Mismanaged Care: The Challenges Facing Judicial Interpretation of Contemporary Health Policy

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At a time when the U.S. Supreme Court stands accused of undermining the legitimacy of American democracy, it might seem superfluous to question its wisdom in the interpretation of more mundane matters of public policy. But the Court is rarely given an opportunity to tinker with electoral outcomes. By contrast, it is constantly in the business of interpreting congressional legislation. Doing so involves more than simply establishing the constitutionality of a law. It also requires sensitivity to the substantive implications of a ruling, as reflected in the Court’s analysis of congressional intent.¹ These judgments are made difficult when the substantive implications are hard to discern or confusingly complicated. These difficulties can compromise sensible judicial interpretation of laws that shape contemporary health policy.

Few domains of public policy rival medical care in sheer complexity. Even experts in the field have, at best, a limited understanding of the constituents of effective treatment.² To complicate things further, American medicine is characterized by dramatic and persistent change, in both the nature of medical services and in the institutional arrangements through which they are financed and delivered. Labels and conceptual frameworks often lag behind these changes, creating a confusing disjunction between the basic features of the health care system and the terms in which that system is typically described.³ These circumstances can greatly complicate the task of judicial review. It is difficult to discern a coherent sense of congressional intent from laws written by those who have at best a partial understanding of the health care system. Only about a quarter of the congressional staff with responsibilities for health care have had any training in the field.⁴ Elected officials face even bigger challenges, since they must have a working knowledge about a wide range of policy concerns. Evidence suggests that they are not always up to these

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challenges, basing health policy decisions on deliberations that can be most charitably described as “ill-informed.” Even when congressional intent can be clearly established, it can be difficult to apply to a health care system that has changed dramatically from the time at which the legislation was enacted.

The Court’s recent decision in Pegram v. Herdrich illustrates these challenges to judicial review. Cynthia Herdrich and her attorneys offered an innovative interpretation of the responsibilities of fiduciaries defined under ERISA. They suggested that if a health insurance plan was connected in some fundamental manner to an employee benefit plan defined by ERISA, then physicians who owned the health plan (as did Lori Pegram, the clinician whose judgment was in question) were effectively acting as fiduciaries for the benefit plan. Giving them a financial incentive to withhold medical care, under this formulation, compromised their roles as fiduciaries.

To interpret (and dispute) these claims, Justice Souter needed to make sense of the arrangements that exist between health plans and employers, as well as those between health plans and physicians. Despite having been able to draw upon a flock of amicus briefs for expert guidance, Justice Souter’s portrayal of the managed care industry bears only a partial resemblance to the American health care system documented by most research. As a result, his claims about the consequences of supporting Herdrich are questionable. Equally problematic, his efforts to interpret congressional intent related to ERISA are compromised by the fact that few in Congress in 1974 could have imagined ERISA being widely applied to health care, let alone the managed care practices that emerged during the 1980s and 1990s. Nor could they have anticipated the implications of physician ownership of managed care plans, since in 1974 virtually all managed care plans operated on a not-for-profit basis. The Court’s consideration of Pegram evoked widespread attention, including extensive coverage in the press and abundant commentary in the academic literature. In my judgment, efforts to derive any sort of substantive meaning or implications from Pegram are problematic, given the questionable understanding of the American health care system that undergirds the decision.

In this commentary, I trace three important forms of misunderstanding. First, viewing the health care system through the lens of ERISA leads to a distorted portrait of the ways in which resources are allocated and the types of fiduciary roles that ought to be protected. Second, Justice Souter misrepresented the importance of financial incentives to the continued viability of managed care plans. Third, he
presented a muddled analysis of the role of profits in the operation of health plans. Consequently, even if one embraces the line of argument suggested in this decision, a more realistic reading of the system to which that logic is applied may lead to very different conclusions than those drawn in this case.

The distortions produced by viewing health policy through ERISA stem from the origins of law. Congress never intended ERISA to apply to medical care. Indeed, it explicitly excluded insurance from the sorts of benefit plans that ERISA exempted from state regulation. However, when large employers subsequently self-insured (i.e., assumed risk for the health care costs of their employees), the health plans with which they contracted were treated as administrators of the benefit plan, rather than as forms of health insurance. Courts have subsequently ruled that a wide range of managed care practices are exempt from state regulations under ERISA, weakening the protections that would otherwise be afforded to enrollees in these plans. As Justice Souter notes, these potential developments were not foreseen in congressional debate, which focused almost entirely on pension plans and benefits. Consequently, ERISA provisions were not crafted in a manner sensitive to the differences between medical care and programs designed to finance a person’s retirement. Viewing contemporary health care practices through their reflection in ERISA plans is thus rather like checking one’s appearance in a funhouse mirror at a carnival. The image is distorted in a variety of ways, which can be seen as either perversely amusing or horrifying, depending on one’s mood. Some practices are stretched almost beyond recognition. Other distinguishing features are scrunched together, making it impossible to separate one from another.

