

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

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JOANNE PETERSON, on behalf	:	CIVIL ACTION
of herself and all others	:	
similarly situated,	:	
	:	
Plaintiff,	:	
	:	
v.	:	NO. 00-CV-605
	:	
CONNECTICUT GENERAL LIFE	:	
INSURANCE COMPANY,	:	
	:	
Defendant.	:	

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**MEMORANDUM**

ROBERT F. KELLY, J.

NOVEMBER 14, 2000

Before this Court is the Motion to Dismiss the Complaint pursuant to Federal Rule of Civil Procedure 12(b)(6) filed by Defendant, Connecticut General Life Insurance Company ("CGLIC" or "CIGNA"). Plaintiff, Joanne Peterson ("Ms. Peterson"), brought this action alleging that CGLIC, a health management organization ("HMO"), violated its fiduciary duty of disclosure to the participants in its health plans in violation of the Employment Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq. ("ERISA"). For the reasons that follow, the Motion is granted.

**I. STANDARD OF REVIEW.**

The purpose of a motion to dismiss for failure to state

a claim is to test the legal sufficiency of the allegations contained in the complaint. Kost v. Kozakiewicz, 1 F.3d 176, 183 (3d Cir. 1993). Under Rule 12(b)(6), the Court must determine whether the allegations contained in the complaint, construed in the light most favorable to the plaintiff, show a set of circumstances which, if true, would entitle the plaintiff to the relief he requests. Gibbs v. Roman, 116 F.3d 83, 86 (3d Cir. 1997)(citing Nami v. Fauver, 82 F.3d 63, 65 (3d Cir. 1996)). A complaint will be dismissed only if the plaintiff could not prove any set of facts which would entitle him to relief. Nami, 82 F.3d at 65 (citing Conley v. Gibson, 355 U.S. 41, 45-46 (1957)).

## **II. DISCUSSION.**

Ms. Peterson is and has been enrolled in a health plan operated by CGLIC as a benefit made available to her by her employer. Ms. Peterson asserts that under the plan, each participant must seek treatment from physicians under contract with CGLIC. Ms. Peterson alleges that CGLIC has violated its fiduciary duty to the plan participants under ERISA by failing to disclose all of its compensation arrangements under the contract between CGLIC and its physicians, consisting of "compensation incentives and disincentives with which CGLIC confronts health care providers, as well as its use of treatment and hospitalization guidelines, and those other internal limitations it has created and imposed which affect the coverage actually

available to its subscribers." (Pl.'s Mem. Law Opp'n Def.'s Mot. Dismiss at 3). She alleges that this is material information that "a reasonable subscriber would find significant both in his or her assessment of whether to become a [CGLIC] HMO subscriber and by an existing subscriber in determining how to deal with his or her [primary care physician]." Id. at 5. She asserts that if this information were disclosed, a subscriber "might conclude that such incentives create too great a risk that a physician will under-prescribe needed healthcare," and that therefore the subscriber's physician "must be questioned more aggressively regarding treatment options if the physician is given incentives or guidelines by [CGLIC] which have the effect of limiting the healthcare to be provided." Id.

However, Ms. Peterson has not alleged that she or any other person ever made a request for information regarding CGLIC's physician financial incentives which was refused or responded to in an incomplete or false manner. Additionally, Ms. Peterson does not dispute CGLIC's assertion that

[i]nformation about how plaintiff's physician is compensated is available for the asking; the complaint does not allege otherwise. In addition to providing a general description of the types of financial arrangements the CIGNA health plans use with contractual providers, the web site for CIGNA health plans invites plan members to ask their physician's administrative staff about which compensation method applies to services provided by a specific physician.

Def.'s Mot. Dismiss at 7 n.5 (citing

[www.cigna.com/healthcare/consumers/policy.html](http://www.cigna.com/healthcare/consumers/policy.html), at 1-2;

[www.cigna.com/healthcare/provdisc.html](http://www.cigna.com/healthcare/provdisc.html), at 1-2).

