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Offshore Gambling: Medical Outsourcing Versus ERISA's Fiduciary Duty Requirement

Christopher J. Brady

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Offshore Gambling: Medical Outsourcing Versus ERISA's Fiduciary Duty Requirement

Christopher J. Brady*

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* Candidate for J.D., Washington and Lee University School of Law, May 2008; B.A., The University of Tennessee, 2005. I would like to thank Professor Thomas H. Rice for suggesting the topic, as well as Professor Timothy S. Jost and Diana Grimes for their guidance and expertise throughout this process. Many thanks also to my friends for providing humor and support throughout the process. Finally, I thank my parents—Charles and Susan Brady—for their encouragement and support throughout.

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"Medical care in America has become dangerously expensive."
Dr. Arnold S. Relman¹

I. Introduction

The unprecedented growth of science and technology in the twenty-first century has led to a world interconnected in a way that was once unimaginable. Borders become nonexistent as individuals, societies, and economies connect and melt together under the banner of globalization.² For better or worse, outsourcing has always been part of the globalization trend.³ For decades, U.S. corporations have been reducing costs by outsourcing operations and capitalizing on the abundance of natural and human resources in Asia.⁴ Today, corporations are not the only ones seeking the cost savings of Asia. In 2005, over 55,000 Americans traveled to Bumrungrad International Hospital in India

1. Dr. Arnold S. Relman, *Foreword* to MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS*, i, ix (1993).

2. See J. Oloka-Onyango, *Reinforcing Marginalized Rights in an Age of Globalization: International Mechanisms, Non-State Actors, and the Struggle for Peoples' Rights in Africa*, 18 AM. U. INT'L L. REV. 851, 885 (2003) (discussing the central features of globalization).

3. See, e.g., Aaron Judson Lodge, *Globalization: Panacea for the World or Conquistador of International Law and Statehood?*, 7 OR. REV. INT'L L. 224, 267 (2005) (discussing Sony's movement of its factory operations to Asia).

4. See, e.g., MICHAEL BACKMAN & CHARLOTTE BUTLER, *BIG IN ASIA: 25 STRATEGIES FOR BUSINESS SUCCESS* 36-37 (2003) (discussing outsourcing of labor to Asian countries as a tool for increasing efficiency and cost savings for developing businesses).

for surgeries, leaving the United States and trusting their bodies to foreign doctors and surgeons.⁵ At a time when approximately 42 million Americans do not carry health insurance,⁶ many uninsured Americans are enticed by the option of a surgical procedure that costs as little as one-tenth of the equivalent surgery in the United States.⁷ The tens of thousands of dollars uninsured Americans save via medical tourism have not gone unnoticed by the rest of the U.S. health care industry. Private companies, health medical organizations, and even states are exploring methods to utilize medical outsourcing to keep health care costs in check.⁸ Although medical outsourcing may appear on the surface to be an attractive alternative to the out of control costs in the United States health care system,⁹ the reality of endorsing medical outsourcing is much more complex. This Note examines the interplay between the fiduciary duty imposed under the Employee Retirement Income Security Act (ERISA) of 1974¹⁰ and the cost savings available to private companies and health medical organizations, and argues that such entities cannot offer plan participants medical outsourcing without violating ERISA's fiduciary duty requirement.

Part II provides an overview of ERISA's scope and goals, focusing on the fiduciary duty ERISA imposes upon plan administrators and which entities within the health care system are subject to the fiduciary duty.¹¹ The Part concludes with an examination of the corollary duty of disclosure and the legal remedies for plan participants when fiduciaries violate their duties under ERISA.¹²

5. See Arnold Milstein & Mark Smith, *America's New Refugees—Seeking Affordable Surgery Offshore*, 355 NEW ENG. J. MED. 1637, 1638 (2006) (providing statistics on the patients treated at Bumrungrad International Hospital).

6. See U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005 (Aug. 2006), <http://www.census.gov/prod/2006pubs/p60-231.pdf> (providing statistics detailing health insurance coverage in the United States) (on file with the Washington and Lee Law Review).

7. See *infra* tbl.1 (comparing the cost of various surgical procedures abroad and in the United States).

8. See *infra* Part III.C (discussing various attempts to standardize medical outsourcing as an element of health care plans).

9. See Michael Klaus, *Outsourcing Vital Operations: What if U.S. Health Care Costs Drive Patients Overseas for Surgery?*, 9 QUINNIPIAC HEALTH L.J. 219, 231 (2006) (stating that the United States spends \$1.8 trillion on health care annually).

10. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2006).

11. See *infra* Part II.B–D (discussing the nature of ERISA's fiduciary duty and who within the domestic health care system is subject to ERISA's duty).

12. See *infra* Part II.C (discussing the duty of disclosure within ERISA's fiduciary duty and the legal remedies available for plan participants when fiduciary duties are breached).

Part III examines the rise of medical tourism and the benefits and risks associated with the practice. The Part discusses the legal risks associated with medical tourism and the motivating factors that drive patients abroad for medical services.¹³ Finally, Part III discusses attempts by companies, health medical organizations, and states to utilize medical tourism via medical outsourcing in their coverage plans.¹⁴

Part IV discusses whether medical outsourcing violates the fiduciary duty imposed under ERISA in light of recent Supreme Court jurisprudence. The Part explores arguments both for and against ERISA liability and concludes that although medical outsourcing does not result in a *de jure* violation of ERISA's fiduciary duty, the financial incentives to both plan participants and plan administrators create a situation resulting in a *de facto* violation of ERISA's fiduciary duty. In conclusion, this Note suggests appropriate steps Congress should take in order to ensure that the vision and purpose of ERISA remain protected as health care evolves in a globalized society.

II. ERISA: An Overview

A. ERISA's Scope and Purpose

The Employee Retirement Income Security Act of 1974¹⁵ reflects the government's belief that employee benefit and welfare plans play such an important role in interstate commerce that these plans represent a national public interest.¹⁶ Therefore, ERISA seeks to ensure the sound management and application of employee benefit and welfare plans¹⁷ via the establishment of "minimum standards . . . assuring the equitable character of such plans and their financial soundness."¹⁸ These standards apply to both employee pension plans and employee welfare benefit plans,¹⁹ which ERISA defines as including

13. See *infra* Part III.B (discussing the lack of legal remedies abroad for victims of medical malpractice and the benefits associated with medical tourism that motivate patients to seek care abroad).

14. See *infra* Part III.C (discussing recent attempts to integrate medical outsourcing into health care plans).

15. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2006).

16. See 29 U.S.C. § 1001(a) (discussing the rationale behind the enactment of ERISA and its goals).

17. See *id.* ("It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans.").

18. *Id.* (setting out the initial scope of ERISA).

19. See *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 127 (1992)

"medical, surgical, or hospital care benefits."²⁰ In order to ensure uniformity, ERISA provides that it "shall supersede any and all [s]tate laws insofar as they may now or hereafter relate to any employee benefit plan."²¹ In determining whether a state law "relates to" an employee benefit plan, the Supreme Court held that Congress intended the words "relate to" in their broadest sense and rejected more limiting preemption language that would have made the clause "applicable only to state laws relating to the specific subjects covered by ERISA."²²

Given the broad scope of ERISA's applicability, the threshold question for evaluating any claim based on ERISA centers on whether a plan falls under ERISA regulation. In making this determination, courts generally follow the test delineated in *Fort Halifax Packing Co. v. Coyne*.²³ In *Fort Halifax*, the

(stating that ERISA's regulations apply to both employee pension plans and welfare plans); see also 29 U.S.C. § 1002(1) (defining "employee welfare benefit plan" and "welfare plan"). 29 U.S.C. § 1002(1) states:

The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, [medical care or benefits].

Id.

20. 29 U.S.C. § 1002(1)(A) (listing the relevant services an employee welfare benefit plan provides for its participants).

21. *Id.* § 1144(a) (describing ERISA's power to preempt state law relating to employee benefit programs).

22. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) (stating that Congress's intent to create a broad preemption is clear in light of the "deliberately expansive" language chosen by ERISA's drafters) (quoting *Shaw v. Delta Air Lines*, 463 U.S. 85, 96 (1983)). *But see* *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins.*, 514 U.S. 645, 658 (1995) (rejecting an overly expansive reading of the "relates to" language).

23. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 23 (1987) (holding that a Maine severance pay statute was not preempted by ERISA because it did not relate to any employee benefit plan). In *Fort Halifax*, the Supreme Court considered whether a Maine statute that required employers to provide a one-time severance payment to employees in the event of a plant closing was eligible for ERISA preemption. *Id.* at 3. Eleven employees of Fort Halifax filed suit seeking severance pay under the Maine statute when their plant closed. *Id.* at 5. Fort Halifax did not have its own severance plan and argued that ERISA preempted the state requirement. *Id.* at 6. The Supreme Court found that the Maine statute was not preempted by ERISA as the statute "neither establishes, nor requires an employer to maintain, an employee welfare benefit 'plan' under [the] federal statute." *Id.* Further, the Court found the statute was not preempted by the National Labor Relations Act because it establishes a minimum labor standard that does not intrude on the collective-bargaining process. *Id.* at 7. The language in ERISA draws a distinction between "benefits" and "plans." *Id.* at 8. Finally, the preemption clause role is to round out the protection afforded plan participants via the elimination of conflicting and inconsistent state and local regulations in favor of a uniform approach. *Id.* at 9.

Supreme Court defined an ERISA plan as one that requires an administrative scheme for it to operate.²⁴ Therefore, ERISA will govern a health plan when an employer establishes an employee benefits plan that (1) requires an administrative scheme and (2) provides the benefits described by ERISA.²⁵ Once a plan meets the basic requirements for ERISA coverage, the next relevant examination focuses on the fiduciary responsibility imposed by ERISA.²⁶

B. Fiduciary Responsibility Under ERISA

The ERISA guidelines that impose fiduciary²⁷ duty requirements on a variety of persons and organizations associated with employee welfare benefit plans form the crux of the issue surrounding medical outsourcing.²⁸ ERISA provides a wide range of remedies for those injured by fiduciaries who breached their duties,²⁹ including repayment by the fiduciary of any losses

The Maine statute does not threaten the protection of plan participants and is not a plan, but rather expands protection and offers a one-time benefit. *Id.* at 10. Therefore, the Maine statute does not meet the necessary criteria for ERISA preemption. *Id.* at 23.

24. *See id.* at 12–19 (describing the various elements necessary to find an employee benefit plan that would be eligible for ERISA preemption).

25. *See* 29 U.S.C. § 1002(1)(B) (2006) (defining an employee welfare benefit plan as one that pays the benefits described in either 29 U.S.C. §§ 1002(1)(A) or 186(c)). A plan should meet the statutory characteristics of an employee welfare plan before one examines the administrative aspect of a plan. It should be noted, however, that the Supreme Court qualified the coverage of ERISA in *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins.*, 514 U.S. 645, 658 (1995), and rejected an overly broad view of the preemption clause's "relates to" language. *Id.* at 662.

26. *See* 29 U.S.C. § 1104 (stating that an ERISA fiduciary should use "the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims" in relation to an ERISA plan).

27. The term "fiduciary," as used in this Note, refers to an ERISA "fiduciary" as defined at 29 U.S.C. § 1002(21)(A):

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Id.

28. *See* 29 U.S.C. § 1104 (discussing the standard of care imposed upon fiduciaries under ERISA).

29. *See* 29 U.S.C. § 1109(a) (describing the scope and nature of remedies against

incurred because of the breach.³⁰ Any plan beneficiary, participant, or other fiduciary can bring a civil action for damages resulting from a breach of fiduciary duty.³¹ In determining whether a person or organization is a fiduciary, courts generally apply a "functional" test,³² centering on whether the person or organization:

(i) . . . exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) . . . renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) . . . has any discretionary authority or discretionary responsibility in the administration of such plan.³³

Courts have further focused on the "discretionary authority"³⁴ language found in 29 U.S.C. § 1002(21)(A).³⁵ Because nonfiduciaries are not liable for monetary damages even if they intentionally participate in a breach of fiduciary duty,³⁶ the finding of fiduciary status is a prerequisite for imposing fiduciary

fiduciaries who breach their duty).

30. *See id.* ("Any person who is a fiduciary . . . shall be personally liable to make good to such plan any losses to the plan resulting from each such breach [of fiduciary duty].").

