a. The panel majority held that respondent had adequately alleged that petitioners were fiduciaries. *Id.* at 11a-15a. Noting that the complaint alleges that petitioners "have the exclusive right to decide all disputed and non-routine claims under the plan," the court concluded that "this level of control satisfies ERISA's requirement that a fiduciary maintain 'discretionary control and authority.'" *Id.* at 14a (emphasis omitted).

The panel majority also held that respondent's allegations, if accepted as true, were sufficient to demonstrate that petitioners breached their fiduciary duty because they acted in their own interest, rather than "with an eye single to the interests of the [plan's] participants and beneficiaries." Pet. App. 16a (quoting *Donovan* v. *Bierwirth*, 680 F.2d 263, 271 (2d Cir.), cert. denied, 459 U.S. 1069 (1982)). The court noted that the complaint alleged that the plan "dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings," thus creating the incentive for them to limit treatment to ensure a larger bonus. *Id.* at 18a-19a (emphasis omitted).

The majority stated that it was not adopting a per se rule "that the existence of incentives *automatically* gives rise to a breach of fiduciary duty," but only that such "incentives *can* rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists." Pet. App. 20a. Addressing the dissent's view that imposition of incentives to limit care should con-

stitute a fiduciary breach only when there is a "serious flaw" in the manner in which the incentive arrangement is established, the majority concluded that there was such a flaw in that the "physician/owners of Carle * * * simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals." *Id.* at 21a (emphasis omitted). The majority referred to the treatment of respondent's appendicitis as an example of the effects of the incentive scheme, *id.* at 24a, 32a-33a, and expounded its view that managed care is having a deleterious effect on the quality of health care in this country, *id.* at 24a-33a.

Finally, the majority concluded that respondent alleged a loss to the plan attributable to the petitioners' alleged breach, in that the plan was deprived of the amounts paid as incentives. Pet. App. 38a. Accordingly, the majority concluded that respondent had alleged the requisite elements of a claim for fiduciary breach under ERISA.

b. Judge Flaum dissented. Pet. App. 38a-47a. In his view, respondent's allegations about the structural incentives for cost containment did not in themselves make out a case of fiduciary breach, because ERISA tolerates some conflict of interest on the part of ERISA fiduciaries, as by permitting the employer or plan sponsor's officer or employee to serve as fiduciary. *Id.* at 40a. The mere existence of such incentives was not enough, in his view, to establish a fiduciary breach because market forces protect the interests of beneficiaries by making it unlikely that the HMO would wish to alienate the employer-sponsor by maintaining an unduly restrictive approach to coverage. *Id.* at 40a-42a. Moreover, Judge Flaum stated his concern that the majority's decision would lead to "untethered judicial assessments of permissible incentive levels in health care plans." *Id.* at 44a.

4. The court of appeals denied rehearing en banc. Pet. App. 48a-49a. Judge Easterbrook, joined by three other

judges, filed an opinion dissenting from the denial of rehearing. *Id.* at 49a-58a. Judge Easterbrook concluded that Carle Care's decision to establish one set of cost-saving incentives rather than another is not an exercise of discretion in the administration of the employee benefit plan, but rather is an exercise of discretion by Carle Care in providing medical services. *Id.* at 52a-53a. He deemed respondent's complaint to allege that the benefit offered by State Farm to its employees was the Carle Care HMO, in which petitioners are acting as suppliers of a service to the plan, not plan fiduciaries. *Id.* at 56a. Judge Easterbrook also stated that in his view the majority's rule was "impossible to cabin, for the plan attacked in this case is an ordinary HMO." *Id.* at 56a.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, "was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans,' * * * and 'to protect contractually defined benefits.'" *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989). The statute thus does not "requir[e] employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans, * * * as by imposing reporting and disclosure mandates, * * * participation and vesting requirements, * * * funding standards, * * * and fiduciary responsibilities for plan administrators." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 651 (1995). Among the various duties that ERISA imposes on fiduciaries of employee benefit plans is a duty of loyalty, under which a "fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. 1104(a)(1); see also 29 U.S.C. 1104(a)(1)(A)(i).

The court of appeals held that respondent stated a claim of breach of the duty of loyalty owed by a fiduciary by alleging that petitioners provided profit-based financial incentives for HMO physicians. Liberally read, as they must be in the context of a motion to dismiss for failure to state a claim, *Conley* v. *Gibson*, 355 U.S. 41 (1957), respondent's allegations challenge a bonus ("year-end distribution") allegedly paid by petitioner HAMP to Carle Clinic physicians that is "fund[ed]" by profits derived from two types of conduct. Pet. App. 86a. The first type is the provision of medical services by "owner/physicians" who allegedly "minimize the use of diagnostic tests," "minimize the use of facilities not owned by Carle," and "minimize the use of emergency and non-emergency consultation and/or referrals" to non-HMO physicians. *Ibid.* The second type is "administering disputed and non-routine health insurance claims." *Ibid.*

The first of these allegations—the "treatment" allegations—fails to state a claim because it does not allege conduct by petitioners in their capacity as ERISA fiduciaries. An HMO acts as a medical care provider, rather than an ERISA fiduciary, when it establishes and implements an arrangement for paying its physicians to treat their patients, even if the arrangement includes incentives for using less costly treatment regimens. If the court of appeals were correct that the law of fiduciary duty under ERISA governed the treatment of patients by HMO doctors, then traditional state regulation of the practice of medicine—along with traditional state-law malpractice and professional licensing regulations—would necessarily be preempted insofar as they applied to ERISA plans. In *Travelers* and subsequent cases, this Court has rejected that overly expansive view of ERISA's scope, and it should do so again here.