Generally speaking, one would not base important decisions—like getting a new haircut or deciding upon a new wardrobe—on how one looked in a mirror of this sort. Yet that is precisely the circumstance facing the Court in this case. It sought sensible policy, but could view that policy only through its reflection under ERISA. Arguably, in order to derive more sensible policies, one must derive a set of principles from congressional debate about ERISA, then adapt those principles to the distinctive characteristics of the contemporary health care arena. Consider how such an approach might have altered the conclusions reached in this case.

The scope of ERISA’s application depends on what is included in a benefit plan. Herdrich’s claim that physician-owners were fiduciaries under ERISA was given some plausibility by prior decisions of lower courts, which had stretched the scope of benefit plans (and hence exemption from state regulation) beyond all recognition, to cover a range of managed care
practices including the delivery of medical care. This interpretation is in some sense understandable, since the real health benefits available to enrollees depend on how health professionals respond to these managed care practices. But it fails to recognize the institutional diversity of the American health care system. A few health plans, such as the Yale Health Plan, do provide services to the employees of a single firm. In this case, the equation of health plan and benefit plan makes sense. However, in most cases, the health plan treats employees of many different firms under complex contractual arrangements. Pegram, for instance, worked for Carle, which contracted to provide health care to State Farm employees. In many HMOs, the physicians are not even direct employees of the health plan, but instead practice in groups, which in turn contract with the HMO. To argue that a benefit plan under ERISA extends to the decisions of clinicians thus requires that a benefit plan subsume these multiple layers of contracts and organization. This is roughly equivalent to suggesting that a pension benefit plan under ERISA extends to include the traders on the floor of the stock exchange who are handling the business of the mutual fund in which the firm’s pension assets are invested. A logical connection can be made, but it is pretty far-fetched to treat this as a unified benefit plan.

Justice Souter recognized that these earlier decisions were problematic. He attempted to establish a new boundary between benefit plans and health plans, defined by whether the practice was established as part of an explicit negotiation between plan administrators and the employers who were purchasing the health benefits. This is a striking shift from the decisions of many lower courts and would help clarify applications of ERISA to medical care. But this approach underestimates the adaptability of contracting practices in American medicine. Justice Souter’s new standard is vulnerable to the same sort of regulatory avoidance that led to the unexpected expansion of ERISA into health care during the 1980s. In order to keep their practices outside the purview of state regulators, managed care plans need only to specify those practices—in even the vaguest of terms—in their negotiations with employers. This would encourage more centralized rationing of health care within a plan, whether or not this is the best way to determine appropriate health care. Many health policy experts would argue that it is not.

Under ERISA, there is one and only one fiduciary role, that of the plan administrator who is expected to ensure that the financial returns for beneficiaries are robust and secure. This is a sensible construction for pension plans, under which the returns to any individual do not draw resources away from other beneficiaries. However, this is not the case for
health care plans. Given their fixed budget, expanding access to health care for any one beneficiary necessarily reduces the resources available to other enrollees. In order to protect the well-being of enrollees under these arrangements, there are necessarily three distinctive fiduciary roles: (1) one to represent the interests of the individual patient, a role conventionally played by the physician, (2) one to represent the collective beneficiary interests in husbanding resources for future use, and (3) one to ensure that the relative influence of the first two fiduciaries is held in appropriate balance. The second of these roles is often assigned to administrators of the health plan, the third role to employers or some third-party regulator.

Justice Souter persuasively argued that physicians should not be held to the same standard as fiduciaries in pension schemes. But equal treatment was not necessarily the right standard for judging fiduciary performance. One could instead argue that ERISA required that those who act as fiduciaries under the plan do so in a manner that is uncompromised by financial incentives or institutional obligations, whatever roles the fiduciaries are expected to perform. Under this interpretation, each of the three fiduciary roles in a health benefit plan would need to be protected, even though each differs in functions and expectations from those assumed by fiduciaries in pension plans.

From this standard, the physician-ownership arrangements questioned by Herdrich could be challenged in either of two ways. First, these arrangements could be seen as compromising the ability of physicians to act as fiduciaries for their patients. The financial incentives associated with ownership create a conflict of interest, potentially undermining the representation of patients’ well-being. Second, physician ownership could be characterized as a failure of the employer’s fiduciary responsibilities. By creating an incentive for physicians to act in ways that are congruent with those of plan administrators, these arrangements upset the balance between the first and second fiduciary roles described above. Arguably, an employer acting as a fiduciary for workers should not contract with health plans that are organized under these terms.