31. *See id.* § 1132(a)(2)–(3) (listing those persons eligible to bring a civil action for breach of fiduciary duty under ERISA). The Supreme Court held in *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996), that a participant or beneficiary may proceed under 29 U.S.C. § 1132(a)(3) to obtain individual "'appropriate' equitable relief." *Varity Corp.*, 515 U.S. at 515. In previous cases, the Court indicated that the term "equitable" gave participants and beneficiaries traditional injunctive remedies and monetary remedies of disgorgement and restitution, but not legal damages. *See Mertens v. Hewitt Assoc.*, 508 U.S. 248, 253–56 (1993) (stating legal damages not available under 29 U.S.C. § 1132(a)(3)). The Eighth Circuit in *Varity Corp.* construed this pronouncement to mean that participants and beneficiaries are not entitled to recover compensatory damages for breaches of fiduciary duty. *See Howe v. Varity Corp.*, 36 F.3d 746, 756 (8th Cir. 1994), *aff'd*, 516 U.S. 489 (1996) (construing equitable relief as not providing for compensatory damages).

32. *See* Robert N. Eccles, *Fiduciary Litigation Under ERISA*, 415 PRACTICING L. INST.—TAX 9, 14 (1998) ("Courts have described the test of determining fiduciary status as a 'functional' one . . .").

33. 29 U.S.C. § 1002(21)(A) (2006).

34. *Id.* ("[A] person is a fiduciary with respect to a plan to the extent . . . he has any discretionary authority or discretionary responsibility in the administration of such plan.").

35. *See, e.g., Olson v. E.F. Hutton & Co.*, 957 F.2d 622, 625 (8th Cir. 1992) (emphasizing the broad scope of the functional approach to fiduciary status under ERISA based upon the "discretionary authority" language); *Acosta v. Pac. Enter.*, 950 F.2d 611, 617–18 (9th Cir. 1991) (stating that a person's actions rather than their official designation dictate fiduciary status under ERISA).

36. *See Mertens v. Hewitt Assoc.*, 508 U.S. 248, 253–54 (1993) (stating that a nonfiduciary is not liable under ERISA for a breach of fiduciary duty, even when intentional). Courts have also severely restricted the equitable relief available against a nonfiduciary. *See*,

liability.³⁷ Some positions are, without question, fiduciary positions under ERISA.³⁸ These positions include plan administrators³⁹ and plan trustees, who by the very nature of the position, have "discretionary authority" within the meaning of § 1002(21)(A).⁴⁰ Some courts have used the functional approach to hold individuals within a corporation who perform the functions necessary to make the corporation a fiduciary individually liable as fiduciaries themselves.⁴¹ In *Confer v. Custom Engineering Co.*,⁴² however, the Third Circuit limited

e.g., Reich v. Rowe, 20 F.3d 25, 28 (1st Cir. 1994) (stating that ERISA's remedies under 29 U.S.C. § 1132(a)(5) do not apply against a nonfiduciary unless he is a party-in-interest as defined by § 1002(14)).

37. See Bruce D. Pingree, *Fiduciary Issues in Welfare Plans*, in ERISA FIDUCIARY LAW 87 (Susan P. Serota ed., 1995) (discussing the criteria used to identify welfare benefit plan fiduciaries).

38. See Eccles, *supra* note 32, at 13 (1998) (discussing the defined fiduciaries under ERISA).

39. See 29 U.S.C. § 1002(16)(A) (2006) (presenting the criteria for those persons defined as plan administrators within ERISA).

40. See 29 C.F.R. §§ 2509.75-8(D-3) (1999) ("Some offices or positions of an employee benefit plan by their very nature require persons who hold them to perform one or more of the functions described in § 3(21)(A) of the Act. . . . Persons who hold such positions will therefore be fiduciaries.").

41. See, *e.g.*, Leigh v. Engle, 727 F.2d 113, 135 (7th Cir. 1984) (stating that nonfiduciaries who appoint plan administrators have a duty to take prudent and reasonable action to determine whether the administrators are fulfilling their fiduciary duties when they have knowledge of a potential conflict of interest).

42. See *Confer v. Custom Eng'g Co.*, 952 F.2d 34, 37 (3d Cir. 1991) (holding that when a corporation serves as an ERISA fiduciary, the officers who exercise discretion on behalf of that corporation are not fiduciaries unless the officers have individual discretionary roles in plan administration). In *Confer*, the Third Circuit considered whether "plan supervisors" or the officers of a corporate plan administrator, as individuals, are fiduciaries under 29 U.S.C. § 1002(21)(A). *Id.* at 35. Confer was injured in a motorcycle accident and sought to recover benefits after his employer fraudulently amended its employee benefit plan to exclude motorcycle accidents and initially denied his claim. *Id.* Both the named plan administrator and plan supervisor were corporate entities, yet Confer sought to recover against the President and Vice President of Custom Engineering as well. *Id.* The court affirmed that a breach of fiduciary duty occurred when the corporation amended its plan to exclude Confer's claim via a backdated amendment. *Id.* The court also found that corporations can serve as fiduciaries based upon 29 U.S.C. § 1002(9). *Confer*, 952 F.2d at 37. However, the court then held that when an ERISA plan names a corporation as a fiduciary, the officers who exercise discretion on behalf of that corporation are not fiduciaries under ERISA unless it can be shown that these officers have individual discretionary roles as to plan administration. *Id.* Because neither the company president nor vice president acted in an individual manner, but rather as agents of Custom Engineering, they caused the company to breach its fiduciary duty but did not become fiduciaries themselves. *Id.* at 38. The court therefore upheld grants of summary judgment in favor of both the president and vice president. *Id.* at 39.

individual liability for officers of a fiduciary corporation so long as the individual acted within the corporate structure.⁴³

While the scope of the functional test is very broad, there are limits on who qualifies as an ERISA fiduciary. The language of 29 U.S.C. § 1002(21)(A) limits fiduciary status by stating that a person is a fiduciary "to the extent" she performs one of the listed functions.⁴⁴ Courts often find that people may be fiduciaries when they do certain things, but that they are entitled to act in their own interest when they do others.⁴⁵ Persons having "purely ministerial" functions, such as applying rules regarding benefit eligibility or making recommendations to others with respect to plan administration, are generally not fiduciaries.⁴⁶ The fact-intensive nature of determining fiduciary status lends itself to contrary conclusions depending on the forum, yet remains a critical step in evaluating ERISA liability.⁴⁷

C. The Fiduciary Duty

Once a person or entity qualifies as a fiduciary, it is important to understand the nature of the duty imposed upon them. ERISA establishes two

43. See *Confer*, 952 F.2d at 37 (limiting the scope of fiduciary duty for officers within a corporate entity that serve as a named fiduciary).

44. 29 U.S.C. § 1002(21)(A) (defining the criteria used to determine a person's fiduciary status under ERISA).

45. See, e.g., *Pegram v. Herdrich*, 530 U.S. 211, 214 (2000) (holding that treatment decisions made by a health maintenance organization through its physician employees do not qualify as fiduciary acts under ERISA); *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 104 (1993) (stating that a fiduciary is only subject to fiduciary duty when making decisions regarding discretionary aspects of a plan); *F.H. Krear & Co. v. Nineteen Named Trustees*, 810 F.2d 1250, 1258-59 (2d Cir. 1987) (stating that an administrative firm is not a fiduciary for purposes of its own selection as service provider, although it could become a fiduciary by controlling its own compensation); *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1325 (9th Cir. 1985) (finding that an employer was a fiduciary because it appointed a plan administrator, but is not itself a fiduciary with respect to plan administration); *Schulist v. Blue Cross of Iowa*, 717 F.2d 1127, 1130-32 (7th Cir. 1983) (stating that Blue Cross may have been a fiduciary for purposes of claims administration but not with respect to selecting itself as a service provider or setting its rate of compensation).

46. See 29 C.F.R. § 2509.75-8(D-2) (1999) ("[A] person who performs purely ministerial functions such as the types described above for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary.").

47. See *Pingree*, *supra* note 37, at 88 (discussing different scenarios and possible outcomes relating to the determination of fiduciary status under ERISA).

central duties to guide the actions of fiduciaries.⁴⁸ The first duty is to act "solely in the interest" of beneficiaries.⁴⁹ The second is the duty of disclosure.⁵⁰

The first duty that applies in the health care context is the duty to act in the sole interest of the plan participant. ERISA requires that fiduciaries "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to [plan] participants . . . and defraying reasonable expenses of administering the plan."⁵¹ In *Donovan v. Bierwirth*,⁵² the court noted that this provision, along with ERISA's related prudence requirement,⁵³ imposes three "different, although overlapping" duties derived from trust law.⁵⁴ Although courts occasionally distinguish between them, most courts have treated the "solely in the interest" and "exclusive purpose" standards interchangeably as codifications of the trust law duty of undivided loyalty.⁵⁵ While the duty to act "solely in the interest"

48. See Eccles, *supra* note 32, at 365 (discussing the basic duties imposed on plan fiduciaries under section 404(a)(1)(A) of ERISA).

49. See 29 U.S.C. § 1104(a)(1) (2006) (describing the prudent man standard of care as it entails loyalty to the interests of the plan participants).

50. See Ethan Lipsig & Joshua H. Sternoff, *Fiduciary Disclosure Obligations, in ERISA FIDUCIARY LAW 320* (Susan P. Serota ed., Supp. 2003) (discussing the judicial origins of the duty of disclosure and its relationship to the statutory elements of ERISA).

51. 29 U.S.C. § 1104(a)(1) (2006).

52. See *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (holding that trustees of a corporate pension plan who were also officers of the corporation violated their fiduciary duty when they refused to sell the pension plan's stock during a hostile takeover attempt). The court in *Donovan* examined whether the failure of ERISA fiduciaries—who were officers of Grumman Corporation—to accept an offer and subsequent purchase of additional company stock during an hostile takeover attempt violated 29 U.S.C. § 1104. *Donovan*, 680 F.2d at 264. The Grumman plan trustees refused an offer from LTV Corporation to acquire seventy percent of outstanding stock for forty-five dollars a share when the shares were trading at approximately thirty-eight dollars on the open market. *Id.* The trustees had done some preliminary investigation into the effect of the takeover on the pension plan but not in accordance with the high standard of management imposed upon fiduciaries. *Id.* at 273. The trustees also realized that the acquisition of the pension plan's stocks would be critical to the success of LTV Corporation's takeover bid. *Id.* at 266–67. Although the trustees believed the takeover bid threatened the long-term viability of the pension plan, their decision to refuse the buyout was inappropriately linked to their desire as officers of the corporation to defeat the takeover bid. *Id.* at 272–73.

53. See 29 U.S.C. § 1104(a)(1)(B) (stating that a fiduciary should use "the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims" in relation to an ERISA plan).

54. See *Donovan*, 680 F.2d at 271 (discussing the three overlapping standards and their distinguishing factors).

55. See, e.g., *Eaves v. Penn*, 587 F.2d 453, 457 (10th Cir. 1978) (comparing the fiduciary standard found in ERISA with the traditional law of trusts).

generally applies to situations where the fiduciary acts in his personal interest, it is not completely unqualified.⁵⁶ Some courts have held that a fiduciary's actions may confer a benefit upon the fiduciary so long as the action was in the best interests of the plan.⁵⁷ In *Donovan*, the Second Circuit stated that a fiduciary may take action that benefits his own interests so long as the action also benefits plan participants.⁵⁸

The Supreme Court recently scrutinized ERISA's fiduciary duty as applied to physicians and health medical organizations in *Pegram v. Herdrich*.⁵⁹ *Pegram* held that decisions that combine treatment decisions and eligibility decisions are not fiduciary in character.⁶⁰ Therefore, a health care plan in which doctors receive year-end bonuses based upon their rationing of expensive medical services does not breach ERISA's fiduciary duty because a decision

56. See, e.g., *Wright v. Nimmons*, 641 F. Supp. 1391, 1408 (S.D. Tex. 1986) (finding that the fiduciary blatantly disregarded his fiduciary duty to the plan in setting his compensation).

57. See *Donovan v. Walton*, 609 F. Supp. 1221, 1245 (S.D. Fla. 1985) ("[A] trustee may make management decisions that incidentally benefit the plan or the trustees provided the judgment is prudent and primarily promotes the interest of plan participants and beneficiaries.").

58. See *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (allowing for fiduciaries to make decisions benefiting both themselves and plan participants). The court stated:

Although officers of a corporation who are trustees of its pension plan do not violate their duties as trustees by taking action which, after careful and impartial investigation, they reasonably conclude best to promote the interests of participants and beneficiaries simply because it incidentally benefits the corporation or, indeed, themselves, their decisions must be made with an eye single to the interests of the participants and beneficiaries.

Id.