By contrast, the activities involved in the second set of allegations—the "administration" allegations—may involve conduct by petitioners as ERISA fiduciaries, because an

entity such as an HMO that exercises discretion in determining whether claims for specific benefits are covered by an ERISA plan is an ERISA fiduciary. Respondent, however, has alleged only that petitioners generate income by performing their roles as fiduciaries under ERISA. That allegation is insufficient to state a claim of breach of fiduciary duty under ERISA, because fiduciaries under ERISA are expected to be compensated for the performance of their duties. Cf. 29 U.S.C. 1108(c). Indeed, even if the complaint could be read to include an allegation that petitioners employ a profit-based system that permits those who assist in claims administration to share in the petitioners' general profits, it would still fail to state a claim of breach of fiduciary duty under ERISA. Unlike an incentive scheme in which claims administrators are directly paid for denying (but not for allowing) claims, a general profit-based compensation arrangement does not in itself conflict with the duties owed by fiduciaries under ERISA. Because none of respondent's allegations therefore states a claim of breach of fiduciary duty under ERISA, the decision of the court of appeals should be reversed.

ARGUMENT

A. An HMO Is Not Itself An ERISA Plan, Although It May Function At Various Times As The Provider Of Medical Services To Such A Plan Or As Administrator, And Therefore Fiduciary, Of Such A Plan

1. In order to determine whether an entity acts as an ERISA fiduciary, it is critical to distinguish between the ERISA plan itself (the administration of which by either the plan sponsor or an outside entity confers fiduciary status on an individual or other entity) and a provider of services to the plan (usually an independent entity not subject to ERISA's fiduciary duty standards). ERISA defines an "employee welfare benefit plan" as "any plan, fund, or

program * * * established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * medical, surgical, or hospital care or benefits" or other benefits. 29 U.S.C. 1002(1). Based on that definition, the essentials of a plan have been interpreted to be the existence of "intended benefits, a class of beneficiaries, [a] source of financing, and procedures for receiving benefits." *Donovan* v. *Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982); accord *Grimo* v. *Blue Cross/Blue Shield*, 34 F.3d 148, 151 (2d Cir. 1994); *Kenney* v. *Roland Parson Contracting Corp.*, 28 F.3d 1254, 1257-1258 (D.C. Cir. 1994) (collecting cases).

2. In this case, the ERISA plan was the arrangement by which State Farm Insurance, respondent's husband's employer, undertook to provide medical care benefits to eligible employees and their families. See J.A. 51-52, 101 (Summary Plan Description of State Farm Group Medical Health Plan, which includes a group medical insurance option and HMO options). As to employees who opt for the Carle Care HMO option, the plan consists of the documents governing State Farm's purchase from HAMP of memberships in the HMO, and the "intended benefit[]," *Dillingham*, 688 F.2d at 1373, under the ERISA plan is coverage for the specific kinds of medical care and treatment specified in the subscription agreement between State Farm and the HMO, Pet. App. 89a-128a. That care in turn is provided by the doctors employed by the HMO. The HMO and its parent entities are thus service providers to the ERISA plan; they are not themselves ERISA plans.

3. Because the HMO and its parent entities are not themselves ERISA plans, not all the acts that constitute management of the HMO are acts that constitute administration of an ERISA plan, to which ERISA fiduciary duties may

attach.[4] To the contrary, in determining whether an HMO is acting as a fiduciary, two major roles in which an HMO typically acts must be distinguished. An HMO typically performs (at least) two distinct functions in the context of an employee welfare benefit plan—providing medical services to beneficiaries and administering certain aspects of the plan. See, *e.g.*, *In re U.S. Healthcare, Inc.*, No. 98-5222, 1999 WL 728474, at *8 (3d Cir. Sept. 16, 1999); *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir.), cert. denied, 516 U.S. 1009 (1995).[5] Those functions lead to differing conclusions regarding an HMO's status as an ERISA fiduciary.

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[4] Because the HMO is not the ERISA plan, the court of appeals erred in suggesting, Pet. App. 16a, 36a, that petitioners here had control over the assets of an employee welfare benefit plan. State Farm and its employees paid a premium to HAMP for subscription in the HMO, J.A. 103; there is therefore apparently no underlying trust funding the ERISA plan. The assets referred to in the complaint belong either to HAMP or Carle Clinic, not to an ERISA plan. The allegation that HAMP made supplemental payments to Carle Clinic, which in turn funded payments to physicians, therefore states nothing more than that HAMP used its own funds as a business entity for that purpose.

It also follows that respondent's allegation (Pet. App. 87a) that "the Plan" has been deprived of the "supplemental medical expense payments," and her corresponding request that petitioners therefore should make reimbursement (presumably to "the Plan") for those expenses, make no sense in ERISA terms. The year-end payments were not plan assets in the first place, and their return to the HMO would not constitute reimbursement to an ERISA plan. Respondent also has sought "such other equitable relief as th[e] court deems just." *Id.* at 87a. If she were to establish that the incentive arrangement was incompatible with ERISA's fiduciary duty provisions, she could obtain a prospective injunction against the arrangement insofar as it affected ERISA plan participants. In addition, to the extent she was adversely affected by the incentive arrangement, she could obtain individual equitable relief, such as the disgorgement of the fiduciary's profits obtained by the breach committed as to her. *Varity Corp.* v. *Howe*, 516 U.S. 489, 507 (1996); *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 260 (1993).