Moreover, Ms. Peterson has not alleged that she or any other participant was ever refused reimbursement for medically necessary care, was ever denied medically necessary care, or was ever injured due to inadequate care. In fact, she asserts that because her claim "is a breach of her statutorily conferred right to information, it makes absolutely no difference whether [she] has been treated improperly by a doctor." (Pl.'s Mem. Law Opp'n Mot. Dismiss at 11). Rather, her theory is that the failure to disclose physician incentives renders the scope of "the safety net of coverage" smaller than promised, and that CGLIC has been unjustly enriched as a result. (Pl.'s Supp. Mem. Opp'n Def.'s Mot. Dismiss at 11). Ms. Peterson seeks two forms of "equitable" relief: (1) "full and accurate disclosure of all material facts regarding physician incentives, treatment guidelines and utilization review," and (2) "disgorgement of the amounts by which [CGLIC] has been unjustly enriched as a result of its failure to disclose the use of range of cost- and treatment-suppressing practices identified in the Complaint." (Pl.'s Mem. Law Opp'n Mot. Dismiss at 9; Pl.'s Supp. Mem. Law Opp'n Mot. Dismiss at 7). She suggests that this amount can be measured by "premiums paid" determined by "actuarial and economic expert testimony." (Pl.'s Supp. Mem. Law. Opp'n Mot. Dismiss at 8).

The question of whether ERISA imposes a universally applicable, automatic duty upon HMOs to disclose all of their physician financial incentives to all of their plan participants has not yet been squarely addressed in this circuit. However, after this action was filed, on August 11, 2000, the United States Court of Appeals for the Third Circuit ("Third Circuit") issued a decision in Maio v. Aetna, Inc., 221 F.3d 472 (3d Cir. 2000), which dealt with this question in the context of the Racketeering Influenced and Corrupt Organizations Act, 18 U.S.C. section 1964 et seq. ("RICO"). By court-approved stipulation, the parties agreed to submit supplemental briefs to discuss the effect of the Maio decision on this matter. CGLIC argues that the Maio decision clearly mandates the dismissal of the Complaint, while Ms. Peterson asserts that it has no impact at all.

In Maio, the Third Circuit affirmed the district court's dismissal of the plaintiff's complaint pursuant to Federal Rules of Civil Procedure 12(b)(1), 12(b)(6) and 9(b). The plaintiffs had filed a RICO action against Aetna, their HMO, alleging that "Aetna represented that HMO members would receive high quality health care from physicians who are solely responsible for providing all medical care and maintaining the physician-patient relationship, when in reality, Aetna's internal policies restrict the physicians' ability to provide the high

quality health care that appellants [had] been promised." Maio, 221 F.3d at 475. They further claimed that "despite Aetna's representations that it compensated its physicians under a system that provides them with incentives based upon the quality of care provided, Aetna's provider contracts actually offer the physicians financial incentives to withhold medical services and reduce the quality of care to HMO members." Id. The plaintiffs also asserted that despite the representations made in its advertising, membership and marketing materials, Aetna failed to disclose the internal policies which "contradict the message conveyed to appellants that quality care was Aetna's primary concern." Id. at 476. Moreover, they claimed that "the substantial difference in the quality of healthcare services marketed by defendants, and the quality of healthcare services actually provided to plaintiffs and the Class, cause membership in the Plan to be worth much less than that actually charged by defendants." Id. at 479.