59. See *Pegram v. Herdrich*, 530 U.S. 211, 214 (2000) (holding that treatment decisions made by a health maintenance organization through its physician employees do not qualify as fiduciary acts under ERISA). In *Pegram*, the Supreme Court reviewed an appellate court's decision that a health maintenance organization's provision rewarding physicians for limiting medical care constituted a violation of ERISA's fiduciary duty, because the policy created an incentive for physicians to act in their own self-interest rather than the exclusive interest of plan participants. *Id.* at 220. The Supreme Court reversed the court of appeals, finding that such a policy did not constitute a breach of fiduciary duty. *Id.* at 214. The Court distinguished between two types of administrative decisions made by health maintenance organizations and their physicians: eligibility decisions and treatment decisions. *Id.* at 228-29. Eligibility decisions are the decisions regarding whether a plan covers a particular condition or the procedure for its treatment, while treatment decisions are the choices about how to diagnose and treat a patient's symptoms. *Id.* at 228. Treatment decisions and eligibility decisions, however, are often "inextricably mixed" according to the Court. *Id.* It was not Congress's intent to treat health maintenance organizations or their physicians as fiduciaries when making such mixed eligibility decisions, and therefore, decisions found to encompass both aspects are not subject to fiduciary duty requirements. *Id.* at 231.

60. See *id.* at 231 ("[W]e think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians.").

treatment and eligibility is so mixed that it would be impossible to distinguish between a physician's judgment and possible financial motivation.⁶¹ Although the Court did leave open the possibility of some extreme plans violating ERISA's fiduciary duty,⁶² *Pegram* weakens the duty to act in the sole interest of plan participants.

Four years after *Pegram*, the Supreme Court narrowed and clarified the scope of *Pegram* with its holding in *Aetna Health Inc. v. Davila*.⁶³ *Aetna* limited *Pegram*'s scope, clarifying that the "mixed decisions"⁶⁴ referenced in *Pegram* only avoid ERISA's fiduciary duties when a treating physician or the treating physician's employer made the decision.⁶⁵ The Court's holding in *Aetna* restores ERISA's fiduciary duty requirement to any benefit or eligibility decision made by a plan administrator, even when such decisions turn extensively on medical judgment.⁶⁶ Post-*Aetna*, mixed eligibility and treatment decisions are defined as "medical necessity decisions made by the plaintiff's treating physician *qua* treating physician and *qua* benefits administrator."⁶⁷

61. See *id.* at 228–29 (stating that a physician's eligibility and treatment decisions cannot be separated from the physician's professional judgment and therefore cannot be analyzed under a fiduciary lens).

62. See *id.* at 227 n.7 ("It does not follow that those who administer a particular plan design may not have difficulty in following fiduciary standards if the design is awkward enough.").

63. See *Aetna Health Inc. v. Davila*, 542 U.S. 200, 221 (2004) (holding that the district court's decision to remand claims against an HMO to state court was in error and that ERISA preempted respondent's claims). In *Aetna*, the Supreme Court considered whether ERISA preempted state suits brought against HMO's which were based upon refusal to cover certain medical services and procedures. *Id.* at 204–07. Respondents relied heavily upon the Court's decision in *Pegram*, arguing the broad scope of *Pegram*'s exclusion of mixed decisions allowed for their claims to rest outside of ERISA. *Aetna*, 542 U.S. at 218. The Court disagreed, stating *Pegram* was not to be so broadly applied. *Aetna*, 542 U.S. at 218. "A benefit determination under ERISA . . . is generally a fiduciary act." *Id.* The Court stated that *Pegram* only applied when the "underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such as a physician's employer." *Id.* at 221 (quoting *Cicio v. Does*, 321 F.3d 83, 109 (2d Cir. 2003) (Calabresi, J., dissenting)). Therefore, the ultimate decision maker in any plan regarding the award of benefits qualifies as a fiduciary and to classify any entity with discretionary authority over the award of benefits as anything but a fiduciary would conflict with ERISA's scope and purpose. *Id.* at 220.

64. *Pegram*, 550 U.S. at 228.

65. See *Aetna*, 542 U.S. at 221 (limiting the exclusionary scope of *Pegram* to those mixed decisions made by a treating physician or the physician's employer).

66. See *id.* at 220 (stating that administrators making benefits decisions based heavily upon medical judgment still generally qualify as plan fiduciaries under ERISA).

67. See *id.* at 221 (defining what decisions qualify as mixed eligibility and treatment decisions).

The second duty ERISA imposes on fiduciaries is the duty of disclosure. Much confusion exists among the courts as to the source and the scope of this duty.⁶⁸ The first branch of this duty is to avoid affirmative misrepresentations.⁶⁹ In *Varity Corp. v. Howe*,⁷⁰ the Supreme Court held that § 1104(a)'s duty to act "solely in the interest of [plan] participants" is inconsistent with lying to a participant.⁷¹ The Court, therefore, concluded that a fiduciary has a duty not to make misrepresentations about the plan.⁷² Several courts have extended the duty of disclosure to include a duty of affirmative disclosure.⁷³ The D.C. Circuit held that when a beneficiary contacts the

68. See Lipsig & Sternoff, *supra* note 50, at 320 (discussing the judicial origins of the duty of disclosure and the variety of methods by which courts have defined the duty).

69. See *id.* at 323–24 ("[A] fiduciary breaches its fiduciary duty if a participant suffers a resultant harm from a fiduciary's material misrepresentation."); see also *Daniels v. Thomas & Betts Corp.*, 263 F.3d 66, 73 (2d Cir. 2001) (listing material misrepresentation of fact as an issue in resolving fiduciary duty claims under ERISA).

70. See *Varity Corp. v. Howe*, 516 U.S. 489, 491 (1996) (holding that Varity Corporation acted as a fiduciary when it deliberately misled plan participants and, in doing so, violated the fiduciary duty imposed under ERISA). In *Varity*, the Supreme Court considered three questions: (1) was Varity acting in its capacity as an ERISA "fiduciary" when it significantly and deliberately misled plan beneficiaries; (2) in misleading the beneficiaries, did Varity violate its fiduciary obligations under ERISA; and (3) does ERISA section 502(a)(3) authorize beneficiaries to bring a lawsuit that seeks relief for individual beneficiaries harmed by an administrator's breach of fiduciary obligations. *Id.* at 491. Varity convinced several divisions of its employees to voluntarily transfer their pension plans to a new subsidiary of Varity by assuring them of the financial stability of the subsidiary. *Id.* at 493–94. The subsidiary had truthfully been set up to consolidate many of Varity's loss prone enterprises and its business plan foresaw a relatively high chance of failure. *Id.* Varity also wished to transfer employees' ERISA plans to the subsidiaries because debt represented by the plans could be eliminated if the subsidiary went bankrupt without the public fallout foreseen from simply canceling the plans without justification. *Id.* The Court found that Varity was both the employer and the plan administrator and therefore was subject to the fiduciary duties imposed by ERISA. *Id.* at 498. Therefore, in attempting to cut losses by convincing employees to move their benefit plans to a failing subsidiary, Varity breached its fiduciary duty to the plan participants. *Id.* at 503, 506. ERISA's fiduciary duty is not consistent with deceiving a plan's participants in order to save a corporation money. *Id.* at 506. Finally, the beneficiaries' suit was authorized under ERISA. *Id.* at 515.

71. See *id.* at 506 ("[L]ying is inconsistent with the duty of loyalty owed by all fiduciaries and codified in section 404(a)(1) of ERISA, 29 U.S.C. § 1104(a)(1)." (citing *Peoria Union Stock Yards Co. v. Penn Mut. Life Ins. Co.*, 698 F.2d 320, 326 (7th Cir. 1983))).

72. See *id.* ("To participate knowingly and significantly in deceiving a plan's beneficiaries in order to save the employer money at the beneficiaries' expense is not to act solely in the interest of the participants and beneficiaries.").

73. See, e.g., *Griggs v. E.I. Dupont de Nemours & Co.*, 237 F.3d 371, 380 (4th Cir. 2001) (stating that a fiduciary is "at times" obligated to affirmatively provide information to the beneficiary without being asked affirmatively); *Palen v. Kmart Corp.*, No. 97-2269, 2000 U.S. App. LEXIS 10780, at *10–12 (6th Cir. May 9, 2000) (citing *Krohn v. Huron Mem'l Hosp.*, 173 F.3d 542, 548 (6th Cir. 1999)) (stating that ERISA's fiduciary duty includes a duty to

fiduciary about his status and options within the plan, the fiduciary has an obligation to provide complete and correct material information.⁷⁴ The Third Circuit also found an affirmative duty to disclose in certain circumstances, holding that when the fiduciary notices that a failure to disclose will cause harm to a plan participant, the fiduciary has a duty to convey "complete and accurate information material to the beneficiary's circumstance."⁷⁵ In another case, the Third Circuit went even further in holding that a specific request by a participant is not necessary to find that the fiduciary had a duty to disclose information material to the participant's situation.⁷⁶ The court made clear that a fiduciary has an affirmative duty to disclose material information even in the absence of an inquiry by a beneficiary.⁷⁷ Not all circuits, however, have adopted this expansive view of the duty of disclosure.⁷⁸ *Pocchia v. NYNEX Corp.*⁷⁹ rejected the argument that a fiduciary is obligated to make voluntary

affirmatively disclose information when the fiduciary knows failure to disclose would result in harm to the beneficiary).

74. See *Eddy v. Colonial Life Ins.*, 919 F.2d 747, 751 (D.C. Cir. 1990) (stating that the ERISA fiduciary duty requires a fiduciary not only to refrain from misinforming a beneficiary but to also inform them with correct and complete information).

75. See *Bixler v. Cent. Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1300 (3d Cir. 1993) (stating that a fiduciary is under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary). The court further stated that a fiduciary's obligations will not be excused merely because a participant failed to comprehend or ask about a technical aspect of a plan. *Id.*

76. See *Jordan v. Fed. Express Corp.*, 116 F.3d 1005, 1016 (3d Cir. 1997) (finding that a specific request for information is not necessary to create an affirmative duty to inform).

77. See *id.* ("[I]t is clear that circumstances known to the fiduciary can give rise to this affirmative obligation [to inform] even absent a request by the beneficiary." (citing *Glaziers & Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Sec., Inc.*, 93 F.3d 1171, 1181 (3d Cir. 1996))).

78. See *Switzer v. Wal-Mart Stores, Inc.*, 52 F.3d 1294, 1299 (5th Cir. 1995) ("[A] plan administrator does not have any fiduciary duty to determine whether confusion about a plan term or condition exists. It is only after the plan administrator does receive an inquiry that it has a fiduciary obligation to respond promptly and adequately in a way that is not misleading.").

79. See *Pocchia v. NYNEX Corp.*, 81 F.3d 275, 278 (2d Cir. 1996) (holding that a plan fiduciary is not required to voluntarily disclose upcoming changes in plan policy until said updates are put into effect, even if the fiduciary is aware of the changes). In *Pocchia*, the Second Circuit considered whether a fiduciary is required under ERISA to voluntarily disclose his knowledge of upcoming changes to a benefit plan before the changes are adopted. *Id.* at 278-79. Plaintiff brought suit against NYNEX after NYNEX implemented changes in its retirement plans several months after plaintiff retired. *Id.* at 277. Plaintiff claimed NYNEX breached its fiduciary duty under ERISA by not informing him of its decision to implement the new plan during his retirement negotiations. *Id.* The court held that a fiduciary is not required to voluntarily disclose changes in plan policy until such changes are enacted, regardless of knowledge. *Id.* at 278.

disclosures to beneficiaries absent an inquiry.⁸⁰ The ultimate scope of this duty, therefore, is somewhat unclear.⁸¹

D. ERISA Fiduciaries in Health Care Plans

After evaluating fiduciary characteristics, the next inquiry becomes who, within the context of a health care plan, is a fiduciary. This subpart will examine the three major agents in a typical health care plan: the health care plan itself, the physician organization responsible for delivering care, and the individual physician who provides the care.

1. The Health Care Plan

The health care plan as a corporate entity is the clearest example of an ERISA fiduciary in contemporary health care systems. While the term "health care plan" is somewhat vague, it generally describes the various corporate structures created in response to the move toward integrating health care services.⁸² Health medical organizations (HMOs), preferred provider organizations (PPOs),⁸³ physician hospital organizations (PHOs),⁸⁴ and other integrated delivery systems, including employers that act as both insurers and health care providers, are common examples of health care plans.⁸⁵ Many

80. See *id.* (stating that a fiduciary does not have to make voluntary disclosures to plan participants without inquiry by the participant).

81. See Lipsig & Sternoff, *supra* note 50, at 320 (discussing the lack of consensus between circuits as to the limits and scope of the duty to disclose under ERISA).