[5] An HMO also acts as insurer to the extent that it bears risk. See generally *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 227 n.34 (1979) (noting that "certain aspects" of advance-payment medical-

a. Insofar as an HMO is a provider of medical services, it is no more subject to ERISA fiduciary duty standards than is any other provider of services to an ERISA plan. Under ERISA, a person is a fiduciary if "he exercises any discretionary authority or discretionary control respecting management of [an ERISA] plan * * * or control respecting management or disposition of its assets," if "he renders investment advice * * * with respect to any moneys or other property of such plan," or if "he has any discretionary authority or discretionary responsibility in the administration of [the ERISA] plan." 29 U.S.C. 1002(21)(A). A provider of medical treatment to a patient does not fall within any of those categories. Accordingly, an HMO, in its role as provider of medical treatment to patients who are beneficiaries of ERISA plans, is not an ERISA fiduciary.[6]

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benefits plans may be the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012). See also *Washington Physicians Serv. Ass'n* v. *Gregoire*, 147 F.3d 1039, 1045, 1046 (9th Cir. 1998), cert. denied, 119 S. Ct. 1033 (1999); *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994). But see *Texas Pharmacy Ass'n* v. *Prudential Ins. Co.*, 105 F.3d 1035, 1038-1039 (5th Cir.), cert. denied, 522 U.S. 820 (1997).

[6] In some cases, a treating physician in an HMO could exercise administrative duties that are clearly distinct from his treatment responsibilities and that therefore potentially subject him to ERISA fiduciary standards when he is exercising those administrative duties. For example, it is possible that a physician who believes that a particular treatment is medically advisable for a patient has the discretionary administrative responsibility within an HMO for determining whether a claim for such treatment is covered by the ERISA plan. Even if a treating physician may in some circumstances occupy such a dual role, however, that dual role would not be triggered merely because the standards that govern the physician's ordinary treatment decisions—medical necessity, the existence of an emergency, etc.—are also the standards governing the HMO's obligation to provide or pay for care for the patient. Otherwise, every treating physician would automatically become an ERISA fiduciary whenever the physician makes a medical judgment about the appropriate care for a patient. Respondent in this case did not allege that any particular circumstances that would trigger such a dual role existed in this case. Therefore, the question whether and to what extent a physician may

Were it otherwise, ERISA would threaten to carve out an enormous hole in traditional state regulation of the practice of medicine and other analogous professions. For if ERISA fiduciary duty obligations governed HMOs in their capacity as providers of medical treatment to patients covered by ERISA plans (as opposed to their capacity as claims administrators, for example), then state laws that govern the same thing—the practice of medicine by HMOs—would necessarily "relate to" ERISA plans and would be preempted under Section 514(a) of ERISA, 29 U.S.C. 1144(a). Indeed, the clearest cases of preemption under ERISA occur when a state law attempts to impose standards on an entity that differ from those imposed by ERISA. See, *e.g.*, *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997) (holding state community property law preempted because it "conflicts with the provisions of ERISA or operates to frustrate its objects"); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990) (state-law cause of action for wrongful discharge to avoid pension obligation "conflicts directly" with ERISA causes of action and is therefore preempted).[7] The courts of appeals, however, have correctly held that state laws governing the practice of medicine by HMOs are not preempted by ERISA.[8] As this Court explained in *De Buono* v. *NYSA-*

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occupy a dual role as treating physician and administrator of an ERISA plan is not presently before the Court.

[7] See also *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 10 (1987) ("We have not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements."); *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (state law that "eliminates one method for calculating pension benefits * * * that is permitted by federal law" is preempted).

[8] See *Pacificare of Okla., Inc.* v. *Burrage*, 59 F.3d 151, 154-155 (10th Cir. 1995) (ERISA Section 514(a) does not preempt state-law action seeking to impose vicarious liability on HMO for malpractice of HMO physician); cf. *U.S. Healthcare, Inc.*, 1999 WL 728474, at *8-*9 (state-law

ILA Medical & Clinical Services Fund, 520 U.S. 806, 814 & n.10 (1997), the fact that a state law is a "regulation of matters of health and safety" "supports the application of the 'starting presumption' against pre-emption."

Moreover, if the provision of medical treatment to patients by an HMO were governed by ERISA fiduciary obligations, a single HMO doctor would be subject to ERISA fiduciary obligations in treating members of the HMO who are ERISA beneficiaries and differing state-law obligations in treating other members of the same HMO. Similarly, HMO physicians who treat ERISA beneficiaries would be subject to fiduciary obligations, while physicians who treat ERISA beneficiaries under a traditional fee-for-service health insurance system would be subject to the quite distinct obligations imposed by state law. Indeed, respondent's own ability to pursue her state-law malpractice claim against Dr. Pegram and against Carle Clinic as Dr. Pegram's employer—as she successfully did in the district court in this case, see Pet. App. 81a—would be open to serious question. "There is not so much as a hint * * * that Congress intended to squelch * * * state efforts" to regulate the practice of medicine when it included fiduciary duty provisions in ERISA. *Travelers*, 514 U.S. at 665.

b. The fact that an HMO does not act as an ERISA fiduciary when it provides medical treatment to patients, however, does not mean that an HMO *never* acts as an ERISA fiduciary. This Court explained in *Varity Corp.* v. *Howe*, 516 U.S. 489 (1996), that a "'person is a fiduciary with respect to a plan,' and therefore subject to ERISA fiduciary

