LEGAL REPORT

U.S. Health Care After Pegram: Betrayal At The Bedside?

Are physicians' incentives to withhold care a breach of patients' trust, or are they essential for clinical efficiency?

by M. Gregg Bloche

In the 1990s the nay-saying health maintenance organization (HMO) bureaucrat became an icon of cold-heartedness in our national life. Americans who shopped tirelessly for the best prices on products and services, elected politicians who promised no new taxes, and otherwise pushed health care payers to resist rising costs nonetheless expected all imaginably beneficial care for themselves and their loved ones—and punishment for health plan officials who said no. HMO horror stories became the stuff of campaign stump speeches, and plaintiffs' lawyers targeted plan managers when medical parsimony went awry.

Through the mid-1990s the managed care industry blunted these legal attacks by persuading the courts that federal law immunized employer-provided health plans from suit for the consequences of care withheld. But rising popular ire put pressure on the industry, through both politics and the marketplace, to rely less on nay-saying bureaucrats to control costs. By the late 1990s health plans were on the defensive in Congress against a “strange bedfellows” alliance of provider groups and consumer advocates—and Republicans and Democrats—intent on ending the industry’s immunity from liability for negligent utilization review (UR).

Although the industry has so far fought off this alliance, congressional debate over whether health plans, like diplomats, should be immune from suit further sullied managed care’s public image. In a tightening labor market, driven by unprecedented economic prosperity, this image problem made a difference. Competing to attract and retain skilled workers, many employers eschewed health plans with anxiety-provoking features, opting instead for coverage models that offered more choice than did hierarchically administered HMOs. Plans responded by “dis-integrating” financing and physician and hospital services, devising customized provider networks for different employers (or other purchasers), and delegating utilization management (UM) to physician groups. Several late 1990s court decisions encouraged these developments by hinting at a contraction of the industry’s immunity from suit for utilization decisions. Physicians’ resistance to health plans’ utilization controls was another factor.

As plans delegated UM to treating physicians, they looked to put these physicians at risk for the costs of care. Myriad capitation schemes, bonuses, withholds, and ownership and profit-sharing arrangements today reward clinical frugality, often without regard for clinical outcomes. These diverse financial incentives defy description and categorization. Some are offered directly by health plans to individual physicians, but many are mediated by physician groups, which accept risk from health plans, then allocate it to individual clinicians. There has been little systematic study of the scope or intensity of risk-bearing by individual physicians, but it is clear that the past several years have seen a wholesale shift of UM responsibility—and financial risk—from health plans to medical groups.

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Pegram v. Herdrich involved a challenge to this move toward much greater reliance on financial rewards for frugal practice. Contrary to what the managed care industry alleged (and some in the media reported), the case entailed neither a wholesale attack on managed care nor an attempt to dismantle all financial incentives to control costs. The injured patient in Pegram challenged neither the basic idea of prepaid care (and the budgetary restraint it requires) nor the UM, cost-conscious clinical practice, and focus on health promotion and disease prevention that have long been vital to managed care. Although an intemperate lower court opinion issued broadsides against managed care—and against all rewards to physicians for cost-conscious practice—the patient's attorney asked the Supreme Court merely to interpret the Employee Retirement Income Security Act (ERISA), which governs employment-based health benefits, to permit the courts to set limits on the use of financial rewards for withholding care.

An amicus brief filed by thirty-five health law, policy, and ethics scholars pointed to ways that the Court could do so without greatly disrupting the industry or undermining its ability to contain costs.

Physicians' Incentives. The incentive scheme employed by the HMO in Pegram involved profit sharing by the plan's physician-owners. Trying to elude the industry's charge that he was targeting all physician incentives, the patient's attorney asked the Court to distinguish between such profit sharing and more common incentive devices, such as capitation, bonuses, and withholds. But this proposed distinction bore no relation to the intensity of the financial pressure that incentive schemes create. This pressure is a function of the amount of physician income at risk, a thing unconnected to an incentive plan's contractual form, be it profit sharing, capitation, or otherwise. The justices thus sensibly declined to treat profit sharing differently from other incentive models.

The countervailing policy and ethics arguments that surround physicians' incentives to limit services did not surface in the Court's opinion. Proponents contend that cost management by treating physicians is more efficient than UR by remote administrators, since the former is cheaper to administer and clinical caretakers know the most about their patients' conditions and needs. But many clinicians and ethicists worry about the departure from the ethic of clinical fidelity to patients that financial rewards for withholding treatment entail. Legal acceptance, let alone promotion, of such incentives, they believe, turns private betrayal into public policy. Patients take comfort from clinical explanations; reveal intimate facts about themselves; and accept unpleasant, sometimes risky recommendations because they believe that their doctors will keep faith. Paying doctors more to do less, the argument goes, corrodes this confidence to a greater degree than do comparably strong fee-for-service incentives.