82. See DONALD K. FREEBORN & CLYDE R. POPE, PROMISE AND PERFORMANCE IN MANAGED CARE: THE PREPAID GROUP PRACTICE MODEL 2-6 (1994) (discussing the various forms of health care plans in the U.S.); PHYSICIAN PAYMENT REVIEW COMM'N ANN. REP. (1995), reprinted in BARRY R. FURROW ET AL., HEALTH CARE LAW 521-24 (3d ed. 1997) (providing a general discussion of the corporate elements of health care plans in the U.S.).

83. See Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1223-26 (1997) (listing PPOs as a type of managed care). Examples of "managed care" include: the health maintenance organization (HMO), which is an organization that fully integrates the insurance and provider aspects of health care delivery; the preferred provider organization (PPO), which is a less integrated version of an HMO, in which physicians often maintain independent practices; and the physician hospital organization (PHO), which is an entity comprised of a hospital and its affiliated physicians that offers centralized management, but a less integrated structure than an HMO. *Id.* at 1224 n.22, 1223-26 (discussing three forms of managed health care plans).

84. See *id.* at 1225 (contrasting PHOs with other types of health care plans).

85. See *id.* at 1223-26 (discussing the various types of health care systems found in the United States and their distinguishing characteristics).

courts have held that because health care plans generally "exercise[] discretionary control over the administration of the plan and for the payment of benefits,"⁸⁶ they qualify as fiduciaries under ERISA.⁸⁷ Although health care plans take many forms⁸⁸ and an examination of the organization's discretionary control over plan administration and payment of benefits remains essential, most plans will exercise the requisite discretion and qualify as ERISA fiduciaries.

2. *The Physician Organization Providing Care to Plan Participants*

While health care plans generally qualify as ERISA fiduciaries, the classification of a physician association is less clear. A physician organization's role within health care systems is generally to provide office-based primary care via contract.⁸⁹ A common example of a physician organization is the independent practice association (IPA),⁹⁰ in which physicians organize for the purpose of negotiating contracts to provide services to health plan subscribers.⁹¹ The scope of the physician organization's duties will vary by the contract, but generally include negotiating contracts with insurers, consolidating practice management functions, and utilizing expensive medical technology by sharing of equipment and costs.⁹² The organization may also provide information to the health care plan in connection with its prospective utilization review of hospital admissions and specialist referrals.⁹³

86. *Morales v. Health Plus, Inc.*, 954 F. Supp. 464, 468 (D.P.R. 1997).

87. *See O'Reilly v. Ceuleers*, 912 F.2d 1383, 1385 (11th Cir. 1990) (holding the defendant HMO to be a fiduciary under ERISA because it exercised discretionary control of the plan and over the payment of benefits); *Weiss v. Cigna Healthcare, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997) (stating that an HMO is an ERISA fiduciary when it exercises discretion over administration of plan).

88. *See supra* note 83 and accompanying text (discussing examples of managed care).

89. *See Noah, supra* note 83, at 1223 (describing the various forms of health care plan management); *see also* CHARLES G. BENDA & FAY A. ROZOVSKY, *MANAGED CARE AND THE LAW: LIABILITY AND RISK MANAGEMENT* ¶ 2.4.1 (2003) (discussing the role of physician organizations in providing health care services through HMOs).

90. *See Brant S. Mittler & Andre Hampton, The Princess and the Pea: The Assurance of Voluntary Compliance Between the Texas Attorney General and AETNA's Texas HMOs and Its Impact on Financial Risk Shifting by Managed Care*, 83 B.U. L. REV. 553, 556 n.11 (2003) ("An IPA is defined as the simplest form of physician organization.").

91. *See* PATRICIA YOUNGER ET AL., *LEGAL ANSWER BOOK FOR MANAGED CARE* 14 (1995) (describing the function and setup of independent practice associations).

92. *See id.* (discussing the various functions of physician organizations such as group practices and independent practice associations).

93. *See* Linda V. Tiano, *The Legal Implications of HMO Cost Containment Measures*, 14

Courts will likely classify such activity as "purely ministerial,"⁹⁴ because the physician organization is simply following preestablished guidelines rather than exercising its own discretion.⁹⁵ A physician organization's contractual relationship might provide discretionary authority over plan administration and payment of claims, but such a situation is exceptional.⁹⁶ Even in such a circumstance, ERISA fiduciary status is limited to those actions in which the person or group is acting in a discretionary capacity.⁹⁷ The physician organization may act as a fiduciary when making administrative decisions regarding the health plan but not when making medical or business decisions that relate to the management of the physician organization.⁹⁸ The fiduciary status of physician organizations, therefore, is a fact-intensive issue that must be decided on a case-by-case basis.⁹⁹

3. *The Physician*

The status of a physician as an ERISA fiduciary is somewhat unclear, but it appears that a physician is not an ERISA fiduciary. Courts classifying a health plan as an ERISA fiduciary have based their conclusion on the fact that the health plan "exercises discretionary control over the administration of the plan and for the payment of benefits."¹⁰⁰ The physician's primary role within a

SETON HALL LEGIS. J. 79, 80 (1990) (noting that as a cost-saving technique HMOs often review doctors' decisions to use expensive medical interventions).

94. 29 C.F.R. § 2509.75-8 (1999).

95. *See id.* (stating that persons following rules and procedures set by others are not ERISA fiduciaries).

96. *See Pegram v. Herdrich*, 530 U.S. 211, 228–29 (2000) (stating that a physician's eligibility and treatment decisions cannot be separated from the physician's professional judgment and therefore cannot be analyzed under a fiduciary lens even though the decision may impact plan administration).

97. *See* 29 U.S.C. § 1002(21)(A) (2006) (stating that a person is an ERISA fiduciary only to the extent the person exercises discretionary authority).

98. A person is a fiduciary only to the extent he or she has discretion over plan management or administration. 29 C.F.R. § 2509.75-8 (1999). A person is not considered a fiduciary when he or she makes decisions based on policies, interpretations, and rules established by others. *Id.* Therefore, medical and business decisions made by physician organizations are distinct from decisions involving plan management or administration, as such decisions relate to the management of the physician organization, not the management or administration of the health plan.

99. *See Pingree*, *supra* note 37, at 88 (stating that determining fiduciary status is often a fact intensive exercise based upon the form of the health care provider).

100. *Morales v. Health Plus, Inc.*, 954 F. Supp. 464, 468 (D.P.R. 1997); *see also O'Reilly v. Ceuleers*, 912 F.2d 1383, 1385 (11th Cir. 1990) (holding the defendant HMO to be a fiduciary under ERISA because it exercised discretionary control of the plan and over the

health plan is to provide medical care directly to plan participants.¹⁰¹ Although a physician exercises a substantial amount of discretion when making medical decisions—arguably enough discretion to make a physician an ERISA fiduciary—the health plan ultimately maintains control over management of the plan and over many of the physician’s decisions.¹⁰² Because fiduciary status requires control and discretion,¹⁰³ and because ultimate control remains with the health plan,¹⁰⁴ a physician would not be an ERISA fiduciary.

Two additional arguments exist against treating a physician as an ERISA fiduciary. First, physicians should not qualify as fiduciaries when performing professional functions because they lack ultimate authority with regard to plan administration.¹⁰⁵ Second, the fact that the law imposes independent fiduciary duties on a physician in the form of malpractice liability¹⁰⁶ ensures the quality of service ERISA fiduciary duties seek to ensure. Both arguments recognize that the physician’s exercise of professional medical discretion is distinct from decisions made with regard to the health care plan.¹⁰⁷ In effect, the physician has an express contract with the health plan and an implicit contract with the patient.¹⁰⁸ The discretion exercised in prescribing medical treatment relates to the physician’s contract with the patient—for which he is already subject to liability for malpractice. Furthermore, no reported decision holds that a treating physician qualifies as an ERISA fiduciary. Because a physician’s medical

payment of benefits); *Weiss v. Cigna Healthcare, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997) (stating that an HMO is an ERISA fiduciary when it exercises discretion over administration of a plan).

101. See Noah, *supra* note 83, at 1223 (describing a physician’s role within the health care system).

102. See MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS* 139 (1993) (discussing the administrative procedures used by HMO’s to control and influence the majority of decisions a physician makes within the plan context).

103. See 29 C.F.R. § 2509.75-8 (stating a person is a fiduciary only to the extent he or she has discretion over plan management or administration and that a person is not considered a fiduciary when he or she makes decisions based on policies, interpretations, and rules established by others).

104. See *supra* note 102 and accompanying text (discussing the methods health care providers use to maintain control over physician’s decisions).

105. See 29 C.F.R. § 2509.75-5 (1999) (stating that professionals should not be considered ERISA fiduciaries solely for providing professional services to a health plan, but instead must meet one of the statutory prerequisites).

106. See FURROW ET AL., *supra* note 82, at 360 (discussing the medical tort system and the duties inherent in preventing malpractice liability).

107. See *Pegram v. Herdrich*, 530 U.S. 211, 228–29 (2000) (stating that a physician’s eligibility and treatment decisions cannot be separated from the physician’s discretionary professional judgment and therefore cannot be analyzed under a fiduciary lens).

108. See *id.* at 223 (discussing the contractual status between doctors and patients).

decisions are distinct from the exercise of any administrative discretion, a physician will likely not qualify as a fiduciary under ERISA.

Although health care plans are the only clear examples of ERISA fiduciaries in the health care context, the exclusion of physicians and physicians' organizations actually serves to narrow the scope of potential ERISA liability resulting from medical outsourcing.¹⁰⁹ The next Part will examine the newly developing practice of medical outsourcing and analyze both the potential benefits and risks present in this burgeoning industry.

III. Medical Outsourcing

A. History and Practice

The term "medical outsourcing" in the context of this Note refers to treatments or surgeries that have been planned in advance to take place outside of a patient's usual country of residence.¹¹⁰ The practice of medical outsourcing finds its roots in medical tourism,¹¹¹ a term describing the practice of visiting a foreign country in order to have cosmetic surgical procedures performed at lower costs.¹¹² Although the practice of medical tourism is not particularly new, "tourists" generally sought low-cost alternatives to expensive cosmetic surgical procedures not covered by health insurance plans.¹¹³ Medical outsourcing, however, tends to focus on finding low-cost alternatives to noncosmetic procedures ranging from hip¹¹⁴ or knee¹¹⁵ transplants to highly

109. See *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1385 (11th Cir. 1990) (holding the defendant HMO to be a fiduciary under ERISA because it exercised discretionary control of the plan and over the payment of benefits); *Weiss v. Cigna Healthcare, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997) (stating that an HMO is an ERISA fiduciary when it exercises discretion over administration of plan). See also *infra* Part II.D (discussing the fiduciary duty imposed by ERISA and the scope of its application).

110. See Atul D. Garud, *Medical Tourism and its Impact on our Health Care*, 18 NAT'L MED. J. INDIA 318-19 (2005) (discussing growth of medical tourism and its impact on India's health care infrastructure).

111. See Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. (forthcoming 2007) (discussing the intersection of medical tourism and commercial outsourcing as a catalyst for the rise of medical outsourcing).

112. See *id.* (defining medical tourism and describing the evolution of the connotation of medical tourist).

113. See *id.* (discussing the different motivating factors for medical tourists).

114. See *id.* (discussing the wide variety of medical procedures available for medical outsourcing).

115. See Unmesh Kher, *Outsourcing Your Heart*, TIME, May 21, 2006, at 44-47

technical and critical procedures such as double-heart-bypass surgery¹¹⁶ and spinal surgery.¹¹⁷ The expansion of surgical services both sought and offered to medical tourists finds its commercial origins in the aftermath of the Asian financial crisis of 1997.¹¹⁸ Hospitals such as Bumrungrad International in Bangkok, Thailand began heavily recruiting foreign patients, and exponential growth occurred as a result of dramatically lower price points for comparable care.¹¹⁹ In 2005, Bumrungrad International alone drew over 400,000 foreign patients, with 55,000 Americans,¹²⁰ a 30% increase from the previous year.¹²¹ While these visits are nominal in comparison to the millions of surgeries performed annually in the \$2 trillion U.S. health care system,¹²² some analysts believe they represent the beginning of a consumer movement rejecting seemingly out of control domestic health care costs.¹²³

B. Benefits and Risks of Medical Outsourcing

Three major factors are the primary motivators for patients seeking medical treatment overseas. The significant cost savings available remains the most prominent factor, but similar standards of care and access to alternative medicines and procedures also play a prominent role.¹²⁴ This subpart examines

(discussing the various types of medical procedures popular in foreign hospitals).