The district court dismissed the complaint, holding that because the plaintiffs could not show a concrete "injury-in-fact," they did not have standing to bring the claims. Id. at 474. The Third Circuit agreed with the result, but held that the plaintiffs could not establish the requisite "injury to business or property" flowing from the HMO's conduct required under RICO. Id. at 501. In so concluding, the court noted that

the plaintiffs had specifically disclaimed any injury due to the denial of benefits, reduction in benefits, inferior care, malpractice, negligence or breach of contract. Id. at 480. The court stated that as a result

[p]laintiffs have disclaimed any injury that has the potential to decrease the value of defendants' plans. The HMOs simply cannot be "worth less" unless something plaintiffs were promised was denied them. A vague allegation that "quality of care" may suffer in the future is too hypothetical an injury to confer standing upon plaintiffs, and in addition, would require this court to assume that in every case, individual physicians and [individual practice associations] will be moved to put their own economic interests ahead of their patients' welfare. Even if this were the inevitable result, defendants would not be the proximate cause of the providers' ethical lapses.

Id.

While we recognize that the facts giving rise to the Maio plaintiffs' claims are nearly identical to the instant case, the Third Circuit made clear that the claims were analyzed under RICO, rather than ERISA. Indeed, the court began its analysis of the plaintiffs' claims by explaining that "[w]hile appellees argue that we may affirm the district court's order dismissing the class action complaint on a variety of grounds, we need address only one issue - that is, whether appellants have alleged a valid RICO injury to business or property sufficient to afford them standing under RICO to challenge Aetna's purportedly fraudulent scheme." Id. at 482. The court therefore viewed its decision as confined to an examination of the requirements

under RICO. In the instant case, Ms. Peterson's claims are strictly for breach of fiduciary duty under ERISA. Accordingly, we do not perceive Maio to be instructive as to the specific question presently before this court. We will therefore consider the effect of other applicable authority.

While Ms. Peterson concedes that the Third Circuit has not yet "specifically addressed the question of an ERISA-imposed fiduciary duty to disclose financial incentives in health insurance plans," she argues that "the Third Circuit has adopted a vigorous form of the rule that the ERISA fiduciary duty mandate includes within it a duty to disclose material information." (Pl.'s Mem. Law Opp'n Def.'s Mot. Dismiss at 17-18). Ms. Peterson relies primarily on three cases which she argues evidence the Third Circuit's willingness to impose a disclosure requirement in the context of physician financial incentives.

Ms. Peterson first cites Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund, 12 F.3d 1292 (3d Cir. 1993). In Bixler, the widow of an ERISA welfare benefit plan participant sued her husband's plan and employer for breach of fiduciary duty under ERISA. The plaintiff claimed that the defendants wrongfully denied her husband medical coverage and failed to inform her that she could pay for the family's continued coverage after the employer withdrew from the plan despite the fact that she had inquired about continued coverage. Bixler, 12 F.3d at

1296. In considering whether the defendants had a duty to disclose the possibility of maintaining coverage, the Third Circuit adopted the approach employed by the United States Court of Appeals for the District of Columbia Circuit in Eddy v. Colonial Life Ins. Co., 919 F.2d 747 (D.C.Cir. 1990), which held that

once an ERISA beneficiary has requested information from an ERISA fiduciary who is aware of the beneficiary's status and situation, the fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance. This is so even if that information comprises elements about which the beneficiary has not specifically inquired.

Id. at 1300. The court went on to declare the following maxim upon which Ms. Peterson relies: "[t]he duty to inform is a constant thread in the relationship between beneficiary and trustee; it entails not only a negative duty not to misinform, but also an affirmative duty to inform when the trustee knows that silence might be harmful." Id.

However, in Bixler, while the court recognized a duty to disclose, it did so in the circumstance where a request for information did not receive a complete and accurate response. Moreover, while Bixler clearly stands for the general proposition that disclosure is required for the protection of the beneficiary, Bixler does not clearly mandate upon all HMOs the imposition of a universal duty to disclose all physician financial incentive arrangements to all plan members absent a

request for such information by a plan participant.

