The Courts And Managed Care

by M. Gregg Bloche

Strangers in the Night: Law and Medicine in the Managed Care Era
by Peter D. Jacobson
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Today's medical marketplace is mostly a judicial creation. In the 1980s the U.S. Supreme Court's market-oriented readings of the law governing employees' fringe benefits created hothouse conditions for the growth of managed care. The Justices—and compliant lower courts—construed this law to broadly preempt state authority over the content and administration of health insurance benefits. In the early 1990s the courts read this preemption to immunize managed health plans from state lawsuits for denial of care.

The federal law at issue, the Employee Retirement Income Security Act (ERISA), was conceived without medical care in mind. Enacted almost thirty years ago, when health insurers paid passively for whatever the doctor ordered, it imposed no substantive duties on health plans. Through the mid-1990s the industry enjoyed extraordinary freedom from regulatory constraint and legal accountability. More recently, though, the legal tradewinds have changed. At first cryptically, then more clearly, the U.S. Supreme Court signaled its intent to reverse course on ERISA preemption and to permit the states to reassert legal authority over the health care sphere. The states have done so, with a vengeance.

Strangers in the Night tells the story of the managed care industry's early success and subsequent failures at resisting regulation. Peter Jacobson enriches this story with discussion of how the different perspectives of medicine and law complicate legal governance and conflict management in the health sphere. The great strength of Jacobson's book is that it renders this complex story accessible to readers concerned about health care policy but unfamiliar with the law; its greatest flaw is that it tries to do too much.

In 270 pages, Jacobson offers a crash course in basic legal concepts, the economics of managed care, the convolutions of ERISA, and the sources of misunderstanding between practitioners of medicine and law. He then proposes his own approach to health care law's central dilemma: the tension between individual need and stewardship of limited social resources. His inventive proposal, which ought to be a must-read for judges, health lawyers, and policymakers, is at risk of getting lost amid material meant as a primer for readers unfamiliar with the workings of managed care and the basics of American law.

I confess that I do not speak to Jacobson's work from a disinterested perspective. We have been coauthors, and we collaborated on an amicus brief for the U.S. Supreme Court in Pegram v. Herdrich, highlighting the problem of role conflict when physicians act as both clinical caretakers and health plan gatekeepers. Thus, I warm to his plea to policymakers and the courts to take the professional ethic of fidelity to patients more seriously than most have so far. Delegating utilization management to treating physicians, then rewarding them fi-
nancially for restricting care, raises a host of is-

dues that regulation skeptics tend to disregard. A market-driven health care system can and
should make space for professional fidelity to
patients—and for the human needs that long
ago gave rise to this ethic.

Jacobson proposes a way of doing so. He
urges judges to build upon the common law
concept of fiduciary duty, which requires ac-
tors to abjure pursuit of economic self-interest
when they enter into contractual relationships
with people ill-situated to assess the quality of
contractual performance. The law imposes fi-
duciary duties on trust fund managers, corpo-
rate directors, attorneys, and physicians, on the
grounds that trust beneficiaries, shareholders,
clients, and patients lack the knowledge re-
quired to reward and punish contractual per-
formance. By nurturing trust in situations that
invite skepticism, fiduciary obligations open
possibilities for mutually beneficial exchange
that would not otherwise occur.

These duties require actors to refrain from
self-dealing at beneficiaries' expense, and they
are thus well matched to situations in which
beneficiaries have common interests. As Jacob-
son concedes, though, the concept of fiduciary
duty does not by itself provide answers when
beneficiaries have competing interests. Fidu-
ciary norms oblige trustees and directors, fund
managers, and others to be prudent stewards
of the financial commons, but they do not speak
to the question of how resources should be di-
vided when people's conflicting needs are mat-
ters of administrative discretion.

Jacobson's answer is that robust affirmation
of fiduciary rules against financial advantage
taking can lay a foundation for public trust in
payers' exercise of discretion. Conflicts of obli-
gation—to individual patients versus the risk
pool—are inevitable, but conflicts of interest
are not. Cost containment, he reluctantly con-
cedes, requires that beneficial care be withheld.
Yet neither utilization reviewers nor gatekeep-
ing clinicians should be influenced by monetary
rewards for denying care. Beyond this, Jacobson
proposes that payers narrow their discretion as
judges do, by giving reasons for utilization
management decisions, aiming for consistency
in these decisions, and making their reasons
accessible to clinicians and consumers.

Might this blend of fiduciary obligation,
transparency, and procedural due process be
the antidote to Americans' skepticism about
managed care? It is worth trying. The Supreme
Court's reversal on ERISA preemption pre-

ts the states with an opportunity for doing
so. Laws in more than forty states mandating
that independent medical review of coverage
denials be available ensure a measure of due
process. The Supreme Court's decision last
June, in Moran v. Rush Prudential HMO, put these
laws out of ERISA's preemptive reach and
cleared the way for more robust state regula-
tion of managed care. But the Court's curious
doctrinal route—treatment of medical review
as more akin to a doctor's "second opinion"
than to a legal proceeding—limits independ-
ent review's potential as a tool for transform-
ing utilization management into a process
marked by reason giving, transparency, and
consistency.

Moreover, as Jacobson notes, courts have
been reluctant to limit financial incentives un-
der the rubric of fiduciary duty, and they have
shown mixed willingness to require that such
incentives be disclosed. Meanwhile, in re-
sponse to market pressures, health care payers
are now moving away from aggressive utiliza-
tion management and financial rewards for
frugal practice. Higher copayments and de-
ductibles are the current cost containment
fashion. It may be premature to proclaim, as
some have, the "death of managed care," but
conflict over the industry's cost-control meth-
ods could fade without being resolved.

Should this happen, judges will still have
much to say about health care. They are Amer-
ica's health policymakers of last resort, called
upon to manage our contradictory demands
for limits on spending and limitless access.
Jacobson's book offers lawyers and judges an
opportunity to better understand the things
that health care litigants quarrel about. It is
also an invaluable resource for providers and
policymakers who want to better understand
the law's stylized, sometimes mystifying treat-
ment of these quarrels.