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claims against HMO for direct negligence and vicarious liability are not subject to complete preemption doctrine under ERISA); *Rice* v. *Panchal*, 65 F.3d 637, 646 (7th Cir. 1995) (vicarious claims not completely preempted); *Dukes*, 57 F.3d at 356 (vicarious and direct claims not completely preempted); *Lupo* v. *Human Affairs Int'l, Inc.*, 28 F.3d 269, 272 (2d Cir. 1994) (vicarious claims not completely preempted).

duties, '*to the extent*' that he or she 'exercises any discretionary authority or discretionary control respecting management' of the plan, or 'has any discretionary authority or discretionary responsibility in the administration' of the plan." *Id.* at 498 (quoting 29 U.S.C. 1002(21)(A) (emphasis added)). In *Varity*, for example, since "obviously, not all of [the employer's] business activities involved plan management or administration," the Court had to determine whether the employer was "wearing its 'fiduciary' * * * hat" when it made the particular representations that were alleged to constitute a fiduciary breach. 516 U.S. at 498. See also *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 887 (1996).

Varity, *Hughes*, and *Lockheed* establish that an entity may become an ERISA fiduciary when it performs particular functions, even if it acts as an independent entity subject to state law (such as a provider of medical services to an ERISA plan and ERISA beneficiaries) in many other of its activities. In particular, insofar as an HMO exercises "discretionary authority or discretionary responsibility in the administration of [the plan]," it takes on fiduciary status under ERISA. 29 U.S.C. 1002(21)(A). Activities that constitute "administration of [the plan]" include "determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records * * * to comply with applicable reporting requirements." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987). In the context of an HMO, the relevant administrative functions frequently performed by an HMO consist of determining eligibility under the ERISA plan, determining whether a particular treatment is covered by the plan, sending required notices and filing reports, and keeping necessary records. An HMO is an ERISA fiduciary only when and

insofar as it exercises discretionary control over those activities.[9]

4. Because an HMO frequently combines under one roof non-fiduciary functions (such as the provision of medical treatment) and fiduciary functions (such as the determination of whether particular medical services are an "intended benefit" under the ERISA plan), it sometimes can be difficult at the margins to sort out when an HMO is acting as an ERISA fiduciary and when it is not. In this case, in determining whether respondent's complaint has alleged a breach of fiduciary duty under ERISA, it is necessary to examine carefully the allegations of respondent's complaint, in order to determine whether they allege conduct by petitioners in their capacity as providers of medical services to the ERISA plan and its beneficiaries, or in their capacity as ERISA fiduciaries.

B. Petitioners Were Not Acting As Fiduciaries Under The "Treatment" Allegations Of The Complaint, Because They Allege Only Conduct That Petitioners Undertook As Providers Of Medical Services

1. The "treatment" allegations of the complaint in this case—referring to the year-end payments to physicians who minimize the use of diagnostic tests and the referral of patients to outside facilities and physicians—concern only the way in which the HMO performs the medical services it is contractually obligated to perform for the ERISA plan and its beneficiaries. They relate to the medical treatment that

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[9] It is of course possible that a particular action can constitute both administration of an ERISA plan and conduct that the State can regulate insofar as it affects outside parties. Cf. *Lordmann Enters., Inc.* v. *Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994), cert. denied, 516 U.S. 930 (1995) (no preemption where health care provider—not plan beneficiary—brings claim of negligent misrepresentation against ERISA plan administrator based on faulty provision of information to health care provider about coverage of the plan).

HMO physicians provide to their patients, and the way in which HMO physicians are reimbursed for providing such treatment. The court of appeals therefore erred in holding that either the HMO or its parent entities were acting in a fiduciary capacity under the "treatment" allegations of the complaint.

2. There could be no basis to argue that, although the HMO's medical treatment of patients is governed not by ERISA but by state law, the HMO's decisions regarding how to compensate its physicians who treat patients are subject to ERISA's fiduciary duty standards. See *U.S. Healthcare*, 1999 WL 728474, at *10 (HMO acted in capacity of "providing and arranging medical services" when it adopted policies that encourage physicians to implement hospital discharge and admittance policies); *Dukes*, 57 F.3d at 353, 360-361 (state-law claim that HMO was negligent in its "selection, employment, and *oversight* of the medical personnel who performed the actual medical treatment" relates to HMO's role as arranger of medical care, and not to HMO's ERISA administration function) (emphasis added). The permissible scope of a State's regulation of medical care clearly extends beyond the direct regulation of the quality of treatment provided by a doctor to a patient and includes as well the means of compensation by which a doctor may be reimbursed for providing care to patients.[10] Cf. *De Buono*, 520 U.S. at 814 & n.10 (traditional state "regulation of matters of health and safety" includes taxation of hospitals). As noted above, if ERISA fiduciary standards govern the

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[10] Cf., *e.g.*, American Medical Ass'n, Council on Ethical and Judicial Affairs, *Code of Medical Ethics* § 8.05, at 128 (1998-1999 ed.) (provisions of medical ethics code governing "contractual relationships that physicians assume when they join or affiliate with group practices or agree to provide services to the patients of an insurance plan"); *id.* § 8.051, at 129 (rules regarding "conflict of interest under capitation" schemes of "[m]anaged care organizations").

compensation arrangements for doctors who treat ERISA patients, then state laws that regulate the same subject matter would be preempted. It would be perverse to argue that state law may govern the quality of medical care provided by HMO physicians to their patients, but it cannot govern the compensation arrangements under which such physicians are reimbursed and which the State may find affect the treatment decisions made by physicians.[11]

Indeed, if the HMO's business decisions, such as how to compensate physicians for their treatment of patients, were subject to ERISA fiduciary duty provisions, it is difficult to understand how the HMO could function as a business entity. As a business entity, HAMP has a financial incentive to arrange for medical care at the least expense to itself; that interest would conflict with its duty as a fiduciary to act solely in the interests of the participants and beneficiaries under ERISA Section 404(a)(1)(A), 29 U.S.C. 1104(a)(1)(A). In determining how to compensate its doctors, HAMP would thus be required to forgo consideration of costs, so that it could act solely in the participants' interests. *Ibid.* There is nothing in ERISA that suggests that Congress intended to place that kind of restraint on an HMO's business activities.