Ms. Peterson also relies upon Glaziers and Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Sec., Inc., 93 F.3d 1171 (3d Cir. 1996), in which certain benefit funds (the "Funds") brought an action alleging breach of fiduciary duty under ERISA against their securities brokerage firm ("Janney"). Specifically, the Funds alleged that Janney failed to disclose material information regarding its suspicion that one of its former employees, Lloyd, with whom the Funds had begun doing business, had engaged in criminal fraudulent conduct.

In Glaziers, the Third Circuit reiterated its prior holding in Bixler that an affirmative duty to inform exists when the trustee knows that "silence might be harmful." Glaziers, 93 F.3d at 1180. The court went on to explain that

[w]e have never held that a request is a condition precedent to such a duty regardless of the circumstances known to the fiduciary. To the contrary, it is clear that circumstances known to the fiduciary can give rise to this affirmative obligation even absent a request by the beneficiary. "The duty to disclose material information 'is the core of a fiduciary's responsibility,'" Bixler, 12 F.3d at 1300. Indeed, absent such information, the beneficiary may have no reason to suspect that it should make inquiry into what may appear to be a routine matter. If Janney was a fiduciary, the Funds' failure to request information concerning Lloyd's departure has no bearing on whether Janney breached the duties it owed the Funds by not volunteering the information.

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We do not, of course, hold that one who may have attained a fiduciary status thereby has an obligation

to disclose all details of its personnel decisions that may somehow impact upon the course of dealings with a beneficiary/client. Rather, a fiduciary has a legal duty to disclose to the beneficiary only those material facts, known to the fiduciary but unknown to the beneficiary, which the beneficiary must know for its own protection. The scope of that duty to disclose is governed by ERISA's Section 404(a), and is defined by what a reasonable fiduciary, exercising "care, skill, prudence and diligence," would believe to be in the best interest of the beneficiary to disclose.

Id. at 1181-1182. The court remanded the case, holding that it was for a fact-finder, in the event that it first found Janney to be a fiduciary, to decide whether Janney's failure to disclose the information it had was a breach of its fiduciary duty under Section 404(a).

While the Glaziers court recognized the possibility that a duty to disclose existed in that case for the protection of the beneficiary, we note that the information allegedly known to Janney but not disclosed concerned a particular potential harm about which Janney had specific knowledge. Importantly, the Glaziers court acknowledged that not all details of a plan must be disclosed, emphasizing that disclosure should be required only when necessary for the "protection" of the beneficiary. The Glaziers ruling does not clearly support Ms. Peterson's request for universal disclosure of all physician financial incentives absent any special circumstance or even a request by a participant.

Ms. Peterson also cites Harte v. Bethlehem Steel Corp.,

214 F.3d 446 (3d Cir. 2000) in support of her claim. In Harte, the plaintiff brought an ERISA action for breach of fiduciary duty against the administrator of his retirement plan, alleging that the administrator failed to timely notify him that his service had been severed for pension purposes due to his two-year absence. Harte, 214 F.3d at 448. Because of this severance, the plaintiff had not accrued the fifteen years required for the pension. Id. However, he alleged that he did not discover that his service had been broken until eight years later. Id.

In deciding whether the plan administrator had a fiduciary duty to inform the plaintiff when his service was severed, the Third Circuit first referred to the United States Supreme Court's holding that "the contours of fiduciary duties must be defined by the courts in 'develop[ing] a federal common law of rights and obligations under ERISA-regulated plans.'" Id. (quoting Varity v. Howe, 516 U.S. 489, 497 (1996)). The court further explained that in its "efforts to develop a federal common law of ERISA rights, we have held that administrators generally have a fiduciary duty 'not to misinform employees through material misrepresentations and incomplete, inconsistent or contradictory disclosures.'" Id. at 452. The court also held that "a misleading statement or omission by a fiduciary is actionable if 'there is a substantial likelihood that it would mislead a reasonable employee in making an adequately informed

retirement decision.'" Id. The court reiterated its decree in Bixler that a fiduciary has an affirmative duty to speak when it knows that "silence might be harmful," and that this duty extends to "those material facts, known to the fiduciary but unknown to the beneficiary, which the beneficiary must know for its own protection.'" Id. (quoting Bixler, 12 F.3d at 1300; Glaziers, 93 F.3d at 1182).

