BNA, INC.

PENSION & BENEFITS

BNA Employee-Owned Since 1947

REPORTER

HEALTH CARE

This Policy Brief, one in a series of policy briefs supported by a grant from the Robert Wood Johnson Foundation, examines the question of whether employer-sponsored health benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) have a fiduciary duty to consider quality when purchasing and administering their plans for participants and beneficiaries.

Is Health Care Quality Purchasing an ERISA Fiduciary Obligation?

BY SARA ROSENBAUM AND PHYLLIS C. BORZI

Introduction: The Evolving Health Care Landscape and its Implications for Law

The concept of health care quality as a concern of health payers is not a recent one; indeed the roots of payer involvement in questions of health care quality can be found in the Medicare peer review reforms of the early 1970s.[1] But this past decade has witnessed substantial growth in payer interest in the quality of care.

A survey conducted several years ago for the Commonwealth Fund found that more than two thirds of employers reported offering HMO products considered health care quality to be a very important influence in their buying decisions.[2] Landmark health quality studies such as *Crossing the Quality Chasm*[3] and the explosion of organizations such as the Leapfrog Group, the National Business Group on Health, the National Quality Forum, and the National Committee for Quality Assurance (whose members include group purchasers and

Sara Rosenbaum is the Harold and Jane Hirsh Professor and Chair, Department of Health Policy, the George Washington University School of Public Health and Health Services. Phyllis C. Borzi is a Research Professor in the Department of Health Policy, the George Washington University School of Public Health and Health Services. Borzi also is co-chair of the BNA Pension & Benefits Advisory Board.

[1] R. Rosenblatt, S. Law and S. Rosenbaum, 1997, 2001. *Law and the American Health Care System* (Foundation Press, NY, NY) Ch. 3.

[2] J.R. Gabel, K. Hunt, and K. Hurst, 1998. *When Employers Choose Health Plans: Do NCQA Accreditation and HEDIS Data Count?* (Commonwealth Fund, NY, NY). Available at http://www.cmwf.org/usr_doc/Gabel_employerschoose.pdf.

[3] Institute of Medicine, Washington D.C.

 ISSN 1069-5117

the companies that sell health service and benefit plans to groups) have further fueled this link between payment and quality.

The evolving relationship between health financing and health quality rests on more than just studies, reports and high-visibility activities, however. Changes in the organization and financing of health care have major implications for the extent to which expectations regarding health quality become embedded in the very act of paying for health care: Even were health care purchasers to remain strictly interested in financing as opposed to the quality of care, the design structure of many of the health benefit products available on the market today focuses the discussion on health care itself.

Several important developments underlie this shift away from financing alone and toward the interaction of financing with health care.

The Advent of Hybrid Health Benefit Products That Link Services and Coverage. In the past two decades the nation has virtually reinvented its approach to health care financing. As recently as 1988, 73 percent of insured workers were members of plans that were considered ''conventional,'' that is, in which coverage was contractually de-linked from health care. Physicians and hospitals operating independently of financing arrangements furnished care and billed patients; patients, in turn, paid health care providers and were then indemnified by their insurers. By 2005, this proportion had shrunk to 5 percent.[4]

Indeed, with the exception of Medicare and the most seriously ill and disabled Medicaid beneficiaries, it is a challenge today to find any insured American whose coverage is not derived through what might be thought of as a ''hybrid'' corporate entity, i.e., a health service and benefit corporation that either requires or incentivizes[5] its members (through the use of substantial cost sharing requirements) to obtain covered benefits through a service network selected and credentialed by the corporation. This operational merger of health care and health benefits has important legal implications, whose effects have been visible for over a decade. What ultimately has emerged is a judicial approach that recognizes that hybrid corporate entities (which can include licensed HMOs as well as other types of corporate health care providers such as PPOs and integrated service systems) ''wear two hats''[6] and therefore can incur legal liabilities in both the coverage and quality arenas (although ERISA preempts certain remedies).[7] Indeed, on occasion these hybrid entities have actively argued that they are, in fact, engaged in health care practice and thus should be exempt from state laws regulating health insurance.[8]

The Diffusion of Health Information Technology (HIT). Health information technology (HIT) is essential to the advancement of a movement toward quality purchasing, because of its capacity to produce more detailed information about the care that is purchased. HIT adoption rates hover around the 15-20 percent level for physician practices and the 20-25 percent level for hospitals.[9]

The federal government's emphasis on HIT adoption,[10] as well as growing interest as a matter of provider custom and practice, promises to speed the adoption process. As health information technology diffuses, the potential for purchasers to have information central to quality purchasing also will grow, thereby raising expectations about purchaser involvement in health care matters.

