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NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

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PEGRAM ET AL. *v.* HERDRICH

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

No. 98–1949. Argued February 23, 2000– Decided June 12, 2000

Petitioners (collectively Carle) function as a health maintenance organization (HMO) owned by physicians providing prepaid medical services to participants whose employers contract with Carle for coverage. Respondent Herdrich was covered by Carle through her husband's employer, State Farm Insurance Company. After petitioner Pegram, a Carle physician, required Herdrich to wait eight days for an ultrasound of her inflamed abdomen, her appendix ruptured, causing peritonitis. She sued Carle in state court for, *inter alia*, fraud. Carle responded that the Employee Retirement Income Security Act of 1974 (ERISA) preempted the fraud counts and removed the case to federal court. The District Court granted Carle summary judgment on one fraud count, but granted Herdrich leave to amend the other. Her amended count alleged that the provision of medical services under terms rewarding physician owners for limiting medical care entailed an inherent or anticipatory breach of an ERISA fiduciary duty, since the terms created an incentive to make decisions in the physicians' self-interest, rather than the plan participants' exclusive interests. The District Court granted Carle's motion to dismiss on the ground that Carle was not acting as an ERISA fiduciary. The Seventh Circuit reversed the dismissal.

Held: Because mixed treatment and eligibility decisions by HMO physicians are not fiduciary decisions under ERISA, Herdrich does not state an ERISA claim. Pp. 5–25.

(a) Whether Carle is a fiduciary when acting through its physician owners depends on some background of fact and law about HMO organizations, medical benefit plans, fiduciary obligation, and the meaning of Herdrich's allegations. The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a

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contract to provide specified health care if needed. Like other risk bearing organizations, HMOs take steps to control costs. These measures are commonly complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health-care services, and penalizing them for excessive treatment. Hence, an HMO physician's financial interest lies in providing less care, not more. Herdrich argues that Carle's incentive scheme of annually paying physician owners the profit resulting from their own decisions rationing care distinguishes its plan from HMOs generally, so that reviewing Carle's decision under a fiduciary standard would not open the door to claims against other HMOs. However, inducement to ration care is the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others. Thus, any legal principle purporting to draw a line between good and bad HMOs would embody a judgment about socially acceptable medical risk that would turn on facts not readily accessible to courts and on social judgments not wisely required of courts unless resort cannot be had to the legislature. Because courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs, this Court assumes that the decisions listed in Herdrich's count cannot be subject to a claim under fiduciary standards unless all such decisions by all HMOs acting through their physicians are judged by the same standards and subject to the same claims. Pp. 5–9.

(b) Under ERISA, a fiduciary is someone acting in the capacity of manager, administrator, or financial adviser to a "plan," and Herdrich's count accordingly charged Carle with a breach of fiduciary duty in discharging its obligations under State Farm's medical plan. The common understanding of "plan" is a scheme decided upon in advance. Here the scheme comprises a set of rules defining a beneficiary's rights and providing for their enforcement. When employers contract with an HMO to provide benefits to employees subject to ERISA, their agreement may, as here, provide elements of a plan by setting out the rules under which beneficiaries will be entitled to care. ERISA's provision that fiduciaries shall discharge their duties with respect to a plan "solely in the interest of the participants and beneficiaries," 29 U. S. C. 1104(a)(1), is rooted in the common law of trusts, but an ERISA fiduciary may also have financial interests adverse to beneficiaries. Thus, in every case charging breach of ERISA fiduciary duty, the threshold question is not whether the actions of some person providing services under the plan adversely affected a beneficiary's interest, but whether that person was performing a fiduciary function when taking the action subject to complaint. Pp. 9–13.

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(c) Herdrich claims that Carle became a fiduciary, acting through its physicians, when it contracted with State Farm. It then breached its duty to act solely in the beneficiaries' interest, making decisions affecting medical treatment while influenced by a scheme under which the physician owners ultimately profited from their own choices to minimize the medical services provided. Herdrich's count lists mixed eligibility and treatment decisions: decisions relying on medical judgments in order to make plan coverage determinations. Pp. 13–18.

(d) Congress did not intend an HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians. Congress is unlikely to have thought of such decisions as fiduciary. The common law trustee's most defining concern is the payment of money in the beneficiary's interest, and mixed eligibility decisions have only a limited resemblance to that concern. Consideration of the consequences of Herdrich's contrary view leave no doubt as to Congress's intent. Recovery against for-profit HMOs for their mixed decisions would be warranted simply upon a showing that the profit incentive to ration care would generally affect such decisions, in derogation of the fiduciary standard to act in the patient's interest without possibility of conflict. And since the provision for profits is what makes a for-profit HMO a proprietary organization, Herdrich's remedy– return of profit to the plan for the participants' benefit– would be nothing less than elimination of the for-profit HMO. The Judiciary has no warrant to precipitate the upheaval that would follow a refusal to dismiss Herdrich's claim. Congress, which as promoted the formation of HMOs for 27 years, may choose to restrict its approval to certain preferred forms, but the Judiciary would be acting contrary to congressional policy if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure. The Seventh Circuit's attempt to confine the fiduciary breach to cases where the sole purpose of delaying or withholding treatment is to increase the physician's financial reward would also lead to fatal difficulties. The HMO's defense would be that its physician acted for good medical reasons. For all practical purposes, every claim would boil down to a malpractice claim, and the fiduciary standard would be nothing but the traditional medical malpractice standard. The only value to plan participants of such an ERISA fiduciary action would be eligibility for attorney's fees if they won. A physician would also be subject to suit in federal court applying an ERISA standard of reasonable medical skill. This would, in turn, seem to preempt a state malpractice claim, even though ERISA does not preempt such claims absent a clear manifestation of congressional purpose, *New York State Conference of*

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Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.,* 514 U. S. 645. Pp. 18–25.

154 F. 3d 362, reversed.

SOUTER, J., delivered the opinion for a unanimous Court.