In short, Justice Souter erred in arguing that because physician-owners could not be judged by the same standards as fiduciaries under pension plans, they could not be considered fiduciaries in any sense. He further erred by conflating the multiple fiduciary roles in health care, assuming that physicians in an HMO necessarily had to balance the interests of individual patients against those of the plan as a whole. Such a balance must be struck in Carle, in which physicians are both clinicians and owners. But there is nothing inherent in managed care that requires such
arrangements, which was precisely what Herdrich was questioning in the first place.

A second crucial misunderstanding in Pegram emerges early in the decision. Herdrich had challenged the arrangements for paying physicians in Carle a year-end distribution—that is, a share of the profits in the plan. These arrangements were portrayed as distinctively powerful in undermining the fiduciary obligations that physicians should be expected to hold.

Justice Souter rejected this claim, on grounds that appear to confuse the incentives facing a managed care plan with those facing the physicians affiliated with that plan. He is correct in suggesting that “the essence of an HMO is that salaries and profits are limited by the HMO’s fixed membership fees,” necessitating “rationing” of health care. But he goes beyond this defining feature of prepaid health plans to claim that “no HMO organization could survive without some incentive connecting physician reward with treatment rationing.” This is neither logical nor factually accurate. The health plan must act to stay within budget. It may do so through a variety of administrative requirements: utilization review, physician or patient education programs, co-payment requirements for enrollees, or limitations on coverage of particular types of treatment. Financial incentives for physicians represent another means of rationing. They certainly are not essential for a health plan to be viable. Past studies suggest that somewhere between 40% and 70% of physicians affiliated with managed care plans have financial incentives incorporated into these contracts. These arrangements are not uncommon, but neither are they so ubiquitous that one cannot imagine having health care sensibly allocated in their absence. Nor are financial incentives necessarily more desirable for keeping health plans within budget than are the other arrangements described above. Indeed, they are arguably more problematic, precisely because they obscure for patients the reasons that they are being denied access to medical care. For example, if an HMO’s utilization review office turns down a proposed treatment as “medically unnecessary,” the patient can identify both the source of the decision and the rationale. If the patient and clinician feel that this decision is unsound, they can ask for an appeal. Indeed, the physician is required to do so under professional codes of ethics. By contrast, if the physician herself makes a decision that a treatment is not cost-effective in response to financial incentives, patients are unlikely to even recognize that they have been denied treatment. Nor do they have an obvious advocate to whom they can turn if they feel that such a decision is flawed.

Justice Souter’s claim that financial incentives are a necessary part of
managed care is a curious one, since he cites (though not for this purpose) some of the very studies that document that many physicians do not have incentives in their contracts with health plans. But it is even more curious in its implications. Justice Souter purports to be cautious about having the Court reach judgments about sound health policy, on the grounds that such decisions involve “complicated factfinding” and “debatable social judgments” that ought to be left to Congress. Yet by claiming that all health plans must rely on financial incentives, he is indirectly assuming that all incentive arrangements must be treated as equivalent by the Court (while acknowledging that, in practice, they may have quite unequal consequences). This means that “the decisions listed in Herdrich’s complaint cannot be subject to a claim that they violate fiduciary standards unless all such decisions by all HMOs acting through their owner or employee physicians are to be judged by the same standards and subject to the same claims.”

This places an extraordinary burden of proof on those seeking to challenge ERISA practices as applied to health care. It is rather like claiming that particular voting practices cannot be challenged on grounds of equal protection, unless every voting practice in every jurisdiction is subject to the same challenge. As recent events demonstrate (e.g., Bush v. Gore) the Court would clearly not take such a position in a voting rights case. If complex policy domains, such as medical care, cause the Court to adopt fundamentally different presumptions, then they create a disturbing sort of double standard in judicial review.

The third fundamental misunderstanding that is evident in Pegram involves the role of profits and profit-making in American medicine. The confusion emerges in several forms, in the latter part in the decision. It begins with the relief that was requested by Herdrich—“the return of profit from the pockets of the Carle’s owners, with the money to be given to the plan for the benefit of the participants.” The Court concludes that this remedy would entail “nothing less than elimination of the for-profit HMO,” a daunting prospect in an industry that by the mid-1990s had more than two-thirds of its plans operating as for-profit enterprises. To Justice Souter, this implication argued strongly for a rejection of Herdrich’s claims.

Herdrich and her attorneys did not intend to attack profit-making in managed care *per se*—they questioned only those profit-making arrangements in which physicians shared in the ownership of the plan. This is not an unreasonable position. Physician ownership of health facilities has been shown to alter their clinical judgment. Past experience in the managed care industry suggests that physician entrepreneurs may
run their health plans in distinctive ways in hopes of attracting corporations to buy them out, at a healthy profit to themselves. One could discourage or prohibit physician ownership without affecting the ability of health plans to sell stock more generally in order to raise capital, to become part of large investor-owned corporations, or to attract entrepreneurs to enter the industry in hopes of making their fortune.