Health Care 'Consumerism.' Changes in the health care marketplace and the availability of more and better health care information (a Google search of ''health care report cards'' yielded 130 million hits as of April 9, 2006)[11] parallel the growth of health care ''consumerism.'' Consumerism as a concept exists at the juncture of the forty-year-old patients' rights movement and the growing emphasis on the market nature of U.S. health care system.[12] Consumerism's essential features are an emphasis on individual responsibility, greater equality in patient and provider relationships, transparency in health care and health care choices, and adequate information to support informed health care decision mak-

[4] Kaiser Family Foundation, 2005. Trends and Indicators in the Changing Health Care Marketplace. http://www.kff.org/insurance/7031/print-sec2.cfm (Accessed April 9, 2006).

[5] The additional cost exposures associated with going ''out of network'' can be considerable: not only higher cost-sharing but also, exposure to balance billing by the out-of-network provider for the difference between the provider's charge and the plan's payment schedule. In addition, while out of network care might not completely eliminate coverage, it may be harder to secure plan approval for follow-up in-network care that has been recommended by an out-of-network provider.

[6] *Pegram v. Herdrich,* 530 U.S. 211, 24 EBC 1641 (2000). See *Corcoran v. United Healthcare Inc.* 965 F.2d 1321, 15 EBC 1793 (5th Cir. 1992); *cert. den.* 506 U.S. 1033; and *Dukes v. U.S. Healthcare*, 57 F. 3d 350, 19 EBC 1473 (3d Cir. 1995); *cert. den. sub. nom.* 516 U.S. 1009 (1995), which offers perhaps the clearest explanation distinguishing claims tied to quality of care from those tied to coverage.

[7] In *Aetna v. Davila,* 542 U.S. 200, 221, 32 EBC 2569 (2004) the United States Supreme Court held that although ERISA preempts state tort remedies for injuries associated with negligent coverage decisions, liability theories predicated in health care quality remain unaffected. The most contentious aspect of the Patients Bill of Rights debate that dominated Washington health policy from 1997 through 2001 focused on the question of liability for coverage and quality of care acts.

[8] *Rush Prudential v. Moran,* 534 U.S. 1063 (2001) (whether HMOs should be bound by state external appeal review statutes applicable to health insurers).

[9] Richard Hillestad et al., 2005. ''Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings and Costs'' *Health Affairs* 24. 1103-1117.

[10] President Bush has identified HIT as a leading issue in his health care improvement platform. http://www.whitehouse.gov/infocus/healthcare/ (Accessed April 9, 2006). HHS Secretary Leavitt's 500-Day Plan has as its first goal is transformation of the health care system through HIT. http://www.hhs.gov/secretaryspage.html (Accessed April 9, 2006). More than 50 bills containing the term ''health information technology'' have been introduced into the 109th Congress. (Thomas search by authors on April 9, 2006)

[11] http://www.google.com/search?hl=en&q=health+care+report+cards&btnG=Google+Search

[12] *Law and the American Health Care System,* op. cit. Ch. 3; George Halvorson and George Isham, 2003. *Epidemic of Care* (Jossey Bass, San Francisco); George Annas, 2004. *The Rights of Patients* (ACLU, NY); Michael Millenson, 2000. *Demanding Medical Excellence: Doctors and Accountability in the Information Age.*

  BPR ISSN 1069-5117

ing.[13] As individuals come to expect more and better information about their health care–particularly if their choices are limited by network requirements[14]–the pressure on group purchasers to factor health quality and health information into the purchasing decisions also can be expected to increase.

In sum, the changing organizational, informational, and societal landscape of the health care system suggests shifting social expectations away from the act of simply paying for care and toward a focus on care itself as an embedded aspect of group purchasing arrangements. To be sure, this evolution is unfolding unevenly across the employment-based purchasing sector, with greater interest among the largest employers. At the same time, regional and national health insurers and health benefit companies act on behalf of smaller group purchasers. The selection and ongoing evaluation of health service providers for network membership and financial participation in the plan places gives these entities a direct corporate interest in matters of health care quality.