116. See *id.* (presenting an example of a person's experience as an open heart surgery patient abroad).

117. See, e.g., Bumrungrad International Hospital—Orthopedics Center, <http://www.bumrungrad.com/htm/eng/main.asp?Filename=clinic/ortho.asp> (last visited Feb. 12, 2007) (detailing the wide range of care provided at Bumrungrad International) (on file with the Washington and Lee Law Review).

118. See CBS News: *Outsourcing Health with Overseas Remedies* (CBS News television broadcast Nov. 4, 2006), available at <http://www.cbsnews.com/stories/2006/11/04/health/main/2153345.shtml> (discussing the factors leading to the expansion of the overseas health care market).

119. See *id.* (discussing the advertising strategies used to encourage medical tourism).

120. See Milstein & Smith, *supra* note 5, at 1638 (providing statistics on the patients treated at Bumrungrad International). Eighty-three percent of those American patients sought noncosmetic surgical treatment. *Id.*

121. See *id.* (stating the number of American patients treated at Bumrungrad increased approximately 30% over the past year).

122. See Kher, *supra* note 115, at 44 (discussing the economic size and importance of the U.S. health care system).

123. See Milstein & Smith, *supra* note 5, at 1638 (discussing the unmanageable costs of health care for low and middle-class American families and its role as a catalyst in the development of medical outsourcing).

124. See Terry, *supra* note 111 (describing the three central factors patients consider when opting to undergo medical procedures abroad).

and presents a critical cost-benefit analysis of each factor. Finally, the subpart discusses the most overlooked risk associated with medical outsourcing, the lack of legal protection in the U.S. court system.

1. Cost Savings

The cost savings associated with medical outsourcing simply cannot be overstated. While costs vary geographically, the average surgical procedure performed in Asia will cost only 20%–25% as much as the comparable American procedure.¹²⁵ The following table provides a brief list of surgical procedures and a comparison of costs between the United States, India, Thailand, and Singapore:

Table 1¹²⁶

	Angioplasty	Gastric Bypass	Heart Bypass	Heart Valve Replacement
U.S. Insurer's Cost	\$25,000–37,000	\$27,000–40,000	\$54,000–79,000	\$71,000–103,000
U.S. Retail	\$57,000–82,000	\$48,000–69,000	\$122,000–176,000	\$159,000–230,000
India Retail	\$11,000	\$11,000	\$10,000	\$9,500
Thailand Retail	\$13,000	\$15,000	\$12,000	\$10,500
Singapore Retail	\$13,000	\$15,000	\$20,000	\$13,000
	Knee Replacement	Spinal Fusion	Hip Replacement	Mastectomy
U.S. Insurer's Cost	\$17,000–25,000	\$25,000–36,000	\$18,000–26,000	\$9,000–14,000
U.S. Retail	\$40,000–58,000	\$62,000–90,000	\$43,000–63,000	\$23,000–34,000
India Retail	\$8,500	\$5,500	\$9,000	\$7,500
Thailand Retail	\$10,000	\$7,000	\$12,000	\$9,000
Singapore Retail	\$13,000	\$9,000	\$12,000	\$12,400

125. See Kher, *supra* note 115, at 44 ("Procedures in Thailand and Malaysia . . . cost only 20% to 25% as much as comparable ones in the U.S.").

126. See *id.* at 47 (providing a comparative table of medical procedure costs in the United States and three foreign locations).

As the data indicates, the difference in cost to the consumer is even greater than the savings experienced by insurance companies, with some savings reaching greater than ninety percent.¹²⁷ Further, assuming medical costs in the United States continue to trend upward, the economic appeal of medical outsourcing will continue to increase.¹²⁸ In fact, 2006 marked the first year in which the average health care expenditures for a family of four exceeded the entire annual earnings of a minimum-wage employee.¹²⁹

The significant differences in health care costs between the United States and global competitors stem from a variety of different causes, one of the most significant being the difference in malpractice insurance premiums.¹³⁰ In Thailand, for example, the average doctor will pay approximately \$5,000 in medical malpractice insurance for one year's coverage.¹³¹ Contrast this with malpractice premiums in the United States, which can cost up to \$100,000 a year for specialists, and a major source of Thailand's savings becomes clear.¹³² However, it is important to note that the lower insurance premiums outside of the United States directly relate to the risk they serve to mitigate—malpractice damage awards. The largest medical malpractice award in Thailand to date was only \$100,000.¹³³ Although the average award in the United States comes to approximately \$1 million,¹³⁴ the average malpractice award payout was \$308,000.¹³⁵ The comparatively low amount of damages in Asia is due largely

127. See *id.* (noting that heart valve replacement, for example, might cost up to \$236,000 in the United States and only \$13,000 in Singapore, a difference of approximately 96%).

128. See Milstein & Smith, *supra* note 5, at 1639 (stating that as health care costs continue to rise, the number of households priced out of the market will increase and therefore enter the medical outsourcing market).

129. See *id.* (discussing the high impact health care costs have on low and middle income Americans).

130. See Mark Roth, *A Cheaper Medical Alternative; For Those With Minimal Health Insurance, Getting Surgery Abroad May Be a Sound Option*, PITTSBURGH POST-GAZETTE, Sept. 10, 2006, at G1 (discussing the various factors leading to lower costs for surgical procedures abroad).

131. *Id.*

132. See *id.* (comparing medical malpractice insurance premiums in the United States to those paid by doctors in foreign countries where medical outsourcing is prevalent).

133. *Id.*

134. See Insurance Information Institute, <http://www.iii.org/media/hottopics/insurance/medicalmal/> (last visited May 17, 2007) (stating that the median medical malpractice jury award is approximately one million dollars) (on file with the Washington and Lee Law Review).

135. See Kaiser Family Foundation, *Payments on Medical Malpractice Claims, 2006*, <http://www.statehealthfacts.org> (last visited Sept. 17, 2007) (providing data and award payment averages for each state and national averages) (on file with the Washington and Lee Law Review).

to the fact that the law does not permit damages for pain and suffering.¹³⁶ Method of payment is another major source of savings in foreign health care systems.¹³⁷ At Bumrungrad International, for example, approximately seventy-five percent of its patients pay for their treatment in cash.¹³⁸ Cash payments result in dramatically less added expense via insurance processing fees, which can run as high as 10% in the U.S. health care system.¹³⁹

The significant cost savings available overseas means little, however, unless it motivates persons to go through the hassle and risk of traveling before and after surgery and recovering in a foreign environment. A study commissioned by Dr. Arnold Milstein¹⁴⁰ suggests that economic motivation comes into play well below the possible savings illustrated in Table 1.¹⁴¹ Poll results suggest that few consumers would chose to undergo surgical procedures abroad for financial incentives below \$1,000.¹⁴² For savings between \$1,000 and \$5,000, however, the numbers increase dramatically.¹⁴³ Forty-five percent of uninsured or underinsured consumers stated they would travel abroad to take advantage of savings, while 19% of insured respondents responded affirmatively.¹⁴⁴ When potential savings increased above \$5,000, the percentage of those willing to travel increased to 61% and 40% respectively.¹⁴⁵ The large number of persons willing to travel abroad for discount surgical procedures highlights the importance of financial incentives in medical

136. See Roth, *supra* note 130, at G1 (discussing malpractice award limits in Thailand and India).

137. See *id.* (discussing other sources of cost savings at Bumrungrad International Hospital).

138. See *id.* ("Seventy-Five percent of [Bumrungrad International's] patients pay cash.").

139. See Cybele Weisser & Amanda Gengler, *50 Ways to Cut Your Health-Care Costs*, in MONEY, [http://money.cnn.com/popups/2006/moneymag/health care/index.html](http://money.cnn.com/popups/2006/moneymag/health%20care/index.html) (last visited July 12, 2007) (stating that most doctors lose thousands each year on credit-card processing fees and that cash payment can result in up to a ten percent discount) (on file with the Washington and Lee Law Review).

140. Dr. Milstein is the chief physician at Mercer Health and Benefits and medical director of the Pacific Business Group on Health in San Francisco. Milstein & Smith, *supra* note 5, at 1640 (2006).

141. See Kher, *supra* note 115, at 45–46 (finding that consumers would be willing to travel abroad for medical procedures for savings of just \$1,000).

142. See *id.* (finding that relatively few consumers will travel 10,000 miles for surgery for less than \$1,000 of potential savings).

143. See *id.* (showing that persons willing to travel increased almost 50% when economic benefit increased).

144. See *id.* (presenting poll statistics regarding the willingness of people to travel for cost savings of over \$1,000 and over \$5,000).

145. See *id.* (presenting statistics comparing consumer's willingness to travel abroad for medical procedures based upon financial incentives).

outsourcing and the potential impact medical outsourcing could have upon the U.S. health care system in the future.

2. *Similar Standards of Care*

Another major catalyst for patients choosing overseas surgical procedures is the availability of similar levels of care and expertise among treating physicians.¹⁴⁶ Many international hospitals, including Bumrungrad International,¹⁴⁷ have been certified under one or both of the international quality assessments administered by the International Organization for Standardization.¹⁴⁸ In fact, the Joint Commission on Accreditation of Healthcare Organizations¹⁴⁹ has accredited over eighty foreign hospitals through its Joint Commission International affiliate.¹⁵⁰ However, since 1965, approximately eighteen thousand organizations received accreditation from the Joint Commission on Accreditation of Healthcare Organizations.¹⁵¹ The accredited organizations pay the Joint Commission to maintain their accreditation and revocation has occurred in less than 1% of all accreditations issued.¹⁵²

An empirical comparison of quality between hospitals in the United States and abroad is difficult due to the fact that hospitals in the United States do not report surgical outcomes or participate in international performance measurement systems.¹⁵³ However, average outcomes for common yet complex operations, such as coronary bypass surgery, are likely to be very similar,

146. See Terry, *supra* note 111 (discussing methods to compare standards of care abroad and within the United States).

147. See Bumrungrad International Hospital, *Hospital Accreditation*, <http://www.bumrungrad.com/htm/eng/main.asp?Filename=about/hospital.htm> (last visited May 17, 2007) (discussing Bumrungrad International's accreditation by Joint Commission International and Thai Accreditation) (on file with the Washington and Lee Law Review).

148. See Milstein & Smith, *supra* note 5, at 1639 (discussing the quality of care in foreign hospitals and the various quality management programs adopted by hospitals abroad).

149. See *id.* (describing the Joint Commission on Accreditation of Healthcare as the organization responsible for accrediting hospitals in the United States for participation in Medicare).

150. See *id.* (discussing certification procedures for international hospitals).

151. See Bumrungrad Hospital Death 2006, <http://www.bumrungraddeath.com> (last visited Feb. 11, 2007) (discussing the history of the Joint Commission on Accreditation of Health care Organizations) (on file with the Washington and Lee Law Review).

152. See *id.* (questioning the validity of the methodology used by the Joint Commission on Accreditation of Health care Organizations when reviewing preexisting accreditations).

153. See *id.* (discussing the lack of statistics available for qualitative comparison of international and domestic hospital services).

because several international hospitals accredited by the Joint Commission International report gross mortality rates of less than 1% for such procedures.¹⁵⁴ Further, internationally trained medical graduates presently account for approximately 25% of the 853,187 physicians in the United States, a number that highlights the training and skill development offered at foreign medical schools.¹⁵⁵

All surgical procedures carry a necessary amount of risk, however, and the story of Joshua Goldberg's death at Bumrungrad International provides a sobering account of the risks of medical tourism. Bumrungrad International Hospital admitted Josh Goldberg on February 12, 2006 after he complained of an abrasion on his left leg that resulted in pain, swelling, and loss of feeling and motion.¹⁵⁶ Allegedly, Mr. Goldberg died twelve days later on February 24 after being administered a cocktail of twenty drugs, six of which were contra-indicated.¹⁵⁷ Mr. Goldberg's family contends that the hospital made no resuscitation attempt after discovering Mr. Goldberg's body, and a report of an independent medical examiner hired by the deceased's family supports their allegation.¹⁵⁸ While Mr. Goldberg's death remains the subject of litigation both domestically and abroad,¹⁵⁹ his alleged experience casts a dark pall over medical standards abroad.

3. *Alternative Medicines and Procedures*

A third motivation for patients seeking medical treatment overseas may be the availability of alternative medicines or procedures not available or banned in the United States. Laetrile, for example, is a compound used in some countries to treat cancer patients but has not been approved for use by the Food and Drug Administration.¹⁶⁰ Laetrile contains a chemical called amygdalin,

154. See *id.* (comparing the relative surgical success rates of international hospitals with domestic hospitals in the United States).