It is true that the remedy that Herdrich requests sounds antithetical to profit-making health plans. Once again however, the ERISA context distorts the central claim in question. ERISA has provisions that limit the financial penalties that can be invoked in legal actions against fiduciaries. The requested relief is the only one available that would create sufficiently large incentives that would induce health plans to change their practices; that is, to drop profit-sharing for physicians. Were this done, profit-making in managed care could go on unfettered, if this was the intent of policymakers. In fact, the historical record suggests otherwise. The Court cites the fact that “for over 27 years the Congress of the United States has promoted the formation of HMO practices,” dating back to the Health Maintenance Organization Act of 1973. Curiously, the Court neglected to point out that this same Act incorporated strong preferences for nonprofit HMOs over their for-profit competitors. Indeed, much of the congressional debate around the legislation involved whether to provide subsidies solely to nonprofit health plans. There is certainly nothing in this early history to suggest that it was the intent of Congress to encourage profit-making in managed care in general, nor to make it possible for physicians to share in this bounty.

Throughout Pegram, there is a curious disjunction between what the Court claims as its goals and the substance of the arguments that it uses to bolster its decision. Although Justice Souter clearly believes that the Court should not make decisions based on its own interpretation of appropriate health policy, that is precisely what it does in denying the validity of Herdrich’s claims. One of the primary criteria by which these claims are judged is in terms of “how this fiduciary standard would affect HMOs.” This requires that the Court accurately assess the nature of the managed care industry and predict the consequences of a particular interpretation of ERISA. It rejects some claims because of the “upheaval that would follow,” and others based on the “risk to the efficiency of federal courts” that might result from legal actions pursued under the auspices of ERISA. In short, cases of this sort rest heavily on the Court’s ability to assess and predict the substantive consequences of particular interpretations of the law.

As we have seen, the Court is woefully inept in these efforts. This is not
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simply because the judiciary is ill-equipped to draw inferences about complex policies in technologically vibrant sectors of American society. It is also because the Court fools itself. In purporting to restrict its scope of discretion, by deferring to other branches of government, it only masks the extent to which its decisions are still based on presumptions about policy and its consequences. The more these choices are cloaked, the more apt they are to be made in a poorly informed manner, and the more likely it is that their implications will be misread by the public and the media. Candor about the limitations of judicial interpretation will not in itself remedy these problems, but they can be made more visible, and hence more readily understood, by those whose lives are affected by the judgments.
References


5. The general challenges facing elected officials are discussed by BRYAN D. JONES, RECONCEIVING DECISION-MAKING IN DEMOCRATIC POLITICS: ATTENTION, CHOICE AND PUBLIC POLICY 78-101 (1990) and DOUGLAS ARNOLD, THE LOGIC OF CONGRESSIONAL ACTION (1994). Whiteman offers a compelling example involving congressional deliberations about how to pay physicians under the Medicare program. “The same may be true about all of the gory details of the physician payment issue; we may not want to know them. Our elected officials certainly don’t know them. During a briefing for members of the Senate Finance Committee, in preparation for the conference committee negotiations with the House, ‘it was clear these guys were coming from nowhere land.’ Staff members were cringing on the sidelines, exchanging ‘looks of astonishment at each of the questions the members were raising’ and hoping that their own member would not embarrass them.” WHITEMAN, supra note 4, at 51.


8. Clark C. Havighurst, American Health Care and the Law - We Need to Talk!, HEALTH AFF., Jul-Aug. 2000, at 84, 92 (“ERISA was enacted in response to some highly publicized instances of fraud and mismanagement with respect to pension funds and was not perceived by Congress as a health care measure at all.”).


13. A number of commentators mistakenly limit the discussion to the first two roles. E.g., Sage, supra note 11, at 222. This is roughly equivalent to the suggestion that the legal system depends only on effective representation for plaintiff and defendant, without recognizing the role played by the judge in ensuring that the two attorneys meet on roughly equivalent terms. For an elaboration of the three-actor schema, see Mark Schlesinger, Countervailing Agency: A Strategy of Principled Regulation under Managed Competition, 75 MILBANK Q. 35 (1997).


15. Pegram, 530 U.S. at 220.
16. Id.


19. Pegram, 530 U.S. at 221.
20. Id. at 222.
22. Pegram, 530 U.S. at 233.
23. Id.


Justice Souter makes the even less plausible claim that Herdrich’s claims might well portend the end of nonprofit HMOs as well. Since these nonprofit plans already operate under a nondistribution constraint that forbids profit-sharing with those affiliated with the plan, this claim is most implausible. Pegram, 530 U.S. at 234 n.11.

27. Pegram, 530 U.S. at 233.
28. Id. at 232.
29. Id. at 233.
30. Id. at 237.