An enduring aspect of the law is the extent to which the interpretation and formulation of law and legal principles evolves with changes in industry custom and practice, changing social expectations, and the diffusion of advances of technology and knowledge.[15] Nowhere is this dynamism in law more evident than in health care, where the legal principles that guide health care have been transformed by a revolution in knowledge, technology, and practice, which has been unfolding over the past half century.[16] These advances have altered not only the nature of patient rights and legal protection but the very nature of the duties owed by entities involved in health care. This evolution in the nature of legal duty is illustrated by two advances in the law: the impact of knowledge, science and technology on medical negligence law during the latter half of the 20th century; and the imposition of new and special duties on hospital emergency departments, as technology improvements created lifesaving techniques in emergency medicine.[17]

Changing customs, mores, and technologies also can alter the legal duties attributable to corporate entities that organize, administer, and oversee hybrid health operations merging coverage and care for multiple group sponsors. The intricate nature of law means that a single corporation can take on various legal ''personalities'' depending on the nature of the legal question posed, and the body of law under which the question is framed. For example, when the question is liability under state law for substandard medical care quality, a series of judicial decisions over the past 20 years have concluded that health care corporations operating as HMOs can be viewed as medical care providers and thus can be potentially exposed to both vicarious and corporate liability for substandard medical care, even in the case of HMOs that operate not as ''brick and mortar'' enterprises but instead as contractual arrangements between intermediaries and provider networks.[18]

Similarly, when the issue is framed as one involving fiduciary duty under the Employee Retirement Income Security Act (ERISA), at least one court has ruled that a health care corporation that functions as an ERISA fiduciary can face liability when information material to patient care, such as the existence of a financial incentive plan that may adversely implicate health care adequacy, is not disclosed to plan participants and beneficiaries.[19]

Federal Medicaid law offers yet a third example of how legal duties can change as the specific conduct—and body of law that gives rise to such conduct—change. Federal Medicaid law requires that state Medicaid agencies act in the best interest of program beneficiaries and ensure plan administration that assures that payments are consistent with health care quality.

Viewed under Medicaid law, state agencies and the health care corporations that administer managed care plans on their behalf, may incur a legal duty to use resources to advance the quality of health care. Whether this legal duty can give rise to a private lawsuit against a state agency for failing to ensure the quality of care has not been tested; what is clear however, is that as described above, poor quality care by a Medicaid HMO might give rise to a legal action against the HMO under state medical liability law.

ERISA Questions. This policy brief focuses on the legal duties created by ERISA. Specifically it considers whether ERISA fiduciaries can be considered to have a fiduciary duty to oversee the quality of health care through the use of health information and quality purchasing techniques. In answering this broad question, three important sub-questions emerge. The first is the nature of the legal duty owed to health plan participants

[13] To understand and appreciate the association between consumerism and the nature and structure of the health care market see, Federal Trade Commission, *A Dose of Competition* (2004). See also James Robinson, 2002. ''The End of Managed Care,'' *Health Affairs* for an excellent discussion of the tension between corporate control over health care access and quality and the need for more consumer direct involvement in purchasing decision-making.

[14] Hybrid product structures using embedded networks can be expected to survive a shift toward high-deductible plans linked to health savings account, since members will continue to require the discounts available from their networks, regardless of whether the service they use is insured or paid from a linked cash account.

[15] Oliver Wendell Holmes, 1881. *The Common Law.* A classic case that best exemplifies the impact of technology and social advances on the law is *The T. J. Hooper,* 60 F.2d 732 (2d Cir. 1932) which is considered a seminal articulation of how courts weigh the impact of technology, knowledge and custom in their approach to defining legal duties. The case involved the question of whether by the late 1920s, a tugboat company that operated without on-board radios that would have provided information about a coming storm should face liability for death and injury stemming from a storm-related wreck. Writing for the Court of Appeals, Judge Hand noted that the evolution of legal duty reflected a careful balancing of industry custom against changes in knowledge and technological capacity and the costs associated with such technology as a result of a high level of diffusion.

[16] S. Rosenbaum, 2003. ''The Impact of Law on Medicine as a Profession.'' *JAMA* 289:1545-1555 (March 26, 2003).

[17] *Law and the American Health Care System,* op. cit. Ch. 3; ''The Impact of Law on Medicine as a Profession,'' op. cit.; George Annas, ''The Patient's Right to Safety,'' *NEJM 354: 19* (May 11, 2006).