155. See G.T. McMahon, *Coming to America—International Medical Graduates in the United States*, 350 *NEW ENG. J. MED.* 2435, 2435–37 (2004) (discussing the influx of international doctors into the U.S. health care system).

156. See Bumrungrad Hospital Death 2006, *supra* note 151 (discussing the event leading up to Mr. Goldberg's admittance to Bumrungrad International).

157. See *id.* (discussing the erroneous administration of drugs leading to Mr. Goldberg's death).

158. See *id.* (stating that an independent medical examiner found no physical evidence of any attempt to revive Mr. Goldberg).

159. See *id.* (discussing Mr. Goldberg's family's pending lawsuits against Bumrungrad International).

160. See The National Cancer Institute, *Laetrile/Amygdalin*, <http://www.cancer.gov/cancer>

which is a plant compound that includes sugar and produces cyanide.¹⁶¹ The cyanide component of amygdalin is the purported active cancer-killing ingredient.¹⁶² Amygdalin occurs naturally in the pits of many fruits and in raw nuts; it is also found in other plants such as lima beans, clover, and sorghum.¹⁶³ In *Rutherford v. United States*,¹⁶⁴ the Tenth Circuit held that terminally ill cancer patients wishing to undergo treatment involving laetrile do not have a privacy right to take whichever treatment they wished regardless of whether the Food and Drug Administration regarded the medication as "effective" or "safe,"¹⁶⁵ and concluded that grandfather provisions were not applicable to exempt the desired medication.¹⁶⁶ Actor Steve McQueen is one of the most recognizable "medical tourists" to travel abroad for treatment with laetrile.¹⁶⁷ McQueen suffered from mesothelioma, an incurable cancer of the lungs related

topics/pdq/cam/laetrile (last visited Feb. 11, 2007) (discussing the alternative cancer treatment of laetrile) (on file with the Washington and Lee Law Review).

161. *See id.* (providing the chemical components active in laetrile).

162. *See id.* (discussing the components of amygdalin and their alleged effect in cancer treatment).

163. *See id.* (discussing the natural sources of amygdalin).

164. *See Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980) (holding that a patient's decision to select a nonapproved treatment is within the area of governmental interest in protecting the public health and that the grandfather provisions of 21 U.S.C. § 321(p)(1) are inapplicable to laetrile). In *Rutherford*, the United States and federal officials sought to prevent a group of terminally-ill cancer patients from using laetrile as a treatment. *See United States v. Rutherford*, 442 U.S. 544, 544 (1979) (stating that cancer patients brought the action to prevent the government from interfering with interstate shipments of laetrile used for their cancer treatment). The Tenth Circuit ruled that terminally ill patients were not entitled to an exception from Food and Drug Administration regulations. *Id.* at 546. The cancer patients asserted that their choice to utilize laetrile as a alternative cancer treatment was protected as a constitutional right to privacy and that laetrile could be approved for use without premarket testing by the Food and Drug Administration under the grandfather clause in 21 U.S.C. § 321(p)(1) (2006). *Rutherford*, 442 U.S. at 544. The court of appeals disagreed, holding that the patient's decision whether to have a treatment is a protected right, but his selection of a particular medication is not. *Id.* at 457. Rather, this decision is within the area of governmental interest in protecting public health and the premarketing requirement of 21 U.S.C. § 355 is an exercise of congressional authority to limit the patient's choice of medication. *Rutherford*, 616 F.2d at 457. The court went on to hold that neither the 1938 grandfather provisions in 21 U.S.C. § 321(p)(1) nor the 1962 amendments to the statute were applicable to the use of laetrile. *Rutherford*, 616 F.2d at 457.

165. *See Rutherford*, 616 F.2d at 457 (discussing the patient's right to privacy issue concerning the use of laetrile).

166. *See id.* ("In short, the record does not support a conclusion that the several conditions in Pub. L. No. 87-781 have been met to permit the application of the grandfather exceptions.").

167. *See Barron H. Lerner, McQueen's Legacy of Laetrile*, N.Y. TIMES, Nov. 11, 2005, at F5 (discussing McQueen's battle with terminal cancer and travel abroad for treatment with laetrile).

to asbestos exposure, and in 1980 he traveled to Mexico for laetrile treatment.¹⁶⁸ McQueen initially reported success from the treatment, but he eventually died in November of 1980 after surgery to remove a cancerous mass from his body.¹⁶⁹ Although McQueen did not survive and the effectiveness of laetrile is widely criticized by the medical community,¹⁷⁰ the opportunity to try all available treatments may spur cancer patients and others to travel abroad for medical treatment.

The availability of alternative procedures or procedures still in clinical trials in the United States provides another catalyst for patients seeking medical treatment abroad. Hip resurfacing, for example, is a relatively common procedure in Asia and Europe but is not available in the United States.¹⁷¹ Experts believe hip resurfacing could eventually replace approximately 20% of hip replacement surgeries, but the approval process is cumbersome and only a small number of medical centers are participating in clinical trials.¹⁷² Duke University Medical Center, for example, only performs four resurfacing procedures a month but gets up to twenty calls a month from patients seeking the procedure.¹⁷³ These patients are willing to pay the entire cost out of pocket; insurance companies do not cover the procedure because it is still "experimental," and costs can run as high as \$40,000.¹⁷⁴ The process is widely available abroad, however, and one patient unable to receive the procedure at Duke recently traveled to India where the procedure cost only \$5,400.¹⁷⁵ The large number of patients seeking the procedure and willing to pay for the entire procedure undoubtedly provides a large pool of prime candidates for surgery

168. *See id.* (stating McQueen developed lung cancer in 1978 after years of exposure to asbestos in racing suits and eventually traveled to Mexico for alternative treatment in 1980).

169. *See id.* (stating McQueen died one day after surgery to remove cancer from his abdomen and neck).

170. *See id.* (discussing the medical community's response to McQueen's initial claims of recovery and the use of laetrile generally).

171. *See* Jean P. Fisher, *Hip Patients Find Surgeons Overseas: Delay in FDA Approval for Hip Resurfacing Means Lost Opportunity at Duke*, NEWS & OBSERVER (Raleigh, N.C.), Apr. 10, 2006, at A1 (discussing hip resurfacing and the clinical trials currently underway in an attempt to win approval by the Food and Drug Administration).

172. *See id.* (discussing the potential future impact of hip resurfacing as an alternative to hip replacement surgery).

173. *See id.* (discussing the limitations placed on clinical centers during the trial process of new procedures and the delay such procedure rationing causes).

174. *See id.* (stating insurance companies will not cover the costs of experimental procedures still in clinical testing and providing cost estimates for the procedure at Duke medical center).

175. *See id.* (comparing the cost and availability of hip resurfacing abroad and in the United States).

abroad. While no one motivation alone will likely cause a patient to travel abroad for surgery, the combination of cost savings, comparable standards of care, and availability of alternative medicine and procedures possesses the potential to influence the health care decisions of thousands of citizens.

4. Limited Legal Protection

The dramatic price gap between surgeries abroad and domestic surgeries stems largely from the differences in malpractice systems of foreign countries as compared to the United States.¹⁷⁶ Customarily, a patient undergoing a surgical procedure in Asia signs an agreement waiving the patient's right to sue his surgeon for medical malpractice under certain conditions.¹⁷⁷ Such a waiver permits surgeons to charge a lower rate for the surgery, because they do not need to pay thousands of dollars for malpractice insurance.¹⁷⁸ Unfortunately, the waiver also releases the surgeon from the policy goals of malpractice insurance: deterrence of negligence, compensation, and corrective justice.¹⁷⁹ By contrasting the methods in which these policy goals are met domestically and abroad, the risks involved with surgical procedures abroad become clear.

Theoretically, malpractice lawsuits deter surgeons from operating carelessly by reminding them of the financial, emotional, and professional consequences of not exercising proper care.¹⁸⁰ Conversely, without the threat of malpractice litigation, surgeons presumably have less incentive to be safe in caring for their patients. However, the few studies that attempted to model the relationship between malpractice claims and rates of medical errors have generated mixed results and are usually subject to methodological criticisms regardless of the results.¹⁸¹ Therefore, there is little evidence that the

176. See *supra* notes 131–135 and accompanying text (discussing the role of medical malpractice liability in explaining the dramatic difference in cost between domestic and international medical procedures).

177. See Mike Adams, *Rising Popularity of Medical Tourism Reveals Deterioration of U.S. Healthcare System*, NEWS TARGET (Apr. 21, 2005), <http://www.newstarget.com/007097.html> (last visited May 17, 2007) (discussing the waiver system widely used throughout Asia to prevent medical malpractice liability) (on file with the Washington and Lee Law Review).

178. See *supra* notes 132–34 and accompanying text (discussing the difference in malpractice insurance premiums in Asia and the United States).

179. See David M. Studdert, et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 283 (2004) (discussing the policy goals of malpractice liability in the health care profession).

180. See *id.* at 286 (discussing the deterrent factor of medical malpractice liability).

181. See *id.* (discussing the flaws present in many of the studies conducted regarding a correlation between malpractice liability and medical negligence).

malpractice system effectively deters medical negligence.¹⁸² Further, the growth of medical outsourcing depends on the availability of consistent levels of care; thus, some scholars have argued that this economic motivation for future profits better serves to deter negligence than the threat of legal recourse.¹⁸³

With respect to the policy goal of compensation, the U.S. system turns on the idea that the party causing an injury should bear the costs of that injury, including lost earnings, medical bills, and pain and suffering.¹⁸⁴ In practice, however, only a small portion of the dollars expended on the malpractice system go to victims of malpractice. Administrative costs account for approximately 60% of the money expended on the malpractice system.¹⁸⁵ Even more disturbing is the estimate that only 2% of negligent injuries result in claims and only 17% of claims involved a negligent injury.¹⁸⁶ Therefore, in exchange for the opportunity to recover compensation for medical errors, all patients pay a premium for medical care. If given the option, some patients might elect to pay a smaller fee for health care or a lower insurance rate and sacrifice the opportunity to recover compensatory damages.¹⁸⁷ Patients abroad illustrate this option perfectly by generally paying a lower medical fee while bearing the full costs of any medical errors. As a result, the cost of medical errors falls almost entirely on the victims of medical errors, not the doctors responsible for those errors. Clearly, patients seeking surgery abroad assume the monetary risk associated with both malpractice and future complications.

182. *See id.* (stating that no positive correlation exists between medical malpractice liability and the deterrence of medical negligence).

183. *See* Klaus, *supra* note 9, at 239 (arguing that the negative economic impact of negligence on the burgeoning medical tourism industry serves as a better deterrent to negligence than direct financial liability).

184. *See* Studdert, et al., *supra* note 179, at 285 (describing the scope of the compensatory policy goal of medical malpractice liability in the United States).

185. *See id.* at 286 (questioning the actual effectiveness of malpractice suits in meeting the purported policy goals of malpractice liability).

186. *See id.* (providing statistical analysis of the effectiveness of legal recourse in compensating victims of medical malpractice).

187. In auto insurance, for example, where consumers have a choice in coverage options, some consumers choose not to pay for optional coverage and instead bear the risk that they will be personally liable for some damages. *See* N.Y. INS. DEPT., 2006 CONSUMER GUIDE TO AUTOMOBILE INSURANCE, <http://www.ins.state.ny.us/auto/2006/auto06.pdf> (last visited Oct. 4, 2007) (providing statistical data relating to optional coverage in automobile insurance) (on file with the Washington and Lee Law Review).

The final policy goal of malpractice is corrective justice.¹⁸⁸ In the United States, corrective justice manifests itself in large damages awards meant to "punish" doctors for their errors.¹⁸⁹ Yet, surgeons in the United States carry extensive malpractice insurance coverage, so the surgeons themselves do not typically pay the penalty for committing a medical error out of pocket.¹⁹⁰ Instead, the large premiums stemming from the malpractice insurance result in an increase in the price of services.¹⁹¹ Corrective justice abroad is found in the same vein as the deterrence factor; whereas a surgeon who commits an error in the United States may be at risk of losing his insurance policy, a surgeon who commits in error in India or Thailand may be at risk of losing foreign patients for himself and his colleagues. Thus, assessing fines on negligent doctors in Asia as a means of corrective justice would not advance patient safety goals.

While different factors theoretically meet the policy goals of malpractice liability abroad, patients must be aware of the differences in available legal recourse. The financial cushion afforded by malpractice jurisprudence in the United States may justify to some the comparatively high cost of services. Others may gladly give up the opportunity to recover future damages for a lower price in the present. Such a situation swings on personal choice and undoubtedly raises the issue of socio-economic discrimination, but such a tangent is beyond the scope of this Note. Regardless of one's motivation for traveling abroad for surgical procedures, the limited legal recourse available outside of the United States is a major risk factor that each individual patient should evaluate and weigh.