Furthermore, if ERISA's fiduciary duty provisions were generally applicable to an HMO's compensation of its physi-

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[11] Many States have enacted legislation limiting incentive payments that may be made to physicians. See, *e.g.*, Alaska Stat. § 21.86.150(i)(4) (Michie 1998); Cal. Health & Safety Code § 1348.6 (West Supp. 1999); Ga. Code Ann. § 33-20A-6 (Supp. 1999); Idaho Code § 41-3928 (1998); Kan. Stat. Ann. § 40-4605 (Supp. 1998); La. Rev. Stat. Ann. § 22:215.19 (West Supp. 1999); Md. Code Ann. Ins. § 15-113(c) (1997); Minn. Stat. § 72A.20 Subd. 33 (1999); Mo. Rev. Stat. § 354.606(9) (Supp. 1999); Mont. Code Ann. § 33-36-204(2) (1997); Neb. Rev. Stat. § 44-7106(2)(h) (Supp. 1998); Nev. Rev. Stat. § 695G.260 (1998); Ohio Rev. Code Ann. § 1751.13(D)(1)(a) (Anderson Supp. 1998); 40 Pa. Cons. Stat. Ann. § 991.2112 (West Supp. 1999); R.I. Gen. Laws § 23-17.13-3(B)(8) (1996); Tex. Ins. Code Ann. § 3.70-3C(7)(d) (West Supp. 1999).

cians for treating ERISA beneficiaries, it would have been unnecessary for Congress to have amended ERISA specifically to address the question of incentives for the containment of medical treatment, as it has done in certain specific areas. In 1996, Congress enacted the Newborns' and Mothers' Health Protection Act, Pub. L. No. 104-204, § 603, 110 Stat. 2935, which amended ERISA to prohibit any "group health plan" or "health insurance issuer offering group health insurance coverage in connection with a group health plan" from offering incentives to an attending medical provider to provide care inconsistent with the statutorily specified two-day or four-day minimum length of hospital stay for a mother and newborn child. 29 U.S.C. 1185(b)(4) (Supp. III 1997). Significantly, a "group health plan" subject to the Act is essentially defined as an ERISA plan "providing medical care," 29 U.S.C. 1191b(a)(1) (Supp. III 1997), while a "health insurance issuer" is separately defined as "an insurance company, insurance service, or insurance organization (including a health maintenance organization * * *)," 29 U.S.C. 1191b(b)(2) (Supp. III 1997). In addition, in 1998, Congress passed the Women's Health and Cancer Rights Act, Pub. L. No. 105-277, § 902(a), 112 Stat. 2681-437 (to be codified at 29 U.S.C. 1185b(c)(2)), which similarly prohibits any "group health plan" or "health insurance issuer" from providing incentives to induce any provider to provide care in a manner inconsistent with its requirements.[12] Congress's adoption of those provisions expressly prohibiting health insurance carriers and HMOs that cover ERISA health plans from employing certain types of incentives for the containment of medical costs indicates that

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[12] The requirements generally provide that a group health plan that offers coverage for a mastectomy shall also provide full coverage for breast reconstruction surgery. § 902(a), 112 Stat. 2681-436 (to be codified at 29 U.S.C. 1185b(a)).

ERISA's general fiduciary duty provisions were not intended to govern that conduct.[13]

C. The "Administration" Allegations Of The Complaint Do State A Claim That Petitioners Were Acting In A Fiduciary Capacity, But They Allege Conduct That Does Not, As A Matter Of Law, Violate Any Fiduciary Duty Under ERISA

1. In addition to alleging that financial incentives exist for physicians to minimize diagnostic tests and certain referrals in the course of providing medical care, respondent's complaint alleges that petitioners maintain a compensation scheme in which a financial incentive exists for determining claims. Although the complaint is not a model of clarity, respondent appears to allege that Carle Care physicians receive year-end payments that are funded by having physicians "determin[e] * * * which claims are covered under the Plan and to what extent," including, for example, determining "whether a course of treatment is experimental" or a "medical condition is an emergency." Pet. App. 86a. Those allegations could encompass a situation in which a Carle Care physician has discretionary authority to determine a question of coverage under the plan, as for example by

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[13] Under provisions of the Social Security Act permitting Medicare recipients to obtain benefits through enrollment in HMOs, specific restrictions apply to physician incentive payments that may be made by such HMOs. See, *e.g.*, 42 U.S.C. 1395w- 22(j)(4) (Supp. III 1997) (HMO may not make a "specific payment * * * to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the [HMO]"). See also 42 U.S.C. 1396b(m)(2)(A)(x) (Supp. III 1997) (applying same rules to Medicaid); 42 C.F.R. 422.208 (implementing Medicare regulation); 42 C.F.R 434.70(a)(2) (implementing Medicaid regulation). A health care reform bill recently passed by the House of Representatives, see pp. 25-26, *infra*, would apply virtually the same restrictions to all group health plans and health insurers. See H.R. 2990, 106th Cong., 1st Sess. § 1133 (1999). See 145 Cong. Rec. H9523-01 (daily ed. Oct. 7, 1999).

resolving a grievance challenging a Carle Care decision not to pay for care that a beneficiary had already received at a non-Carle Care facility, on the ground that the episode had not been an emergency. See *id.* at 107a, 125a.[14] Insofar as the complaint could be read to allege discretionary conduct in claims administration, it alleges conduct by petitioners in their capacity as ERISA fiduciaries.