[18] See, e.g., *Jones v. Chicago HMO* 191 Ill. 278 (2000); *Dukes v. U.S. Healthcare Inc.* 57 F.3d 350 (1995); *Aetna v. Davila*, *supra,* note 7.

[19] *Shea v. Esensten* 107 F.3d 365, 20 EBC 2561 (8th Cir.), *cert. den.,* 522 U.S. 914 (1997), *appeal after remand,* 208 F.3d (8th Cir.), *cert. den.,* 531 U.S. 871 (2000).

and beneficiaries by ERISA ''fiduciaries.'' The second is the nature of the remedy available to individuals who claim injury as a result of a breach of fiduciary duty. The third concerns the proper role of federal oversight of fiduciary conduct. In a context of health care, these three questions can be refined as follows:

- First, do ERISA-governed employee health plans have a fiduciary duty to consider quality when they select or evaluate the performance of the health coverage and service plans offered to participants and beneficiaries?
- Second, would individuals injured as the result of poor quality health care under an employer-sponsored plan have a right to recover for breach of fiduciary duty, and what would that recovery look like?
- Third, what is the proper federal oversight role in a health care system in which employer-sponsored plans are making decisions for health plan participants that carry significant implications for health care quality?

At this relatively early point in the evolution of fiduciary legal duties for health care quality decisions, these questions do not have definitive answers. At the same time, it is possible to see the evolution of a legal standard related to quality purchasing as result of the interaction between ERISA's fiduciary standard and the evolution of health care purchasing and the availability and use of health information.

The ERISA Fiduciary Duty and Its Implications for Health Quality Accountability

An Overview of the ERISA Fiduciary Function. ERISA is the most important federal law governing noncash compensation provided by employers, including pensions and other employee benefits, such as health benefits (which are considered benefits provided by ''employee welfare benefit plans'' under ERISA). The courts have created two important distinctions in the functions performed by those involved in ERISA plan establishment and maintenance.

The first function is the ''settlor'' function. When an employer or plan sponsor acts in its ''settlor'' capacity (that is, when making basic design decisions about what services and benefits to include in a plan *at all*), the plan sponsor acts solely at its own discretion and plan members have no enforceable rights. In a health care context, the settlor function arises in the context of an employer's initial business decision whether to establish an employee benefit plan at all, as well as the employer's determination of the types of benefits that will be offered to employees and their families (e.g., health insurance and health services, long-term disability insurance, pensions, etc.). Other settlor functions involve decisions regarding whether to modify, amend or terminate the plan.

The second function is that of a ''fiduciary.'' The fiduciary function arises once an employee benefit plan is established. In a health benefit plan context, the ERISA fiduciary may be the health insurer from whom the employer buys the health benefit product that is offered under the plan. Given the virtual eclipse of the indemnity insurance market, it is likely that the health benefit product will combine coverage (either extensive or limited depending on the range of benefits and the cost sharing required) with a network of service providers operating on either a loosely or tightly configured basis.

The ERISA fiduciary might also be the employer (or employees of the employer) itself. Employers that self-insure typically contract with health benefits corporations (insurers and HMOs) to administer their health plans. In that case, either the employer simultaneously acts as its own plan fiduciary on behalf of participants and beneficiaries or the entity with which it contracts may agree to serve as a fiduciary. Alternatively, but far less likely than either of these approaches, these entities may serve as co-fiduciaries.

Like the administrator of a trust, each ERISA plan fiduciary (who may or may not be the day-to-day plan administrator)[20] has an obligation to plan participants to manage plan assets and administer the plan prudently and solely in their interests. Thus, ERISA fiduciaries must meet the ERISA prudence standard and comply with other ERISA fiduciary duty requirements.[21]

It can be difficult to distinguish between ''fiduciary'' and ''settlor'' functions. For example, most ERISA experts believe that deciding whether to offer employees a choice of a tightly controlled HMO or a loosely structured PPO is a ''settlor'' function, because it is a decision related to the *design* of the benefit plan. Fiduciary decisions, on the other hand, typically arise in carrying out or implementing those decisions (i.e., which HMO or PPO to contract with to provide benefits). In addition, fiduciary decisions generally have an impact on benefit accessibility and utilization by particular plan participants. Thus, decisions about whether a particular covered health care benefit is medically necessary for a participant, or whether to authorize patient care from an out-of-network provider (for example, referral to a non-network provider in the case of an HMO that uses strict network controls for certain services), are examples of possible fiduciary activities subject to ERISA's fiduciary duty rules.