The court held that a plan administrator may be liable for breach of fiduciary duty under ERISA if the administrator does not inform a participant that his employment is severed and the participant might reasonably assume that he is still employed. Id. at 453. However, the court specifically stated that it was not holding that a fiduciary must inform a beneficiary of its interpretation of a plan any time before the participant's service is broken. Moreover, the court limited its holding to "situations where an employee is severed," and declined to address other changes in status which could trigger a duty to notify. Id. Furthermore, the court stated

[w]e are not blind to the potential administrative strain on an ERISA administrator. A broad fiduciary duty to inform beneficiaries about the effects of all plan provisions upon them could give rise to a "practically impossible burden of anticipating, and comprehensively addressing, the individualized concerns of thousands of employees."

Id. (quoting Childers v. Northwest Airlines, Inc., 688 F. Supp. 1357, 1362 (D. Minn. 1988)). However, under the facts of that

case, the Harte court decided that the burden of informing plan participants when they have been severed was not "too great a burden." Id.

Accordingly, we do not believe that Harte requires the broad duty to inform plan participants of physician financial incentives that Ms. Peterson seeks. Harte specifically dealt with a change in status as it related to retirement benefits, and the court was careful to limit its holding to cases involving employment severance. The court also expressed reluctance to impose a fiduciary duty in certain cases, recognizing the potential burden upon plan administrators that a broad duty to inform would entail.<sup>4</sup>

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<sup>4</sup> Ms. Peterson also relies heavily upon the United States Supreme Court's recent decision in Pegram v. Herdrich, 120 S.Ct. 2143 (2000), in which the Court, after rejecting a substantive ERISA challenge to financial incentives, stated the following:

Although we are not presented with the issue here, it could be argued that [the defendant HMO] is a fiduciary insofar as it has discretionary authority to administer the plan, and so it is obligated to disclose characteristics of the plan and of those who provide services to the plan, if that information affects beneficiaries' material interests.

Pegram, 120 S.Ct. at 2154 n.8. Ms. Peterson claims that the above language "makes it clear that plaintiff's Complaint states a claim and that CIGNA's motion to dismiss should be denied." (Pl.'s Mem. Law. Opp'n Def.'s Mot. Dismiss at 7). However, the Court explicitly stated that it had not been presented with the issue that Ms. Peterson claims it decided. Moreover, even if the above language provides that such a claim could be advanced under ERISA, it certainly does not define its parameters, i.e., whether a broad duty to disclose may be imposed or whether special circumstances must exist.

Clearly, as Ms. Peterson admits, the Third Circuit has not yet specifically addressed the question of whether ERISA imposes a broad fiduciary duty to disclose financial incentives in health insurance plans. Moreover, we do not agree with Ms. Peterson that the above case law constitutes the Third Circuit's "ringing endorsement" of such a universal, automatic duty upon all HMOs to disclose every aspect of their physician financial incentives without a request from the participant or without any other special circumstance. Rather, those Third Circuit cases which have addressed the fiduciary duty to disclose, as discussed above, have done so only where a plan participant makes a specific inquiry or where the fiduciary knew of the plaintiff's particular circumstances requiring disclosure and the non-disclosure resulted in a particular injury. Further, while the Third Circuit is arguably willing to expand the protections afforded by ERISA's disclosure provisions, its reluctance to overly burden plan administrators with broad disclosure duties, as expressed in Glaziers and Harte, recommends against the imposition of the blanket duty Ms. Peterson seeks. Because the burden of the duty Ms. Peterson asks us to impose is staggering, without a clear endorsement from the Third Circuit, we are reluctant to permit this action to go forward and result in an