In a long and consistent line of decisions under ERISA's preemption provision, 29 U.S.C. 1144, this Court has recognized that the processing of claims for benefits by an insurer is a plan function. In *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 658 (1995), for example, the Court noted that state laws that are preempted because they "relate[] to" employee benefit plans include those that "mandat[e] employee benefit structures or their administration." Similarly, the Court's decision last Term in *UNUM Life Insurance Co.* v. *Ward*, 119 S. Ct. 1380 (1999), that a state-law rule regarding claims processing by an insurer is saved by ERISA's insurance savings clause was necessarily based on the proposition that the state-law rule "related to" the ERISA plan. See 119 S. Ct. at 1386 (noting parties' agreement on that point). And in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 47-48 (1987), the Court began its analysis of the question whether the causes of action there were preempted by noting that the plaintiff's common-law causes of action against an insurer for "bad faith" claims processing of the plaintiff's disability claim under an ERISA plan "relate to" the ERISA plan.

Those preemption decisions establish that, because claims processing is a plan function even when performed by in-

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[14] The plan document cited in the text is the subscription agreement between State Farm (the employer) and Carle Care (the HMO) that provides for enrollment of State Farm employees in Carle Care and sets the benefits to be provided.

surance companies or other entities that are separate from the plan itself, state laws that attempt to regulate claims processing under ERISA plans are preempted (unless saved by ERISA's insurance savings clause, see *UNUM*, 119 S. Ct. at 1386-1391). Therefore, insurers that process claims under ERISA plans are performing a plan-administration function when they do so. And insofar as adjudicating claims involves the exercise of some discretion, insurers that engage in the administration of ERISA plans by performing claims processing are acting as ERISA fiduciaries when they do so.[15] Because there is no reason to distinguish between traditional fee-for-service insurers and HMOs in any of these respects, it follows that HMOs may act as ERISA fiduciaries when they engage in claims administration under an ERISA plan.[16]

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[15] See, *e.g.*, *Englehardt* v. *Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1352 (11th Cir. 1998); *Bailey* v. *Blue Cross & Blue Shield of Virginia*, 67 F.3d 53, 56 (4th Cir. 1995), cert. denied, 516 U.S. 1159 (1996); *Tregoning* v. *American Community Mutual Ins. Co.*, 12 F.3d 79, 82 (6th Cir. 1993), cert. denied, 511 U.S. 1082 (1994); *Libbey-Owens-Ford Co.* v. *Blue Cross & Blue Shield Mut. of Ohio*, 982 F.2d 1031, 1035 (6th Cir.) (an insurance company with discretionary authority to determine claims is an ERISA fiduciary "whether the * * * company is the carrier administering claims under an insurance policy or * * * is administering claims for a fee under a self-insured plan"), cert. denied, 510 U.S. 819 (1993).

[16] The courts of appeals have held that state-law claims arising from claims denials by HMOs are preempted (unless saved by the insurance savings clause). See, *e.g.*, *Parrino* v. *FHP, Inc.*, 146 F.3d 699 (9th Cir.) (state-law claim based on HMO's denial of particular cancer therapy), cert. denied, 119 S. Ct. 510 (1998); *Turner* v. *Fallon Community Health Plan*, 127 F.3d 196 (1st Cir. 1997) (same), cert. denied, 118 S. Ct. 1512 (1998); *Cannon* v. *Group Health Serv., Inc.*, 77 F.3d 1270 (10th Cir.) (state-law claim of delay by HMO and insurers in authorizing particular cancer treatment), cert. denied, 519 U.S. 816 (1996); *Kuhl* v. *Lincoln Nat'l Health Plan, Inc.*, 999 F.2d. 298 (8th Cir. 1993) (state-law claim of delay in HMO's authorization for out-of-network surgery), cert. denied, 510 U.S. 1045 (1994).

The Department of Labor's claims-processing regulations similarly establish that the processing of claims is an essential plan function. See 29 C.F.R. 2560.503-1. Those regulations further recognize that claims processing may be done by an insurer, 29 C.F.R. 2560.503-1(c), that a plan's claims procedures may provide that claims for benefits must be filed with "an insurance company, insurance service, or other similar organization," 29 C.F.R. 2560.503-1(d)(3), and that such organization may be designated to provide notice of denial of a claim to a beneficiary, 29 C.F.R. 2560.503-1(f). Of particular significance here, the regulations provide that, with respect to plans in which benefits are provided by "an insurance company, insurance service, or other similar organization," the plan may provide that such organization "shall be the 'appropriate named fiduciary'" for purposes of deciding appeals from denied claims. 29 C.F.R. 2560.503-1(g)(2). The regulations furthermore provide that claims procedures specified in the Public Health Service Act, 42 U.S.C. 300e, are sufficient to satisfy ERISA requirements "with respect to any benefits provided through membership in a qualified health maintenance organization," 29 C.F.R. 2560.503-1(j). They thus make clear that HMOs, like other health insurance entities, engage in the administration of ERISA plans when they process claims.[17]