Because the line between ''fiduciary'' and ''settlor'' functions is often hard to draw in a health care context given the merger of care and coverage, it may be helpful to examine how ERISA law has evolved in the world of pensions, particularly regarding so-called section ''401(k)'' plans. The Department of Labor has long taken the position in regulations and in litigation (particularly the recent cases involving 401(k) plan investments in employer stock)[22] that selecting the investment options to be offered to participants in a 401(k)

[20] Employers that self-insure the health benefits may hire a large health services company to administer the plan but may retain the right to make their own fiduciary decisions. Employers that purchase insured health plans shift the insurance risk to the carrier and assign to the carrier selling the insured product both plan administration and fiduciary responsibilities. In other words, the entity that holds the financial exposure typically retains the fiduciary controls.

[21] See, e.g., *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 18 EBC 2841 (1995); *Lockheed Corp. v. Spink*, 517 U.S. 882, 20 EBC 1257 (1996).

[22] In both *In re Worldcom, Inc. ERISA Litig.*, 263 F. Supp. 2d 745, 30 EBC 2035 (S.D.N.Y. 2003), and *In re Enron Securities, Derivatives & ''ERISA'' Litig.*, 284 F. Supp. 2d 511, 31 EBC 2281 (S.D. Tex. 2003), the Department of Labor argued that, given what was happening with respect to the value of employer stock, the plan fiduciaries had a duty to cease purchasing additional employer stock and to cease offering an employer stock option in the 401(k) plan. See also, the Secretary of Labor's amicus briefs in *Tittle v. Enron Corp.*, No. 01-3913 (S.D. Tex. filed Aug. 30, 2002), *In re Schering-Plough Corp.*, No. 04-3073 at 17 & n.17 (3d Cir. filed Oct. 20, 2004),

  BPR ISSN 1069-5117

plan is a fiduciary activity subject to ERISA's fiduciary rules and that once these options have been selected, fiduciaries have an ongoing duty to monitor their performance and suitability.[23] In other words, although the decision of a plan sponsor to offer a 401(k) plan and to allow participants investment choice are settlor decisions, once the plan sponsor begins the process of determining which specific investment options will be offered and selecting the financial services vendor to operate the 401(k) plan, the employer has, in effect, taken off its plan sponsor (or settlor) hat and replaced it with its fiduciary hat. When the fiduciary makes those selection decisions, factors such as customer service, competence, integrity, accessibility, accountability, ability of participants to access and move money within their accounts, privacy and security issues, etc. must be taken into account when the fiduciary decides which financial services vendor to choose. Moreover, under ERISA, once the plan is established and the service providers are in place, fiduciaries have an ongoing duty to monitor their continued suitability as plan vendors, by monitoring their records of performance and service to participants, among other things.

Does the Concept of Fiduciary Obligation Extend to Quality Purchasing in Health Care? In a health care context, fiduciary conduct may be implicated at two basic points: (1) at the initial point of contracting with a company that will administer (and in some cases, insure) the plan; and (2) during the period of performance, when the fiduciary would be expected to scrutinize plan performance. Where the health benefit consists of a hybrid product combining coverage and networked services, the fiduciary obligation would appear to extend to scrutiny of not only the quality of *coverage* administration but also, *the quality of the product's care.* In effect, the system of care is *embedded in* the coverage arrangement. While the fiduciary can no more guarantee a quality result than a pension fiduciary can guarantee a high rate of return on all investments, this is a separate matter from whether the fiduciary has an obligation to ensure that the product meets organizational and operational standards of quality.

In health care, fiduciary activities can be further distinguished by whether the activity involves information about care or information about coverage. On the health information front, at least one federal appeals court has determined that a breach of fiduciary duty occurs when an ERISA plan fiduciary fails to provide a patient with information material to his or her health care treatment decisions.[24] On the other hand, another court has found that a plan fiduciary has no obligation to provide accurate information to plan members regarding coverage limits and restrictions,[25] even though such information ultimately could influence care seeking patterns.