C. Standardization Attempts

The mutual benefit that medical outsourcing can provide to both patients and insurers has led to several different attempts at standardizing medical outsourcing as a central component of health insurance. In June 2006, David Boucher, an assistant vice president at Blue Cross Blue Shield of South Carolina, traveled to Bangkok to examine the facilities at Bumrungrad International first hand.¹⁹² Boucher stated that the HMO was "taking a serious

188. See Studdert, et al., *supra* note 179, at 283–84 (stating that corrective justice is a social goal of malpractice litigation).

189. See *id.* at 284 (discussing the goals and scope of corrective justice as a policy element of medical malpractice law).

190. See *id.* (discussing the insurance industry's effect on the goal of corrective justice).

191. See *id.* (stating that the premiums for doctors' malpractice insurance is passed on to patients via the cost of services).

192. See *CBS News*, *supra* note 118 (discussing the growth of medical outsourcing as a

look at [medical outsourcing]"¹⁹³ as an alternative for the 1.5 million people covered by the HMO's plan.¹⁹⁴ Blue Cross Blue Shield would not be the only HMO to offer savings for patients willing to have medical procedures performed abroad. Both Blue Shield and Health Net of California currently offer reduced rate health insurance policies to participants willing to have medical services performed in Mexico.¹⁹⁵

Small businesses are the entities most likely to take advantage of medical outsourcing as a cost saving mechanism for health insurance plans. In fact, United Group Programs (UGP), a Florida based company that sells self-insurance policies to small businesses, offers a plan which lists Bumrungrad International as its preferred provider of medical services.¹⁹⁶ The "mini-medical"¹⁹⁷ plan offers to save employers more than 50% on major medical expenses and reduce employees' out of pocket expenses to zero.¹⁹⁸ With potential savings so high, even major corporations are investigating the possibility of medical outsourcing. Blue Ridge Paper Products Incorporated planned to send the first U.S. employee to India for a gall-bladder operation in September 2006.¹⁹⁹ Carl Garrett volunteered for Blue Ridge's pilot program and planned to share in the company's savings,²⁰⁰ but Mr. Garrett's union blocked his departure.²⁰¹ The United Steelworkers issued a statement condemning Blue Ridge's plan as a "shocking new approach"²⁰² to cutting medical costs and demanded the company offer Mr. Garrett a health care option

cost saving option in the insurance industry).

193. *Id.*

194. *See id.* (providing statistics detailing the number of plan participants whose insurance may be affected by medical outsourcing).

195. *See id.* (discussing existing plans that allow patients to pay reduced premiums in exchange for seeking health care abroad).

196. *See Kher, supra* note 115, at 45 (stating that United Group Providers is one of the first insurance companies to offer medical outsourcing as a central element of a health plan).

197. *Id.*

198. *See CBS News, supra* note 118 (detailing the possible cost savings advertised by United Group Providers for those companies utilizing medical outsourcing as an element of their health care plans).

199. *See id.* (discussing Blue Ridge Paper Products's pilot program allowing employees to seek medical treatment abroad in exchange for a share of the savings).

200. *See id.* (stating the incentives Blue Ridge Paper Products provided for employees participating in the pilot program).

201. *See Saritha Rai, Union Disrupts Plan to Send Ailing Workers to India for Cheaper Medical Care*, N.Y. TIMES, Oct. 11, 2006, at C6 (discussing the United Steelworkers's opposition to union members seeking medical treatment abroad).

202. *Id.*

in the United States.²⁰³ Blue Ridge withdrew eligibility for the pilot plan from Mr. Garrett and all union employees but continued to offer the option to salaried employees.²⁰⁴

The most groundbreaking and controversial attempt to introduce medical outsourcing on a large scale took place in the West Virginia legislature where House Bill 4395 proposed to add financial incentives for public employees willing to travel abroad for treatment.²⁰⁵ Delegate Ray Canterbury, one of the bill's sponsors, estimated it would save the state up to \$2 million annually.²⁰⁶ The bill proposed adding the following statute to the West Virginia Public Employees Insurance Act:

§ 5-16-28. Authorization for treatment in foreign health care facilities accredited by the Joint Commission International (JCI); Incentives for covered employees; rebate of savings.

(a) Not later than the first day of July, 2006, the director shall establish a program of incentives for covered employees who elect to obtain medical care or medical procedures in health care facilities accredited by the Joint Commission International (JCI)

The incentives shall include:

- (1) Waiver of all co-payments and deductible payments;
- (2) Payment of cost of round trip air fares for the covered employee and one companion;
- (3) Lodging expenses in the foreign country for the companion for the length of the treatment or procedure;
- (4) Lodging expenses in the foreign country for the covered employee and the companion for not more than seven days of convalescence after the treatment or procedure;

203. *See id.* (stating that the United Steelworkers would not allow Mr. Garrett to travel abroad for his medical procedure and insisted upon a domestic health care alternative).

204. *See id.* (discussing the future of the pilot program at Blue Ridge Paper Products).

205. *See* H.D. 4359, § 5-16-28, 77th Leg., 2d Sess. (W. Va. 2006) (proposing a system of financial incentives for state employees willing to take part in medical outsourcing) (on file with the Washington and Lee Law Review).

206. *See CBS News, supra* note 118 (discussing the potential savings to the State of West Virginia if health insurance for state employees included a medical outsourcing option).

- (5) Payment to the covered employees hiring agency for seven days of paid sick leave which are not counted against the employees accrued sick leave; and
- (6) Rebate not more than twenty percent of the cost savings directly to the covered employee.

(b) The director shall establish a fund within the agency for the deposit of the remaining eighty percent cost savings. Not later than the first day of July of each fiscal year, the director shall rebate the moneys in the fund in equal amounts to each covered employee.²⁰⁷

The extraordinary incentives Canterbury proposed to establish highlight the potential cost savings available.²⁰⁸ Delegate Canterbury's proposal is unique even among plans utilizing medical outsourcing because it allows plan participants to receive an aggregate of 100% of the total savings.²⁰⁹ While Canterbury's plan undoubtedly will not pass—special interest groups representing health care providers were "very distressed" by the plan²¹⁰—his proposal represents an acknowledgement that health care in the United States has become prohibitively expensive and medical outsourcing looms large as a potential savior to business and states alike who are buckling under the financial pressure.

IV. Medical Outsourcing Versus ERISA's Fiduciary Duty

A variety of factors serves to motivate HMO and employee welfare plan administrators to consider integrating medical outsourcing into employee benefit plans.²¹¹ The cost savings are undoubtedly significant and would likely lead to extended health care coverage for Americans who currently cannot afford health care.²¹² Yet the risks are significant as

207. See H.D. 4359, § 5-16-28 (proposing the West Virginia Public Employees Insurance Act).

208. See *supra* Part III.B (discussing the potential cost savings to both employers and plan participants as a motivating factor for participating in medical outsourcing).

209. See H.D. 4359, § 5-16-28(b) (allowing a 20% cost rebate to an individual employee and an 80% rebate to the covered employees).

210. See *CBS News, supra* note 118 (discussing the response Mr. Canterbury's plan garnered among lobbyists representing health care organizations).

211. See *supra* Part III.B (discussing the variety of benefits available through medical outsourcing).

212. See *supra* Part III.B.1 (discussing the potential cost savings associated with medical outsourcing); see also *supra* Part III.C (discussing how medical outsourcing might lead to

well.²¹³ In determining whether to utilize medical outsourcing, HMO and plan administrators must also remember their fiduciary duty under ERISA "[to] discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to [plan] participants . . . and [to] defray[] reasonable expenses of administering the plan."²¹⁴ Within this duty lies the inherent conflict between medical outsourcing and ERISA's fiduciary duty: When a fiduciary decides to incorporate medical outsourcing, does the cost saving element qualify the decision as "defraying reasonable expenses" or do the risks and potential profit to the plan preclude the decision from being in the sole interest of plan participants? Arguments exist for both sides and this Part will explore both possibilities.

A. Medical Outsourcing Does Not Violate ERISA's Fiduciary Duty

Three arguments exist for proponents of medical outsourcing even in light of ERISA's fiduciary duty. First, the cost savings associated with medical outsourcing falls within the scope of ERISA's fiduciary duty, because plan administrators are obligated to discharge their duties for "the exclusive purpose of . . . defraying reasonable expenses of administering the plan."²¹⁵ Second, the Supreme Court's decision in *Pegram* also bolsters the argument that medical outsourcing does not violate ERISA's fiduciary duty, because medical outsourcing may be characterized as a mixed eligibility and treatment decision.²¹⁶ Proponents of medical outsourcing will argue that the decision to send a participant abroad for treatment is a mixed medical and eligibility decision made by a physician and therefore is exempt from ERISA's coverage. Finally, supporters will contend that the mere availability of medical outsourcing does not violate ERISA. ERISA only imposes a fiduciary duty on those persons who exercise discretionary control over the management of a plan or its assets.²¹⁷ A plan participant who chooses medical outsourcing makes an "administrative decision" that cannot lead to an HMO or plan manager's breach

extended health care coverage).

213. See *supra* Part III.B (discussing the risks associated with seeking medical treatment abroad).

214. 29 U.S.C. § 1104(a)(1) (2006).

215. *Id.*

216. See *supra* note 59 and accompanying text (providing an explanation of *Pegram* and its holding).

217. See 29 U.S.C. § 1002(21)(A) (2006) (defining the criteria used to determine a person's fiduciary status under ERISA).

of fiduciary duty; a patient's decision is independent from the management of the plan and the disposition of its assets.²¹⁸

1. Medical Outsourcing is Within the Scope of ERISA's Fiduciary Duty

One of the major aspects of a fiduciary's duty under ERISA is to administer the benefit plan in a manner that defrays as much expense as is reasonably possible.²¹⁹ Medical outsourcing presents the opportunity to cut health care costs by up to 90%,²²⁰ thus a strong argument exists that adding medical outsourcing as a component of a health care plan fits within the duty of an ERISA fiduciary to defray plan expenses. In complying with the fiduciary requirements of ERISA, administrators and fiduciaries must act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."²²¹ Although this standard is more stringent than the prudent man standard found in the common law of trusts,²²² it still provides a fair amount of discretion to plan administrators. As long as a plan administrator acted in the sole interest of the beneficiaries when deciding to utilize medical outsourcing in an employee benefit plan, such a decision apparently falls within the scope of ERISA's fiduciary duty.²²³ The viability of this argument depends largely on whether Congress intended the discharge of benefits and cost containment to be equal duties for the fiduciary or if one was to trump the other. Although ERISA's statutory language does not state a preference for either duty, the statute does show a particular concern for economic considerations.²²⁴ Two declarations of policy found in ERISA lend support to the importance of cost control in managing employee benefit plans. ERISA declares, "Congress finds . . . the

218. *See id.* (defining a fiduciary under ERISA).

219. *See* 29 U.S.C. § 1104(a)(1) (discussing the major duties of ERISA fiduciaries).

220. *See supra* tbl.1 (providing a comparison of medical procedure costs abroad and in the United States).

221. 29 U.S.C. § 1104(b).

222. *See, e.g.,* Rice v. Rochester Laborers' Annuity Fund, 888 F. Supp. 494, 499 (W.D.N.Y. 1995) (comparing the standard of care exercised by ERISA fiduciaries to those of a trustee at common law).

223. *See supra* Part II.C (discussing and defining the scope of a fiduciary's duty under ERISA, including the duty to act in the sole interest of plan beneficiaries).

224. *See* 29 U.S.C. § 1001(a) (2006) (discussing the congressional findings associated with ERISA and the goals of the statute); *see also id.* § 1001b(c)(5) (presenting the containment of premium costs as a major policy goal of ERISA).

soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered"²²⁵ and that the policy of ERISA is "to maintain the premium costs of such a system at a reasonable level."²²⁶ These two declarations of policy are central to the proposition that medical outsourcing is a reasonable measure of complying with the fiduciary requirements of ERISA.