[17] The Department of Labor has published a new proposed claims procedure regulation. 63 Fed. Reg. 48,390 (1998). That regulation "would establish new standards for the processing of group health, disability, pension, and other employee benefit plan claims filed by participants and beneficiaries." *Ibid.* The proposed regulation was designed in large part to address the "dramatic changes" that "have occurred in the health industry" caused by the "growth of managed care delivery systems." *Id.* at 48,391. The proposed regulation therefore specifically addresses claims procedures of "group health plan services or benefits," see, *e.g.*, *id.* at 48,405, and plans in which benefits are provided by "an insurance company, insurance service, third-party contract administrator, *health maintenance organization*, or similar entity," *id.* at 48,406 (emphasis added).

2. For the foregoing reasons, we disagree with Judge Easterbrook's suggestion, dissenting from denial of rehearing en banc, that "the Carle Care HMO system [is] the benefit promised by the ERISA plan," not the "particular medical services" offered by the HMO. Pet. App. 55a. That suggestion would place HMO coverage in an entirely different regulatory category from other forms of health coverage, such as traditional health insurance. This Court's decisions in *Pilot Life* and *UNUM* establish that the benefit offered in a traditional insured ERISA plan is not the insurance policy, but the specific benefits offered under the insurance policy; because the processing of claims for particular benefits is a subject addressed by ERISA, the state laws governing claims processing in those cases "related to" ERISA plans. Yet, if Judge Easterbrook's rule were adopted, the rule would be precisely the opposite in the case of an HMO. There is no reason why the scope of ERISA's coverage—and, correspondingly, of state law's application—should vary so widely depending on whether an ERISA plan offers traditional health insurance coverage or HMO coverage instead.

Moreover, Judge Easterbrook's proposal would have serious consequences for the operation of HMOs. For example, this Court's decision in *Pilot Life* was based on the premise that a state-law claim for "bad faith" processing of claims by an insurer under an ERISA plan is preempted, because such a claim "relates to" the ERISA plan. But if the "intended benefit," see p. 10, *supra*, of the ERISA plan is simply membership in an HMO, then the only "claims processing" that would occur under ERISA with respect to the HMO is the processing of claims that an individual is entitled to enroll in the HMO; claims for particular medical benefits would not be claims for benefits under the ERISA plan, but would rather be internal matters between the HMO and its members. It follows that state laws governing the pro-

cessing of claims for particular medical benefits would govern that area entirely, including state law provisions permitting compensatory and punitive damages and other remedies not permitted by ERISA.

Congress currently has before it a variety of proposals that would eliminate ERISA preemption of state-law causes of action for damages (including, in some cases, punitive damages) by ERISA beneficiaries against HMOs and other group health plans. For example, H.R. 2990, a bill recently passed by the House of Representatives, see 146 Cong. Rec. H9523-01 (daily ed. Oct. 7, 1999), would eliminate preemption of such damages actions "in connection with the provision of insurance, administrative services, or medical services by [a] person to or for a group health plan * * * or * * * that arises out of the arrangement by [a] person for the provision of such insurance, administrative services, or medical services by other persons." H.R. 2990, 106th Cong., 1st Sess. § 1302(a) (1999).[18] It is a premise of the House bill that ERISA currently operates to restrict such state-law causes of action, because they would regulate benefits decisions under ERISA. Under Judge Easterbrook's reading, however, any such legislative change would be unnecessary, since decisions by HMOs regarding whether particular medical benefits are covered would not be decisions concerning the benefits due under an ERISA plan and would therefore not be subject to preemption under ERISA. Any such far-reaching change should be enacted by Congress, not by

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[18] A number of bills addressing HMOs and their relationship to ERISA are currently in the forefront of congressional consideration. Quality Care for the Uninsured Act of 1999, H.R. 2990, 106th Cong., 1st Sess., 145 Cong. Rec. H9523-01 (daily ed. Oct. 7, 1999); Patients' Bill of Rights Plus Act, S. 1344, 106th Cong., 1st Sess., 145 Cong. Rec. S8623 (daily ed. July 15, 1999) (bill passed as amended); see H.R. Res. 348, 106th Cong., 1st Sess., 145 Cong. Rec. H11341 (daily ed. Nov. 2, 1999) (House disagrees with Senate amendment to H.R. 2990 and agrees to conference).

judicial fashioning of an artificially narrow definition—apparently applicable only to HMOs and not to traditional insurers—of the "intended benefits" offered under an ERISA plan.

3. Because processing of claims for medical benefits—whether undertaken by the plan sponsor, a traditional fee-for-service insurer, or an HMO—is a function of ERISA plan administration, any individual or entity that exercises discretion in the processing of such claims is an ERISA fiduciary. And to the extent the complaint in this case alleges that Carle Care physicians make discretionary decisions in deciding claims, it has alleged conduct that is fiduciary in nature. Cf. *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1331-1332 (5th Cir.) (decision that a particular benefit is not covered by the plan involves plan administration, even though there is a medical component to the decision), cert. denied, 506 U.S. 1033 (1992); see generally 29 C.F.R. 2509.75-8 (determining benefit eligibility will involve fiduciary status if discretion is exercised, *i.e.*, if it involves more than "ministerial functions * * * within a framework of policies, interpretations, rules, practices and procedures made by other persons"). Indeed, petitioners appear to have acknowledged that fiduciary status and a duty of loyalty apply in such a context, stating that in contrast to the HMO's cost-containment and other business decisions, the HMO "must make coverage and eligibility decisions under the plan with an 'eye single' to the interests of the patient/beneficiaries." Pet. 28. Similarly, in their reply brief at the certiorari stage, petitioners stated that they "freely acknowledge that they are plan fiduciaries when they engage in activities denominated as fiduciary by ERISA, *e.g.*, when they provide information to participants as required under ERISA *and when they make decisions about who is eligible for plan benefits*." Pet. Reply Br. 7 (emphasis added).