As noted, federal ERISA law in the area of pensions is more developed than in health care. But since the ERISA statutory standard of fiduciary conduct is identical for both pension and health plans, similar principles should apply in a health benefits context. The parallel nature of ERISA interpretations in a pension and health plan context certainly has been the case over the past 30 years. Thus for example, just as the decision to establish a pension plan at all is a settlor function, the same is true in the area of health care: the decision to establish an employee health benefit plan offering network-linked services, to modify or terminate such a plan, or to design the coverage aspects of the health plan, would be considered a settlor function, just as they would in the case of pensions.[26] At the same time, decisions regarding *which company or companies will be eligible to furnish the health benefit plan* should fall into the fiduciary category, as would decisions about whether to retain the company or oversee the company's administration of a hybrid benefit. And as in the case of pensions, an ERISA fiduciary engaged in health plan administration would be expected to take into consideration issues of quality, not just price, through prudent selection of a health plan in terms of both its coverage administration and health quality record. And in carrying out its duty to monitor health plan performance on behalf of participants and beneficiaries, an ERISA fiduciary would be expected to focus on issues of quality as well, particularly in the case of plan benefits that entail the use of hybrid products offering network-linked coverage.

The notion that fiduciary conduct would encompass quality evaluation and oversight again finds precedent in the world of pensions. Although there are no specific statutory provisions or regulations under ERISA that require fiduciaries to focus on health care quality, the Department of Labor has signaled that fiduciaries that administer pension plans should look beyond cost considerations in selecting service providers. For example, in an opinion letter dated February 19, 1998,[27] when asked whether it was appropriate for trustees of ERISA health and welfare multiemployer trusts to consider quality in selecting health plan service providers, and not simply select the lowest bidder, the Department said that the quality of services is a factor relevant to selecting a service provider because ''failure to take quality of services into account in the selection process would constitute a breach of the fiduciary's duty under ERISA, when . . . the selection involves the disposition of plan assets.''

---

and *Langbecker v. Electronic Data Systems,* C.A. No. 6.03 MD-1512 (5th Cir. filed April 5, 2005, at 25).

[23] See, for example, the preamble to regulations regarding ERISA § 404(c) which implement a statutory safe harbor for plan fiduciaries who allow participants in 401(k) plans to control investment decisions within the investment options under the plan. Under this safe harbor, a person who is otherwise be a fiduciary is not liable for losses to a plan resulting from the participant's selection of investments in his/her own account, provided that the participant exercised investment discretion with regard to those investments. 29 C.F.R. § 2550.404(c)-1.

[24] *Shea v. Esensten, supra,* note 19.

[25] *Jones v. Kodak Medical Assistance Plan*, 169 F.3d 1287 (10th Cir. 1999).

[26] *McGann v. H. and H. Music Co*., 946 F. 2d 401 (5th Cir. 1991); *Jones v. Kodak Medical Assistance Plan*, *supra,* note 25.

[27] DOL Information Letter, to Diana Orantes Ceresi, Associate General Counsel, Service Employees International Union (SEIU), February 19, 1998, from Bette J. Briggs, Chief, Division of Fiduciary Interpretations, Office of Regulations and Interpretations, Pension and Welfare Benefit Administration (PWBA), U.S. Department of Labor (PWBA is now called the Employee Benefit Security Administration (EBSA)), available at http://www.dol.gov/ebsa/regs/ILs/il021998.html. This letter is commonly referred to as ''the Ceresi letter.''

Some might argue that the Department's response leaves open the question as to whether quality must be considered in the more typical case where the ERISA health plan is ''unfunded'' (that is, benefits are paid out of the general assets of the employer rather than through a trust consisting of plan assets). But focusing on the issue of whether the plan benefit is or is not unfunded would seem irrelevant to the question of the nature of the duty. In considering fiduciary duty cases in a health care context, courts have never held that the unfunded nature of a health benefit plan affects the obligation of a fiduciary to act as such; indeed, during a coverage year the plan can be thought of as containing assets, since the health services are available as the result of payment of a plan premium. Furthermore, although it is true that a fiduciary under ERISA is a person who has discretionary control over plan assets and their disposition, discretion over plan administration also triggers fiduciary liability. It is hard to imagine that the fiduciary duty of a plan administrator to consider issues of quality as he or she evaluates the merits of competing health plans, networks of providers and heath care institutions could be materially different based solely on whether or not the benefits provided by the ERISA plan were paid from a trust or from corporate general assets. In both cases, the person administering the plan would be a fiduciary and the duty to consider quality-related issues would be the same.