2. *Medical Outsourcing is a Mixed Decision and Not Subject to ERISA*

The second argument for allowing medical outsourcing under ERISA's fiduciary duty requirements centers on the Supreme Court's decision in *Pegram*.²²⁷ In *Pegram*, the Court distinguished between eligibility decisions and treatment decisions made by fiduciaries and went on to describe a hybrid between the two types of decision—a "mixed" treatment and eligibility decision.²²⁸ Such decision exists when the decision between treatment and eligibility is "inextricably mixed."²²⁹ The Court declared such mixed decisions to be nonfiduciary in nature.²³⁰ Decisions concerning medical outsourcing arguably qualify as mixed decisions as well. According to *Pegram*, eligibility decisions focus on a plan's coverage of a particular condition or medical procedure, while treatment decisions center on how to go about diagnosing and treating a patient's condition.²³¹ The decision to utilize medical outsourcing encompasses both eligibility and treatment. Medical outsourcing would undoubtedly affect a plan participant's eligibility or coverage for a particular condition or procedure, as many participants who were once ineligible would be able to afford coverage which relies on medical outsourcing.²³²

Further, medical outsourcing centers upon the means by which a health care system treats a patient's condition. Therefore, under this analysis, medical

225. 29 U.S.C. § 1001(a).

226. 29 U.S.C. § 1001b(c)(5).

227. See *supra* note 59 and accompanying text (describing *Pegram*).

228. See *Pegram v. Herdrich*, 530 U.S. 211, 228 (2000) (discussing and distinguishing treatment, eligibility, and mixed decisions within the health care context).

229. See *id.* at 228–29 (listing examples of mixed decisions as physicians' decisions about the use of certain diagnostic tests; seeking consultations and referrals to other doctors; and diagnosing the emergency character of a medical condition).

230. See *id.* at 231 (excluding mixed treatment and eligibility decisions from fiduciary responsibility under ERISA).

231. See *id.* at 228 (defining treatment decisions and eligibility decisions in a health care context).

232. See *supra* Part III.B–C (discussing the significant cost savings available through medical outsourcing and attempts by plan administrators to integrate medical outsourcing into insurance plans to cut costs for all parties).

outsourcing is a mixed decision to which fiduciary standards do not apply. The Court's decision in *Aetna*, however, adds an interesting wrinkle to this approach in ruling that mixed decisions still may qualify as fiduciary in nature when made by plan administrators.²³³ The viability of a *Pegram* analogy to support medical outsourcing therefore depends on who within a health care program makes the decision to utilize medical outsourcing.

3. ERISA's Fiduciary Duty Requirements Apply Only to Plan Administrators

The final argument for incorporation of medical outsourcing into employee benefit plans without violation of ERISA requirements focuses on the manner in which medical outsourcing is made available to plan participants. Under ERISA, persons who exercise some control over the distribution of benefits or assets in a health care plan are subject to fiduciary guidelines.²³⁴ Proponents of medical outsourcing will argue that both the decision to enroll in a plan which offers medical outsourcing and to undergo surgery abroad are ultimately decisions made by the patient. A plan participant who chooses to expose himself or herself to medical outsourcing in any form or fashion cannot lead to a breach of fiduciary duty by a plan fiduciary because the patient is not a fiduciary.²³⁵ Further, offering a patient a low cost option for medical insurance or surgery should qualify as an administrative option given to patients, not a decision which triggers fiduciary responsibility.²³⁶

B. Medical Outsourcing Does Violate ERISA's Fiduciary Duty

The central argument against integrating medical outsourcing into health care plans hinges on the proposition that medical outsourcing violates the fiduciary duties imposed by ERISA. While no single aspect of medical outsourcing results in a *de jure* violation of ERISA, the combined effects of

233. See *supra* note 63 and accompanying text (providing a synopsis and explanation of the Court's holding in *Aetna*).

234. See 29 U.S.C. § 1002(21)(A) (2006) (defining a fiduciary under ERISA).

235. See *supra* Part II.B (presenting and discussing the requirements to qualify as a fiduciary under ERISA)

236. See 29 C.F.R. § 2509.75-8 (1999) (stating a person is an ERISA fiduciary only to the extent the person exercises discretionary authority). Plan fiduciaries providing the option of medical outsourcing do not possess discretionary authority, but rather pass that discretion to the plan participant.

medical outsourcing on plan participants amounts to a de facto violation of a plan administrator's fiduciary duty and the policy goals of ERISA. Medical outsourcing puts both patients and plan administrators in a unique and dangerous position. Plan administrators and other health care fiduciaries have the opportunity to save millions of dollars by utilizing medical outsourcing in just a fraction of the cases plan participants present annually.²³⁷ Such significant savings would undoubtedly affect all entities involved; plan participants would see premiums trend downward and corporate earnings would trend upward. There can be little doubt, however, that the majority of savings would go to shareholders and employees of the health care system, including the fiduciaries making medical outsourcing decisions. While ERISA allows fiduciaries to benefit from plan decisions as long as those decisions are in the best interest of plan participants, the strong appearance of impropriety in such a situation is difficult to ignore.

1. Medical Outsourcing Results in a De Facto Violation of ERISA

The financial incentive for plan administrators to encourage and offer medical outsourcing makes up the crux of medical outsourcing's ERISA violation. Although ERISA fiduciaries may benefit from plan decisions as long as such decisions are also in the best interest of plan participants, the potential savings for fiduciaries who incorporate medical outsourcing are so great that it is impossible to remove financial benefits from the decisionmaking process.²³⁸ ERISA emphasizes the interest of plan participants above all other entities when outlining the fiduciary's duties.²³⁹ Fiduciaries who make the decision to offer plan participants the choice of medical outsourcing merely add a layer of decisionmaking to their fiduciary violation. Although the ultimate decision to utilize medical outsourcing may remain with the plan participants, the decision to offer medical outsourcing is enough to violate ERISA's fiduciary responsibilities. Medical outsourcing proponents argue that by deferring the ultimate decision regarding medical outsourcing to plan participants, fiduciaries excuse themselves of any potential liability. However, in making the decision to allow patients to choose between medical outsourcing and domestic care, the

237. See *supra* tbl.1 (illustrating the dramatic financial savings possible to both plans and plan participants through the use of medical outsourcing).

238. See *id.* (providing an example of the possible financial savings from medical outsourcing); see also *supra* Part II.C (discussing the requirement that all plan decisions be made in the best interest of plan participants).

239. See Part II.C (presenting the fiduciary requirements of plan administrators under ERISA).

large financial incentives available to the health plan undoubtedly influence the plan administrator and result in plan participants' exposure to the dangers of medical outsourcing. An administrator/HMO violates his duty to act "solely in the interest" of the plan participant when he forces a participant to choose between financial windfall for both the participant and the plan, and regulated versus unregulated medical procedure. Regardless of who makes the final decision, the mere act of plan administrators enables plan participants to expose themselves to medical outsourcing due to the potential monetary savings and therefore violates ERISA's fiduciary responsibilities.

2. *Medical Outsourcing Violates ERISA's Public Policy Goals*

The plight of plan participants forced to choose between medical outsourcing and prohibitively expensive domestic care embodies the public policy problem medical outsourcing presents. The dramatic savings opportunities presented by medical outsourcing would allow for many people who could not previously afford health care to gain coverage.²⁴⁰ While this result seems in line with ERISA's policy goals, the impact on middle class America is cause for concern. The average American family of four cannot afford health care premiums while maintaining a lifestyle based upon minimum wage.²⁴¹ ERISA's initial declaration of purpose focuses on setting minimum standards to allow for the equitable distribution of health care services.²⁴² By forcing plan participants to choose between domestic care, which may result in financial devastation, and under-regulated care abroad, which leaves patients without legal remedy, fiduciaries violate ERISA's goals of equitable distribution and minimum standards of care. When a medical emergency arises, families must choose between expensive domestic care that carries the security of malpractice liability and medical outsourcing that provides care for a fraction of the cost but with additional risks. The social policy argument serves as a catalyst to the financial impropriety resulting from medical outsourcing combining to result in a de facto violation of ERISA's fiduciary duty. While medical outsourcing does present the opportunity for expanded health care coverage in the United States, the financial impropriety it breeds, whether

240. See *supra* Part III.C (discussing current attempts to integrate medical outsourcing into health care plans that would allow for broader and more accessible coverage through lower premiums and overall cost).

241. See Milstein & Smith, *supra* note 5, at 1639 (providing statistics reflecting the dramatic cost of health care to middle class America).

242. See *supra* Part II.A (discussing the scope and policy goals of ERISA).

actual or apparent, and the irresponsible public policy it promotes far outweigh any potential benefits. Only through careful control and regulation can medical outsourcing become a viable alternative in American health care systems.

C. Potential Solutions

A structured integration of international care could result in health care coverage for hundreds of thousands of currently uninsured Americans and revolutionize the medical industry in the United States. Such integration will require keen congressional oversight, however, to ensure the rights of plan participants are not ignored. The high financial incentives HMO and welfare plan managers have to increase outsourcing among participants demands Congress regulate the practice as not to allow an abandonment of fiduciary duties via the transfer of the decisionmaking process.

Congress should move to enact a statute similar to West Virginia's proposed statute that would allow for medical outsourcing, yet still ensure fiduciary responsibility. The statute should resolve two main issues surrounding medical outsourcing: the disposition of financial benefits from medical outsourcing and potential complications to plan participants from foreign care. In promoting financial equality among plan participants and plan administrators, the statute should set a predetermined percentage of savings for each entity in the health care plan to receive. Such a division of savings between parties would ensure that plan administrators did not attempt to integrate medical outsourcing without providing a substantial benefit to plan participants. Further, a statute would satisfy fiduciaries' duty to disclose—public law would provide notice of potential savings—and law would supersede fiduciaries in the distribution and regulation of corporate benefits.

Another portion of the financial savings available from medical outsourcing should be set aside for continued treatment of persons utilizing medical outsourcing. Such a plan would allow for financial savings while still providing a safety net for any medical care needed as a result of medical outsourcing. The scope of such a plan would ultimately be left to the legislature to set based upon their understanding of the overall scope of ERISA and the public policy goals of medical malpractice liability. Ideally, however, such a fund would be available to patients who needed follow up or corrective care in the United States after being victims of medical malpractice or negligence during medical outsourcing. The fund would serve as internal integration of malpractice insurance into medical outsourcing. Claims to a medical emergency fund could dissipate after a predetermined amount of time,

likely based upon the average recovery time or complication window in American hospitals. Although the health of the fund might initially seem at risk, the substantial savings and relatively low complication rate in medical outsourcing would likely allow the fund to grow quickly and provide a safety net to those persons choosing medical outsourcing. Congressional action to regulate medical outsourcing could allow the U.S. health care system to reach countless additional persons while simultaneously lowering costs and complying with ERISA's established standards and policies.

V. Conclusion

Medical outsourcing presents an interesting conundrum for both Congress and the health care industry to struggle with in the years ahead. The benefits of medical outsourcing, both actual and potential, are too great to be ignored, but appear to violate the standards and protections put in place by ERISA. If medical outsourcing continues unregulated, it will only be a matter of time before ERISA violations create another generation of class action lawsuits. Congress must carefully balance the risks and benefits of medical outsourcing with the policy goals of ERISA to integrate medical outsourcing into the United States' health care system.

ERISA sets out clear goals and standards to govern health care plan fiduciaries. A fiduciary is to "discharge [his] duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to [plan] participants . . . and defraying reasonable expenses of administering the plan."²⁴³ This duty combines with the duty of disclosure to create the crux of the fiduciary requirements under ERISA. Both of these standards ensure that the policy goal of ERISA, "to protect interstate commerce and the interests of participants in employee benefit plans . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans," are met.²⁴⁴ Medical outsourcing presents a unique challenge to ERISA as it may simultaneously be in the financial interest of both plan participants and plan administrators, but not in the health interest of plan participants.

Medical outsourcing could provide for a vast amount of monetary savings for both plan participants and plan administrators. In addition, the health care options offered are generally equivalent to the services and level of quality offered in the United States. However, the legal remedies and protections

243. 29 U.S.C. § 1104(a)(1) (2006).

244. 29 U.S.C. § 1001(a).

available abroad are dismal in comparison to the protections available domestically. The difference in medical malpractice liability contributes a large portion of the savings resulting from medical outsourcing through reduced insurance premiums and damage awards. If the benefits available through medical outsourcing are to become available to the U.S. health care system, the government must regulate the practice and provide a balance that minimizes the risk involved while maximizing the benefits provided.

The proposed West Virginia statute provides a good framework for Congress to move towards an integration and regulation of medical outsourcing in the U.S. health care system. The current state of medical outsourcing allows for financial impropriety by fiduciaries that not only violates ERISA's specific regulations, but also the general policy of the statute. Regulations that guarantee equitable distribution of financial benefits are the first step towards integrating medical outsourcing. Creating a fund for internal "self insurance" by large health care plans is another key aspect of ensuring the continued protection of a plan participant's interest while still reaping the benefits of medical outsourcing. Congressional regulation and oversight of the risks and benefits of medical outsourcing can solve the current ERISA violation and provide a new future for domestic health care in the United States.