The "administrative" allegations in the complaint, if liberally construed, could be read to allege conduct by petitioners in their fiduciary status. Those allegations state that petitioners "administer[] disputed and non-routine health insurance claims." Pet. App. 86a. Specifically, the complaint alleges that petitioners "determin[e] * * * which claims are covered under the Plan" and several other issues that are determinative of coverage, such as "what the applicable standard of care is," "whether a course of treatment is experimental," "whether a course of treatment is reasonable and customary," and "whether a medical condition is an emergency." *Ibid.* Because those specific allegations are phrased in terms of "administering" the plan, rather than providing medical care, we do not read them to refer to a treating physician's determination of how to treat a patient, whether a course of treatment is sufficiently proven to be safe, or whether an emergency exists that calls for the use of particular medical emergency protocols. Rather, we read those allegations to refer to the claims administration process within the HMO, which is triggered when individuals (or, perhaps, treating physicians) seek determination of whether particular medical services are covered by the plan. Insofar as the complaint alleges that petitioners act in the role of claims decisionmakers, the complaint therefore alleges that they act as ERISA fiduciaries. See also J.A. 102 (Summary Plan Description of State Farm Group Medical Health Plan) ("Although State Farm * * * is the Plan Administrator and Plan Sponsor * * *, any and all benefit determinations will be made by each individual HMO.").

4. Although the complaint does allege that petitioners act as ERISA fiduciaries insofar as they make determinations concerning benefits under the ERISA plan, the question remains whether the complaint adequately alleges the existence of an incentive scheme that would constitute a violation of the duty of loyalty in the context of exercising

that particular fiduciary responsibility, *i.e.*, of deciding benefit claims.

In our view, the fact that a denial of coverage by a Carle Care physician represents a cost saving for the HMO and that this same physician has some ownership interest in the HMO would not in itself establish a fiduciary breach. Under typical arrangements for employee benefit plans, such as an insured health plan where the insurance company has discretionary authority to decide claims, or a plan under which a company employee has such authority and the employer pays claims out of its own assets, there is some measure of divided loyalty on the part of a claims decisionmaker. ERISA, however, tolerates the level of divided loyalty that is intrinsic to those common arrangements, so that ERISA plans will be created and insurance companies and others will find it practical to work for them. Cf. 29 U.S.C. 1108(c) (party-in-interest may serve as fiduciary).[19] The mere existence of such a potential conflict is not therefore a basis for a claim of breach of fiduciary duty.

On the other hand, a claim that an incentive scheme constituted a breach of fiduciary duty would be established if the scheme provided incentives of such a nature that the individual deciding claims for benefits would be unable to set aside personal interest and make the benefits determination based on the terms of the plan. Cf. *Donovan* v. *Bierwirth*, 680 F.2d 263, 271 (2d Cir.) (trustees should "avoid placing themselves in a position where their acts as officers or directors of the corporation will prevent their functioning

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[19] *Firestone Tire & Rubber* established that any such arrangement should be "weighed as a factor in determining whether there is an abuse of discretion" in a claim for denial of benefits under ERISA Section 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B). 489 U.S. at 115 (internal quotation marks omitted). The courts of appeals have varied in their approach to factoring in such systemic divided loyalties. See *Doyle* v. *Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998).

with the complete loyalty to participants demanded of them as trustees"), cert. denied, 459 U.S. 1069 (1982). For example, a compensation scheme that provided direct financial incentives to plan fiduciaries for making adverse rulings on benefits claims—*e.g.*, a (highly unlikely) scheme providing fiduciaries with a fee for each claim they deny—would run afoul of the duty of loyalty.

5. Read literally, the "administrative" allegations in the complaint merely allege that petitioners "seek to fund their supplemental medical expense payments * * * by administering disputed and non-routine health insurance claims" and making the determinations necessary to such administration. Pet. App. 86a. That is merely an allegation that petitioners make a profit by administering the ERISA plan, and it certainly does not state a claim of breach of fiduciary duty. Even if it were construed, however, to allege as well that petitioners employed some form of compensation scheme in which those processing claims for the HMO shared in the HMO's general profits, it would not allege a breach of fiduciary duty under ERISA, for the reasons given above.

Nothing in the complaint itself suggests that respondent was intending to plead that petitioners employed the kind of unusual incentive scheme, described above, in which those who decide disputed claims would be paid on the basis of how many claims they deny or would otherwise be paid in a way that violates ERISA's standards of fiduciary duty. Indeed, the court of appeals read the complaint to allege only that physicians at the HMO who participate in claims processing are provided with a bonus payment based on the HMO's overall profits. See, *e.g.*, Pet. App. 19a ("Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (i.e., the costs of providing medical services) and revenues (i.e., payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bo-

nuses.") (emphasis omitted); *id.* at 21a (complaint alleges that petitioners "control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals") (emphasis omitted). Because the "administrative" allegations of the complaint therefore do not allege a breach of fiduciary duty under ERISA, the judgment of the court of appeals should be reversed.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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