What Rights and Remedies Are available to Plan Participants and Beneficiaries for Fiduciary Breaches Involving Quality Purchasing? ERISA provides plan participants and beneficiaries with an express right of action to seek recovery of plan benefits that are due; beneficiaries and participants also may challenge other types of conduct as a breach of fiduciary duty, such as the failure to ensure the disclosure of material plan information.[28] In a benefit claim case, however, the courts have interpreted ERISA to recognize no remedy other than benefits due; damages are not recoverable in an ERISA benefits claim.[29]

With respect to claims involving breaches of fiduciary duties under ERISA section, the Supreme Court has narrowly defined ''equitable relief'' to also preclude money damages, limiting such relief to only those categories of relief that were typically available in equity in the days of the divided bench.[30]

At the same time, however, it is important to remember that the same conduct can give rise to multiple types of claims under multiple legal theories. Given the recognition by the United States Supreme Court that quality of care claims fall outside of ERISA, it might be that a claim of injury as a result of a company's failure to use health information to assure quality might succeed when framed as a violation of state health care quality law.[31]

What does all this mean for remedies for substandard quality care? Where a plan participant or beneficiary sues a health benefits corporation alleging a breach of a federal ERISA fiduciary duty to ensure quality care, the claim may have merit if a court views quality oversight as a fiduciary function and the plaintiff can draw a link between the corporation's conduct and his or her injury. But, under current Supreme Court precedent, the plaintiff would not have a viable damages remedy under ERISA. On the other hand, were the plaintiff to bring a *state law claim grounded in theories of medical liability* against the corporation, this type of state claim might well survive ERISA preemption and, if proven, permit the plaintiff to recover damages related to the injury suffered. In other words, even were courts to recognize a quality claim as falling within the ERISA fiduciary duty, there might be no remedy other than a benefit of appropriate quality. But depending on the state, a quality claim might be pursued under state theories of medical liability, giving the injured person a means of recovery of damages.

Should the absence of a federal damages remedy for a fiduciary breach in connection with health quality end the discussion? While it is easy to equate legal duty with *individual rights and remedies*, in fact, the absence of a damages remedy for individuals is only one aspect of legal accountability.

For example, the Department of Labor, which has ERISA enforcement responsibility, could increase its activities related to oversight of fiduciary practices related to health care. These increased duties could include setting clear standards regarding the quality purchasing responsibilities of fiduciaries and enforcing these standards through oversight and intervention in cases in which fiduciaries are unable to demonstrate compliance with minimum quality purchasing practices. Such practices might be drawn from evolving industry standards: collection and analysis of minimum data sets related to the qualifications of provider networks, use of centers of excellence, valid and reliable measures of health care quality, and collection of data on the outcomes of care; use of data to develop contracts with health benefit corporations that contain strong performance incentives; and data transparency practices such as posting minimum information for participants and beneficiaries regarding the quality of care.

Another approach to ensuring greater ERISA fiduciary accountability for quality might be to link the accreditation of health benefit corporations selling administered products to ERISA health plans in which the employer acts as the fiduciary to evidence of active involvement by the plan administrator in health quality activities similar to those outlined above.

Concluding Thoughts

A changing health care system, greater involvement of purchasers in matters of health quality, and broad public attention to the issue of health care quality all point to fundamental changes in the way in which the law understands and interprets ERISA fiduciary obligations in a health care context. This evolution could lead to broad accountability standards for plan fiduciaries and administrators, even if damages for failures of quality are not a recognized form of recovery under ERISA. As health information technology advances and health care purchasing increasingly is understood to encompass quality measurement, the potential impact on the meaning of the ERISA fiduciary obligation is relatively easy to see. Whether this impact translates into accountability practices on the part of fiduciaries depends

[28] *Shea v. Esensten, supra,* note 19.

[29] *Mertens v. Hewitt,* 508 U.S. 248, 16 EBC 2169 (1993).

[30] *Id.*, at 207-208. This was elaborated on by the Court in *Great-West Life and Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 27 EBC 1065 (2002) and, most recently, in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S.Ct. 1869, 37 EBC 1929 (2006).

[31] *Aetna v. Davila, supra,* note 7.

  BPR ISSN 1069-5117

on the degree to which changing notions of fiduciary standards are embraced and advanced as part of the ERISA federal oversight process. In other words, whether a changing ERISA duty translates into meaningful health care improvements may be more a function of regulatory oversight than private litigation. In this respect, an ERISA fiduciary obligation to engage in quality purchasing represents a clear test of the notion that there are many alternative pathways to accountability beyond private enforcement based on liability principles.