Some commentators dismiss these fears, arguing that insurance has rendered the Hippocratic ideal of undivided loyalty to patients obsolete and that physicians should embrace an alternative ethic that blends obligations to individuals and stewardship of collective resources. Patients who pay little or nothing out of pocket for services don't care whether the clinical benefits are worth the cost, this critique holds, and doctors who indulge their patients' cost-blind wishes are coconspirators in social waste. Rewards for withholding care, it is said, are a needed countermeasure to the waste that insurance, alongside Hippocratic loyalty, engenders.

Fiduciary Duty under ERISA. These difficult issues smoldered beneath the legal arguments in Pegram about the fiduciary-duty provisions of ERISA. ERISA's preemption of state
law has long been the managed care industry's shield against tort liability, but the injured patient in Pegram tried to wield ERISA as a sword against the profit-sharing scheme at issue. Each side made formalistic arguments, beyond this essay's scope, about whether ERISA's fiduciary-duty language applied to UM by treating physicians and, if so, whether this language limited plans' ability to offer rewards for withholding care. But the underlying struggle in the case was between the injured patient's portrayal of such rewards as both a breach of trust and a threat to health care quality and the industry's defense of them as vital to its own survival, as well as to pursuit of clinical efficiency.

To be sure, the Supreme Court could not simply opine as to the proper resolution of this struggle, and the associated ethics and policy issues, without regard for the language of ERISA and the clarity of the Court's ruling as a guide for lower courts and potential litigants. ERISA's ambiguity gave the justices flexibility to rule either way on whether utilization management by treating physicians is a fiduciary function and, if so, whether limits on these physicians' financial incentives are needed to protect plan participants. But this ambiguity, along with the enormous variety (and range of intensity) of physician incentive arrangements, made the setting of clear, predictable limits a daunting task for the justices—and the lower courts.

The Supreme Court declined to undertake this task. The justices conceded that health plans make benefit-eligibility decisions through the treating physicians whom they reward for limiting care. But the Court then drew a line between the injured patient’s portrayal of such rewards as both a breach of trust and a threat to health care quality and the industry’s defense of them as vital to its own survival, as well as to pursuit of clinical efficiency.

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breach of trust at the bedside do not count.

To be sure, fiduciary duty under ERISA is a different notion than the Hippocratic ethic of fidelity to individual patients. ERISA plan administrators owe fiduciary duties to employee-beneficiaries as a group. To require a health plan administrator to act only in the interest of a sick patient, as the plaintiff in Pegram tried to do, would be to require her to abdicate her stewardship of the risk pool as a whole. Yet to the extent that the professional ethic of fidelity to individual patients is socially desirable, regard for it is in the interest of beneficiaries as a group. The conflict between responsibilities to the sick and to the risk pool as a whole is as poignant under ERISA as in society more generally. In saying little about how plan administrators should manage this conflict and not acknowledging the constraints that the ethic of fidelity to individuals puts upon treating physicians’ ability to strike a balance, the justices passed on two of the central moral questions in American medicine.

As many have noted, Pegram left open the possibility of plan liability under ERISA for failure to tell subscribers about physicians’ financial incentives to limit care. More importantly, though, the Court said that “mixed” treatment and coverage decision making is actionable under state law, clearing the way for state suits targeting the types of incentives at issue in Pegram—and perhaps opening the door to plan liability for negligent UM. Pegram’s biggest impact, therefore, will be to shift the locus of legal action to the states as conflict over health plans’ efforts to influence clinical decision making continues unabated.

Rationing. Beyond this, the Court did the nation a moral service with its bracing candor about rationing. Eschewing industry euphemism, the Court said that “inducement to ration care goes to the very point of any HMO scheme” and that congressional promotion of HMOs constitutes endorsement of “the profit incentive to ration care.” In so doing, the Court challenged Americans to come to terms with the conflict that animates most health law disputes: the conflict within ourselves, between our desire to control costs and our insistence on care without compromise for ourselves and our loved ones.

The challenge for health plans is to come up with creative ways to manage this contradiction. Over the long haul, paying physicians to ration furtively, under cover of promises of “medically necessary” care, is unlikely to succeed. Americans are likely to find out and to feel betrayed—and to become as irate about bedside gatekeepers as they are now toward remote HMO bureaucrats. This challenge, not class-action lawyers or aggressive regulators, poses the greatest threat to managed care.

Preparation of this commentary was supported by a Robert Wood Johnson Foundation Investigator Award in Health Policy Research. The author thanks Carol Banta, Peter Jacobson, Marc Rodwin, and William Sage for their comments and suggestions.

NOTES

3. Courts crafted an artificial distinction between treatment and coverage decisions (or between the “quality” and “quantity” of health care provided), allowed malpractice suits to proceed in the case of the former, and began to shrink the latter category (and thus to reduce the industry’s immunity).
8. The amicus brief filed in Pegram by thirty-five health law, policy, and ethics scholars (including the author) offered a detailed interpretive path to “yes” answers to both of these questions.