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effective amendment of ERISA to encompass such claims.<sup>5</sup>

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<sup>5</sup> We note that two cases outside of this circuit, although not binding on this Court, have addressed the duty of HMOs to disclose physician financial incentives. In Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997), the plaintiff, who was complaining of heart pains, asked his primary care physician whether he should see a heart specialist. Shea, 107 F.3d at 626. His physician advised him not to, but failed to disclose that the type of referral the plaintiff sought was discouraged under the physician compensation arrangement with the plaintiff's HMO. Id. at 627-627. The United States Court of Appeals for the Eighth Circuit ("Eighth Circuit") held that this failure to disclose was a breach of fiduciary duty under ERISA. Id. at 629. Specifically, the court held that "[w]hen an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties." Id. However, while the Shea court did impose the duty to disclose financial incentives, it did so under circumstances in which the non-disclosure followed a specific inquiry by a particular individual.

Moreover, in Ehlmann v. Kaiser Found. Health Plan of Texas, 198 F.3d 552 (5th Cir. 2000), the United States Court of Appeals for the Fifth Circuit ("Fifth Circuit") upheld the district court's dismissal of the plaintiffs' claim that their HMO breached its fiduciary duty under ERISA to disclose its physician financial incentives, even though no request for such information had been made by any plaintiff. Ehlmann, 198 F.3d at 554. The Fifth Circuit refused to add a disclosure provision to those already enumerated in ERISA, concluding that such effective amendments to ERISA are within the sole province of Congress, and declining to "encroach on that authority by imposing a duty which Congress has not chosen to impose." Id. at 555. Moreover, the court noted that the cases in which a duty to disclose financial incentives had been imposed, including Shea, all involved a specific inquiry or other special circumstances, and therefore did not support "a broad duty to disclose to all plan members the details of its physician compensation and reimbursement schemes." Id. at 556.

Parenthetically, the fact that the Third Circuit in Maio did not cite either Ehlmann or Shea, the two circuit court cases dealing with the nearly identical legal theory as the instant case and which pre-dated Maio, lends support to our conclusion that Maio is not controlling authority on the precise issue before this Court.

In conclusion, we observe that Ms. Peterson fails to rebut two propositions advanced by CGLIC which weaken her claim. She fails to dispute CGLIC's contention that the information she seeks is available on CGLIC's website, a fact which, if true, would suggest that CGLIC has already conformed with the disclosure duty Ms. Peterson seeks. Moreover, she does not dispute CGLIC's assertion that the House of Representatives and the Senate have "recently passed separate bills that would amend ERISA to require the very disclosure plaintiff seeks here - although even those bills would require the disclosure only upon request by a beneficiary, and not as an automatic duty as plaintiff urges here." (Def.'s Reply Mem. Support Mot. Dismiss at 16)(citing H.R. 2990, 106th Cong. § 1121(c)(1999); S. 1344, 106th Cong. § 111(a)(1)(1999)). The fact that Congress is currently considering whether ERISA should be amended to impose a broad disclosure duty of financial incentives upon HMOs strengthens CGLIC's argument that such decisions are properly made by the legislature. Accordingly, CGLIC's Motion is granted and Ms. Peterson's complaint is dismissed.

An appropriate Order follows.

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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JOANNE PETERSON, on behalf	:	
of herself and all others	:	CIVIL ACTION
similarly situated,	:	
	:	
Plaintiff,	:	
	:	
v.	:	NO. 00-CV-605
	:	
CONNECTICUT GENERAL LIFE	:	
INSURANCE COMPANY,	:	
	:	
Defendant.	:	

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**ORDER**

AND NOW, this 14th day of November, 2000, upon consideration of Defendant's Motion to Dismiss, and Plaintiff's Response thereto, it is hereby ORDERED that the Motion is GRANTED and Plaintiff's Complaint is dismissed.

BY THE COURT:

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Robert F. Kelly,                      J.